EXAMINING THE IMPACT OF ILLEGAL IMMIGRATION ON THE MEDICAID PROGRAM AND OUR HEALTHCARE DELIVERY SYSTEM

HEARINGS

BEFORE THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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EXAMINING THE IMPACT OF ILLEGAL IMMIGRATION ON THE MEDICAID PROGRAM AND OUR HEALTHCARE DELIVERY SYSTEM

THURSDAY, AUGUST 10, 2006

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Brentwood, TN.

The committee met, pursuant to notice, at 10:00 a.m., in the Main Room, Brentwood City Hall, 5211 Maryland Way, Brentwood, Tennessee, Hon. Nathan Deal [member of the committee] presiding.

Members present: Representatives Deal and Blackburn.

Staff present: Ryan Long, Counsel; Brandon Clark, Policy Coordinator; Chad Grant, Legislative Clerk; Purvee Kempf, Minority Professional Staff Member.

MR. DEAL. The Committee will come to order, and the Chair recognizes himself for an opening statement.

This morning will hold the first session of a 2-day field hearing entitled, "Examining the Impact of Illegal Immigration on the Medicaid Program and Our Healthcare Delivery System."

Today, we will hear from three panels of distinguished and expert witnesses about the impact that illegal immigration is having on our healthcare delivery system and get their perspective on a few recent legislative provisions that were produced by this Committee in an effort to help address this ever-growing problem.

Once this portion of the field hearing has concluded, we will recess until Tuesday morning, at which point we will reconvene in Dalton, Georgia, to learn more about how illegal immigration is impacting that community and what steps Governor Perdue and others in Georgia are taking to address this problem.

Given that there are well over 11 million illegal aliens currently residing in the United States and the fact that this number is rapidly growing every day that we allow our borders to remain unsecured and our immigration laws to remain unenforced, there is no question that the problem of illegal immigration is one of the most important public policy debates currently in Congress.

I stand with my Republican colleagues in House in strong support of enacting an immigration reform bill that does what the American people expect and deserve.

We want to strengthen our borders and enforce our immigration laws. Because as any healthcare provider will tell you, an ounce of prevention is certainly worth a pound of cure.

Unfortunately, it is clear that there are those on the other side of this issue that have absolutely no plan for securing our borders and no plan for stopping the flood of illegal immigration that is currently negatively impacting our public safety, our children's schools, and our healthcare system.

In 1996, Congress responded to the will of the people and passed the Illegal Immigration Reform and Immigration Responsibility Act, and one of the main provisions of that legislation was to limit all Federal benefits, including Medicaid coverage, to those who are lawfully in the United States.

Of course, people on the other side of this issue opposed that provision back then because they believed that your hard-earned tax dollars should go to pay for healthcare services for people that are in this country illegally.

And, it is a lot of these same people that are now opposing our efforts, to ensure that only citizens get access to the taxpayer-funded benefits.

The most unfair thing about what our opponents are advocating is that an illegal immigrant on Medicaid would almost certainly have a better healthcare benefits package than what is available to most taxpayers who are paying for those Medicaid benefits, and are paying for their own healthcare out of their own pockets.

Of course, we are not just sitting back and waiting for one single comprehensive legislative solution to pass both Houses of Congress. We intend to address this problem whenever and wherever we can.

To help address the negative impact of illegal immigration on our healthcare system, the Energy and Commerce Committee produced two important provisions in the Deficit Reduction Act of 2005, which is commonly known as the "DRA."

One of the provisions that I authored and fought to include in the DRA was a provision that requires States to obtain documentary evidence that the person applying for Medicaid benefits is actually a United States citizen, as required by law.

This is not a new concept for government programs, since the Medicare and SSI programs both require proof of citizenship for all beneficiaries. It's just that Medicaid hasn't been seriously reformed since the 1960s and was a little behind the times.

Before the enactment of this provision, the Inspector General of the Department of Health and Human Services found that 46 States and the District of Columbia allowed self-declaration of citizenship for Medicaid eligibility, and 27 of those States never verified any citizenship statements at any point.

This means that people simply had to say that they were citizens, in whatever language they choose to say it in, and that they would be eligible for thousands of dollars of taxpayer funded Medicaid benefits.

I believe that is simply unacceptable.

Of course, the advocates on the other side of this issue fought very hard to prevent this provision from being included in the DRA and they fought very hard to defeat this needed legislation when it was being voted on by Congress.

And now, some of those same advocates are fighting just as hard to weaken this common-sense provision as much as possible, but it is my hope that those who are implementing this provision will stand firm on what I consider a very important issue.

Another provision we included in the Deficit Reduction Act was a provision to allow States the flexibility to impose cost sharing on healthcare services furnished in an emergency room that a physician determines is not a real medical emergency, such as an ear infection or strep throat.

To protect beneficiaries, this provision requires that an available and accessible alternative must be available to the beneficiary and the treating hospital must refer the individual to that alternative site in order for the co-pay, which we have provided, to be charged.

Like the citizenship-verification provision, this provision is designed to eliminate millions of dollars of waste in the Medicaid system by helping to ensure that Medicaid patients receive care in the most appropriate setting.

This provision, I believe, also helps patients. Studies have shown that patients who receive care in the appropriate setting have better healthcare outcomes.

As we all know, the ER is not the best place to receive primary care services or preventative healthcare.

Although this provision only applies to Medicaid beneficiaries, it will also help reduce some of the negative impact of illegal immigrants improperly utilizing the ER, and it provides $50 million in grant funding to the States to establish alternative non-emergency providers in communities across the United States.

In addition to the increased number of alternative non-emergency providers, this provision will also make hospital personnel more familiar and comfortable with referring non-emergency patients to the appropriate

healthcare providers. It will also increase communication between ER personnel and those non-emergency providers.

The logic behind this provision is also very simple. It costs approximately $340 to care for a non-emergency patient in the emergency department while it costs less than $70 to care for the same patient in a health clinic or physician's office.

That means over five people can be treated in a physician's office for less money than one person can be seen in the emergency department.

Again, I believe that this is a common sense approach to reforming a Medicaid program, and I believe it is one of those serious reforms that we should help sustain.

As always, I am looking forward to having a cooperative and productive conversation on this topic today and to working with my colleagues to come up with even more effective solutions to the problems that I'm sure we will address during this hearing.

Again, I would like to thank all of our witnesses who will be participating today. We look forward to hearing your testimony.

And again, I express my appreciation to Congresswoman Blackburn and her staff.

At this time, as a part of the committee formalities, I would like to ask unanimous consent that all Members be allowed to submit statements and questions for the record. Without objection, it is so ordered.

I would also like to ask unanimous consent that all members be given 10 minutes of question time per panel and that all members be given 5 minutes for opening statements at both venues of this field hearing, and, without objection, it is so ordered.

I would like at this time to recognize my friend from Tennessee, Mrs. Blackburn, for 5 minutes for an opening statement.

[The prepared statement of Nathan Deal follows:]

PREPARED STATEMENT OF THE HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

- The Committee will come to order, and the Chair recognizes himself for an opening statement.
- This morning will hold the first session of a two-day field hearing entitled "Examining the Impact of Illegal Immigration on the Medicaid Program and Our Healthcare Delivery System."
- Today, we will hear from three panels of distinguished and expert witnesses about the impact that illegal immigration is having on our healthcare delivery system and get their perspective on a few recent legislative provisions that were produced by this Committee in an effort to help address this ever-growing problem.

- Once this portion of the field hearing has concluded, we will recess until Tuesday morning, at which point we will reconvene in Dalton, Georgia, to learn more about how illegal immigration is impacting that community and what steps Governor Perdue and others in Georgia are taking to address this problem.
- Given that there are well over 11 million illegal aliens currently residing in the United States and the fact that this number is rapidly growing every day that we allow our borders to remain unsecured and our immigration laws to remain unenforced, there is no question that the problem of illegal immigration is one of the most important public policy debates currently before Congress.
- I stand with my Republican colleagues in House in strong support of enacting an immigration reform bill that does what the American people expect and deserve.
- We want to strengthen our borders and enforce our immigrations laws. Because as any healthcare provider will tell you, an ounce of prevention is worth a pound of cure.
- Unfortunately, it is clear that those on the other side of the issue have absolutely no plan for securing our borders and no plan for stopping the flood of illegal immigration that is so negatively impacting our public safety, our children's schools, and our healthcare system.
- In 1996, Congress responded to the will of the people and passed the "Illegal Immigration Reform and Immigrant Responsibility Act," and one of the main provisions of this legislation was to limit all Federal benefits, including Medicaid coverage, to those who are lawfully in the United States.
- Of course, people on the other side of this issue opposed this provision back then because they believed that your hard-earned tax dollars should go to pay for healthcare services for people that are in your country illegally
- And it is a lot of these same people that are now opposing our efforts to ensure that only citizens get access to the taxpayer funded benefits.
- The most unfair thing about what our opponents are advocating is that an illegal immigrant on Medicaid would almost certainly have a better healthcare benefits package that what is available to most of the taxpayers who are paying for those Medicaid benefits.
- Of course, we are not just sitting back and waiting on a single comprehensive legislative to pass both Houses of Congress. We intend to address this problem whenever and wherever we can.
- To help address the negative impact of illegal immigration on our healthcare system, the Energy and Commerce Committee produced two important provisions in the Deficit Reduction Act of 2005, which is commonly known as the "DRA."
- One of the provisions that I authored and fought to include in the DRA was a provision that requires States to obtain documentary evidence that the person applying for Medicaid benefits is actually a U.S. citizen, as required by law.
- This is not a new concept for government programs, since the Medicare and SSI programs both require proof of citizenship for all beneficiaries. It's just that Medicaid hadn't been seriously reformed since the 1960's and was a little behind the times.
- Before the enactment of this provision, the Inspector General of the Department of Health and Human Services found that 46 states and the District of Columbia allowed self-declaration of citizenship for Medicaid, and 27 of those States never verified any citizenship statements at any point.
- This means that people simply had to say that they were citizens, in whatever language they chose to say it in, and they would be eligible for thousands of dollars of taxpayer funded Medicaid benefits.
- This was simply unacceptable.
- Of course, the advocates on the other side of this issue fought very hard to prevent this provision from being included in the DRA and they fought very hard to defeat this needed legislation when it was being voted on by Congress.
- And now, these same advocates are fighting just as hard to weaken this common-sense provision as much as possible, but it is my hope that those implementing this provision will stand firm on this important issue.
- Another provision we included in the Deficit Reduction Act was a provision to allow States the flexibility to impose increased cost-sharing on healthcare services furnished in an emergency room that a physician determines is not a real medical emergency, such as an ear infection or strep throat.

- To protect beneficiaries, this provision requires that an available and accessible alternative must be available to the beneficiary and the treating hospital must refer the individual to that alternative site in order for the co-pay to be charged.
- Like the citizenship-verification provision, this provision is designed to eliminate millions of dollars of waste in the Medicaid system by helping to ensure that Medicaid patients receive care in the appropriate setting.
- This provision also helps patients. Studies have also shown that patients who receive care in the appropriate setting have better health outcomes.
- As we all know, the ER is not the best place to receive primary care services or preventative healthcare.
- Although this provision only applies to Medicaid beneficiaries, it will also help reduce some of the negative impact of illegal immigrants improperly utilizing the ER by providing $50 million in grant funding to the States to establish alternative non-emergency providers in communities across the United States.
- In addition to the increased number of alternative non-emergency providers, this provision will also make hospital personnel more familiar and comfortable with referring non-emergency patients to the appropriate healthcare providers. It will also increase communication between ER personnel and these non-emergency providers.
- The logic behind this provision is simple. It costs approximately $340 to care for a non-emergency patient in the emergency department while it costs less than $70 to care for the same patient in a health clinic or physician's office.
- That means over five people can be treated in a physician's office for less money than one person can be seen in the emergency department.
- Again, I believe that this is a common sense approach to reforming a Medicaid program that is in serious need of reform.
- As always, I am looking forward to having a cooperative and productive conversation on this topic today and to working with my colleagues to come up with effective solutions to the problems addressed at this hearing.
- Again, I would like to thank all of our witnesses for participating today. We look forward to hearing your testimony.
- And I would like to thank Congressman Blackburn and her staff for serving as such gracious hosts and for all their hard work that has made today's field hearing possible.
- At this time, I would like to ask for Unanimous Consent that all Members be allowed to submit statements and questions for the record.
- I would also like to ask for Unanimous Consent that all Members be given 10 minutes of question time per panel and that all Members be given 5 minutes for opening statements at both venues of this field hearing.
- With that, I would like to recognize my friend from Tennessee, Ms. Blackburn, for 5 minutes for an opening statement.

MRS. BLACKBURN. Thank you, Mr. Chairman. I thank you for visiting our 7th District today to investigate the financial burden that is placed on our healthcare system by illegal immigration.

I also want to say thank you to the City of Brentwood, to the Mayor, the Commissioners, and the staff, for their hospitality in welcoming us and allowing the use of this facility today. Thank you also to the Committee staff, to your staff, and to my staff, for the preparations that have gone into today's hearing.

I would like to also welcome and thank our witnesses who are joining us today to help our committee, the Energy and Commerce Committee, explore some of the anecdotal information we are hearing every day on the costs of this problem, and the problem that it is creating for our Nation's healthcare delivery.

I was a bit amused with the headline in the *Tennessean* today, and then a part in their article where it says, "... and a Washington, D.C. think tank has begun to counter the arguments that it thinks might be brought up today."

So, to our witnesses, may I assure you that we are definitely interested in, and want to hear, and need to hear, the information that you are bringing to us. It is not for the sake of argument that we come, but we come in search of solutions, and we thank you for joining us as we work toward a solution.

As the Chairman noted in his statement, for the past 20 years Federal benefits have been limited to those, to those, who have lawfully entered the United States. Yet, as we know, many of those legal limits are either ignored or avoided through fraud. We have a large and growing illegal entry problem, and along with that illegal entry we are increasingly finding that taxpayer funded benefits are being provided to illegal aliens.

The problem appears to be a mixture of legal loopholes, weak or nonexistent verification procedures, and false documentation. Our hope is that your testimony will, indeed, provide additional insight on these situations.

We know that the strain is on our emergency rooms, our schools, and our safety net programs for seniors and low-income Americans. They have already taken a toll, and it does not appear to be abating.

I do applaud Chairman Deal's work on the issue and his effort to reform the residency verification process in Medicaid. I strongly supported his effort to add language to the Deficit Reduction Act to ensure that states verify lawful presence in the U.S. before approving a benefit.

As the Chairman stated, today's hearing is one of many that will examine how States are implementing this money-saving provision and review the current status of Medicaid payments for both emergency and non-emergency care.

I want to state unequivocally that primary responsibility for preventing illegal entry rests with the Federal government. Border security is the Federal government's obligation, but it is also necessary for local and State governments to be vigilant partners in guarding taxpayer dollars and benefit programs like Medicaid from abuse.

It benefits States to diligently keep records on the illegal use of taxpayer-funded services. To be good partners, the Federal government and our States have to know the extent of the problem--that's one of the reasons, as I've said, that we are here today.

The House has also passed a border security bill which includes provisions of a bill I introduced to mandate the use of the Employer Verification Program. This one element I believe would help

Government and employers quickly verify an individual's legal presence in the United States. It's a free program, so it does not add cost to an employer's hiring process.

The primary point of our investigation is simple: We have limited resources to support programs for those in this country legally, and it is simply inappropriate that taxpayer dollars be used for those who have broken our laws and are defrauding our system. To know the extent of the costs involved, Congress must hold hearings like this one today.

I am looking forward to hearing from the witnesses on the costs that they are seeing and having their thoughts regarding how we might best address the misuse of taxpayer dollars. As I've said, your knowledge and your insights are vital components of a workable solution.

Again, I thank the Chairman for holding the hearing, and I yield back the balance of my time.

[The prepared statement of Marsha Blackburn follows:]

PREPARED STATEMENT OF THE HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mr. Chairman,

Thank you for visiting our 7th District today to investigate the financial burden being placed on our health care system by illegal immigration.

I also want to thank the witnesses joining us today to help our Energy and Commerce Committee explore some of the anecdotal information we're hearing every day on the costs this problem is creating for the nation's health care delivery.

For the past 20 years, federal benefits have been limited to those who are lawfully in the United States.

Yet, as we know, many of those legal limits are either ignored or avoided through fraud. We have a large and growing illegal entry problem and along with that illegal entry we're increasingly finding that taxpayer funded benefits are being provided to illegal aliens.

The problem appears to be a mixture of legal loopholes, weak or nonexistent verification procedures, and false documentation.

The strain on our emergency rooms, schools, and safety net programs for seniors and low-income Americans has already taken a toll and does not appear to be abating.

I applaud Chairman Deal's work on this issue and his effort to reform the residency verification process in Medicaid. I strongly supported his effort to add language to the Deficit Reduction Act to ensure that states verify lawful presence in the U.S. before approving a benefit.

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It benefits states to diligently keep records on the illegal use of taxpayer-funded services. To be good partners, the Federal government and our States have to know the extent of the problem -- that's one of the reasons we're here today.

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The primary point of our investigation is simple -- We have limited resources to support programs for those in this country legally and it is simply inappropriate that taxpayer dollars be used for those who've broken our laws and are defrauding our system. To know the extent of the costs involved Congress must hold hearings like this one.

I am looking forward to hearing from the witnesses on the costs they're seeing and thoughts regarding how we might best address this misuse of taxpayer dollars.

Again, I thank the Chairman for holding this important hearing and yield the balance of my time.

MR. DEAL. Well, I thank the gentlelady, and at this time we are ready to proceed into the testimony from the first panel of witnesses, and if they would both take their seat at the podium here.

We are pleased to have as our first panel Representatives from the legislature here in the State of Tennessee. First of all, the Honorable Bill Ketron, who is a Tennessee State Senator; and the Honorable Donna Rowland, who is a Member of the Tennessee House of Representatives.

Lady and gentleman, we are pleased to have you here. Normally, southern hospitality would require that I recognize the gentlelady first, but in looking at her statement she sort of makes a reference to your statement first Senator, I will begin with you.

You are recognized, Senator Ketron.

STATEMENTS OF HON. BILL KETRON, MEMBER, TENNESSEE STATE SENATE; AND THE HON. DONNA ROWLAND, MEMBER, TENNESSEE STATE HOUSE OF REPRESENTATIVES

MR. KETRON. Thank you very much, Mr. Chairman, members of the subcommittee.

I would like to first welcome you to the great State of Tennessee, the Volunteer State, and hope you enjoy your short stay here with us today. We are very proud of our State and its leaders, including the Congressman from the 7th District, Marsha Blackburn.

I also want to take the opportunity to meet with you today to discuss the illegal immigration problem here in the United States, and specifically here in Tennessee.

I will start by repeating something that I heard the other day, which is very relevant. Every State is a border State. Ten years ago, many people would have chuckled if you said that illegal immigration would have been a problem anywhere, except for Texas, Arizona, California, or

New Mexico. In Tennessee, particularly over the last few years, the number of illegal immigrants have appeared to rise dramatically.

As a State Senator, I have spent the past 4 years working on changes in our public policy in regard to illegal immigration. One of the specific areas of concern to me was that the ease for illegal immigrants to obtain valid Tennessee driver's licenses. I have heard repeatedly the stories and news accounts of the astounding number of immigrants coming to Tennessee to get a driver's license. I did not feel that Tennessee needed to be in the business of providing driver's licenses to those who had not established their true identity so that they could be free to move about the country. I am proud to say that Tennessee now prohibits the acceptance of matricular consular card by the Department of Safety as proof of identification for the driver's license application and issuance purposes.

I also feel Tennessee has been attractive to illegal immigrant population due to one of the most generous healthcare plans in the United States which is called TennCare. Although there is debate over how much Medicaid actually goes to illegal immigrants, it is very clear that the emergency care in the hospitals and state clinics have felt the burden of healthcare to the community.

Furthermore, Tennessee's job opportunities due to tremendous growth have spurred the need of thousands of jobs that illegal immigrants are willing to do for less money than the legal citizen workforce.

I hear many individual accounts of how illegal immigration has taken a toll on Tennessee, but three common themes persist. First, illegal immigration is eating away at the foundation of our State's healthcare systems. Second, our K-12 educational systems are struggling to deal with a huge influx of illegal aliens--many of whom do not yet speak English or read English. Third, our law enforcement system is besieged with the problem of how to deal with the rising number of illegals crowding jails that are already at capacity, not to mention the rise of violent crimes committed by undocumented immigrants.

These are some of the questions that I have been asked. How many illegal immigrants are getting free healthcare while Tennesseans go without?

How many of our tax dollars are spent on healthcare for illegal immigrants?

How many of the prisoners in our State and local prisons are illegal immigrants?

What is the effect of having children in our classrooms who cannot speak English?

Is it true that illegal immigrants are still getting driver's licenses?

How many Tennesseans have been victims of crimes at the hands of illegal immigrants?

We, here in Tennessee, are working to find the answers but we could use your help.

At their core, the people in Tennessee want to see Tennessee families come first. This State has to make a decision to remove several thousand people from receiving healthcare, yet when illegal immigrants continually fill our emergency rooms and State clinics, people want to know why their neighbors and relatives don't have greater access to healthcare.

Tennesseans want criminals locked up and off the streets, and when they realize that our prisons are overcrowded and our tax dollars are paying for illegal immigrants who should not be here in the first place, they question our law enforcement priorities. We must protect our citizens from the most dangerous criminals.

Tennessee has fallen behind in education, and teachers are forced to lay a foundation for many of our students who cannot yet speak or read English while trying to advance students who have mastered and passed the basics. We have to challenge the students, not slow them down.

Aside from the three prevailing themes I have already mentioned, I personally plan to continue my focus on the driver's license restrictions in our State. We have got to protect our citizens on the road every day. I have fought for English-only driver's testing in Tennessee, but that was a small fix considering we have many illegal immigrants on the road every day. Tennessee has been unfortunate through this summer to see its issues effects on the lives of people every day.

I would like to conclude my remarks by saying that it's been an honor to address this distinguished body. I hope that together, at both the State and the Federal level, we can come up with some common-sense solutions to solve the problem now but not later.

Mr. Chairman, we, here in Tennessee, feel the same way that you do in Washington. Our forefathers came here to establish laws that all of us as citizens of this country must obey. We, like Representative Rowland, ourselves, like you, you established laws that we all must abide by to keep from having chaos in our country.

When we pass laws for people to abide, it's not fair to turn a blind eye for those who don't have to obey the laws, and that's what's happening and it continues, and that's what's causing the divide in this country. We must all obey the laws, no matter who you are or where you come from. And, if it says that you are legal, then you must be legal. That is the law. That's all we request.

Thank you.

[The prepared statement of Bill Ketron follows:]

PREPARED STATEMENT OF THE HON. BILL KETRON, MEMBER, TENNESSEE STATE SENATE

Mr. Chairman, Members of the Subcommittee:

I would like to first welcome you to the great state of Tennessee, the Volunteer state, and hope you enjoy your short stay. We are very proud of our state and its leaders, including the Congressman from the 7th District, Marsha Blackburn.

I want to also thank you for the opportunity to meet with you today to discuss the illegal immigration problem in the United States, and specifically here in Tennessee.

I will start by repeating something I heard the other day that is very relevant. Every state is a border state. Ten years ago many people would have chuckled if you said that illegal immigration would be a problem anywhere except Texas, Arizona, California, and New Mexico. In Tennessee, particularly over the last few years, the number of illegal immigrants has appeared to rise dramatically.

As a state Senator, I have spent the past 4 years working on changes in our public policy in regard to illegal immigration. One of the specific areas of concern to me was the ease for illegal immigrants to obtain a valid Tennessee driver's license. I have heard repeatedly the stories and news accounts of the astounding number of immigrants coming to Tennessee to get a driver's license. I did not feel that Tennessee needed to be in the business of providing driver licenses to those who had not established their true identity so that they could be free to move about the country! I am proud to say Tennessee now prohibits the acceptance of matricula consular cards by the Department of Safety as proof of identification for a driver's license application and issuance purposes.

I also feel Tennessee has been attractive to the illegal immigrant population due to one of the most generous healthcare plans in the United States--TNCare. Although there is a debate over how much Medicaid actually goes to illegal immigrants, it is very clear that emergency care in the hospitals and state clinics have felt the burden of healthcare to this community.

Furthermore, Tennessee's job opportunities due to tremendous growth have spurred the need for thousands of jobs that illegal immigrants are willing to do for less money than the legal citizen workforce.

I hear many individual accounts of how illegal immigration has taken a toll on Tennessee, but three common themes persist. First, illegal immigration is eating away at the foundations of the states Health Care systems. Second, our K-12 educational systems are struggling to deal with a huge influx of illegal aliens—many of whom do not yet speak or read English. Third, our law enforcement system is besieged with the problem of how to deal with rising numbers of illegals crowding jails that were already at capacity — not to mention the rise in violent crimes committed by undocumented immigrants.

These are some questions that I have been asked:

How many illegal immigrants are getting free health care while many Tennesseans go without?

How many of our tax dollars are spent on health care for illegal immigrants?

How many of the prisoners in our state and local prisons are illegal immigrants?

What is the effect of having children in our classrooms who cannot speak English?

Is it true that illegal immigrants are still getting driver's licenses?

How many Tennesseans have been victims of crimes at the hands of an illegal immigrant?

We, here in Tennessee, are working to find the answers but we could use your help.

At their core, the people in Tennessee want to see Tennessee families come first. This state had to make a decision to remove several thousand people from receiving healthcare, yet when illegal immigrants continually fill our emergency rooms and state clinics, people want to know why their neighbors and relatives don't have greater access to healthcare.

Tennesseans want criminals locked up and off the streets, and when they realize that our prisons are overcrowded, and our tax dollars are paying for illegal immigrants who should not be here in the first place, they question our law enforcement priorities. We must protect our citizens from the most dangerous criminals.

Tennessee has fallen behind in education, and teachers are forced to lay a foundation for many of our students who can't yet speak or read English while trying to advance students who have mastered and passed the basics. We have to challenge our students, not slow them down.

Aside from the three prevailing themes I have already mentioned, I personally plan to continue my focus on driver's license restrictions in our state. We have got to protect our citizens on the road every day. I have fought for English-only driver's testing in Tennessee, but that is a small fix considering we have many illegal immigrants on the road every day. Tennessee has been unfortunate enough this summer to see how this issue affects the lives of people every day.

I would like to conclude my remarks by saying what an honor it has been to address this distinguished body. I hope that together, at both the state and federal level, we can come up with some common sense solutions to solve this problem now - not later.

MR. DEAL. Thank you, Senator.

Representative Rowland, you are recognized for your statement.

MS. ROWLAND. Good morning, Mr. Chairman, honorable members of the subcommittee. It's a pleasure to be here today and to give some southern charm to each of you.

I want to welcome you to Tennessee and for this opportunity to express my community's concerns regarding illegal immigration.

My colleague, Senator Ketron, has done an excellent job of providing you an overview of the issues we hear on a daily basis.

I first want to commend you on the passage of the Deficit Reduction Act with the inclusion of the Citizenship Verification Provision. But, please allow me to express some strengths that must remain a part of that provision.

Since acceptable documentation under this provision includes driver's license, the Federal government must immediately require States to issue driver's license and any other government-issued document only to those that can prove that they are a citizen or legal resident of said State.

In the case of questionable self-documents and declarations, simply requiring that a reasonable person find such statement suspect cause a very legally challengeable situation. The term reasonable is open for interpretation. Unfortunately, we can no longer take for granted that your definition of reasonable or my definition of reasonable mirrors anybody else's definition of reasonable.

Regrettably, self-declaration or the honor system has not proven to be a trusted avenue for citizenship verification. Our country has spent years, via the Social Security Administration and the department formerly known as Immigration and Naturalization Services, to develop systems of tracking citizens and legal residents. There are so many steps in life at which someone must prove their identity. At birth, for example, a Social Security number is issued. If it is missed there, a Social Security number is required for tax returns. If it is missed there, a Social Security number is required for admission into our education system. The process for receiving and verifying a Social Security number, or other legal immigration documents, allow for the verification of one's identity and legal status, and it must be included and not deviated from.

I understand that there are variations from State to State. Due to the Federal funding that you provide to each State, you can, and you do have the power, to require this verification process be consistent.

Governments do this all the time. For example, just recently on the State level in Tennessee, we developed a standard parenting plan form to be used in the court systems. Now, this plan had been implemented and successful for many years, and it was an excellent tool for our court systems to use, but there were as many different forms as there were counties, because the locals were allowed to design the form. We are such a mobile society that the degree of continuity must exist in order for law and order to be effective.

Detailed checklists must be provided. This continuity has to exist among the States. Unless this is accomplished, States will continue to have multiple reinventions of the wheel. I'm proposing to the Federal government nothing more than I proposed time and again to my local State government, in the way of continuity and consistency.

Now, I want to address our efforts to date here in the State of Tennessee. As a responsible representative of this State, I have introduced and supported numerous bills that would have protected Tennesseans, and I'm going to give you a list of those.

Require citizenship or legal residence to receive a driver's license.

Forbid Certificates of Driving for illegal aliens.

Require citizenship proof prior to registering to vote.

Require driver's license exam to be taken in English only.

Require citizenship verification for non-emergency healthcare services.

Require Tennessee to join the Federal program for verification of work authorization.

Require the Tennessee Highway Patrol to assist the Federal government in enforcement by way of a memo of understanding. It is

my understanding that the State Department is very excited about the possibility of working with the States in this manner.

Regrettably, each of those bills failed in Tennessee this year. On the other side, States such as Arizona, Colorado, Georgia, Idaho, Kansas, Oklahoma, and Wyoming have been successful in implementing legislation similar to those I just mentioned that were introduced in Tennessee.

Unfortunately, in Tennessee we have a majority of elected officials who prefer to publicly state that illegal immigration is just a Federal issue.

My colleague has already stated that, from his perspective, every State is a border state. I too submit to you that every State is a border State. But, additionally, every town is a border town. At the Federal level, as elected officials, you have the responsibility for securing our borders. On the State level, it is my duty, and the belief of my constituents, to protect the borders of the State of Tennessee.

Today, I come to you and ask for your help, and this is how you can help us on the Federal level.

By requiring consistency among States.

By clearly defining processes, acceptable documentation, et cetera.

By clarifying that illegal immigration is a Federal issue, is a State issue, is a town issue.

The process for legal immigration is not meant to hinder anyone, it is meant to assure this great country is protected from such hindrances as illnesses, acts of aggression, et cetera.

We must all work together and stop passing the responsibility from one entity to the next. If we don't, soon we will no longer be the greatest country there is. We will no longer be a country.

I will conclude my remarks by saying what an honor it has been to address this body. I do look forward to working on this issue and other issues in partnership with other States and the Federal government, for a better and more secure future, and I would welcome the opportunity to discuss in detail any of the legislation that I've brought forward that we discussed this year.

Thank you very much for this opportunity.

[The prepared statement of Donna Rowland follows:]

PREPARED STATEMENT OF THE HON. DONNA ROWLAND, MEMBER, TENNESSEE STATE HOUSE OF REPRESENTATIVES

Mr. Chairman and Honorable members of this Subcommittee:

Welcome to Tennessee and thank you for the opportunity to appear and express my community's concerns regarding Illegal Immigration.

My colleague, Senator Ketron has done an excellent job of providing an overview of the concerns we hear daily regarding this issue.

I would like to commend you on the passage of the Deficit Reduction Act with the inclusion of the Citizenship Verification Provision. Please allow me to express some strengths that are absent from this provision.

Since acceptable documentation under this provision includes driver's license, the federal government must immediately require states to issue driver's license and any other government issued photo card or identification document only to those that can prove they are a citizen or legal resident of said state.

In the case of questionable self declaration statements, simply requiring that a reasonable person find such statement suspect causes a very legally challengeable situation. The term reasonable is open for interpretation. We can no longer take for granted that your definition of reasonable mirrors anyone else's definition of reasonable.

Regrettably, self declaration or the Honor system has not proven to be a trusted avenue for citizenship verification. Our country has spent years via the Social Security Administration, as well as the former Immigration and Naturalization Services to develop systems of tracking and identifying citizens and legal residents. There are so many steps in life at which some one must prove their identity. At birth, a social security number or taxpayer identification number is assigned, if it is missed there, a social security number or taxpayer identification number is required for tax returns, if it is missed there; a social security number or taxpayer identification number is required for admission into our education system. The process for receiving and verifying a social security number or taxpayer identification or other legal immigration document allows for verification of one's identity and legal status.

I understand that there is variation among the states for citizenship verification. Due to the Federal funding each state receives, you have the power to make this verification process consistent.

Governments do this all the time. Just recently on the state level, Tennessee developed a standard parenting plan form to be used in the court systems. While this plan, which had been implemented years before was an excellent tool, there were as many different forms as there were counties due to the form design being left to the locals to develop. We are such a mobile society now that some degree of continuity must exist for law and order to be effective.

Detailed checklists must be provided in order for continuity to exist among the states. Unless this is accomplished, states will continue to have multiple re-inventions of the wheel. I am proposing to the Federal Government nothing more than I propose time and again to my own state government in the way of continuity and consistency.

Now, to address our efforts to-date. As a responsible representative of this state, I have introduced and supported numerous bills that would have protected Tennesseans.

Require citizenship or legal residence to receive a driver's license.

Forbid Certificates of Driving for illegal aliens.

Require citizenship prove prior to registering to vote.

Require driver's license exam to be taken in English only.

Require citizenship verification for non emergency health care services.

Require Tennessee to join the federal program for verification of work authorization.

Require the Tennessee Highway patrol to assist the federal government in enforcement by way of a memo of understanding (It is my understanding that the

State Department is very much in support of working together with our law enforcement in this manner).

Regrettably, each of these bills failed in Tennessee this year. Yet other states (Arizona, Colorado, Georgia, Idaho, Kansas, Oklahoma, and Wyoming) have been successful in implementing legislation similar to those we introduced in Tennessee.

Unfortunately, in Tennessee we have a majority of elected officials who prefer to publicly state that illegal immigration is a federal issue.

My colleague has already stated that, from his perspective, every state is a border state. I too submit to you that every state is a border state. Additionally, every town is a border town. At the federal level, as elected officials you have the responsibility of securing our borders. On the state level, it is my duty (and the belief of my constituents) to protect the borders of the state of Tennessee.

Today I ask you to help us.

By requiring consistency among states.

By clearly defining processes, acceptable documents, etc.

By clarifying that illegal immigration is a federal issue, a state issue and a town issue.

The process for legal immigration is not meant to hinder anyone, it is meant to assure this great country is protected from such hindrances as illness, acts of aggression, etc.

We must all work together and stop passing the responsibility. If we don't soon we will no longer be the greatest country there is. We will no longer be a country.

I will conclude my remarks by saying what an honor it has been to address this distinguished body. I look forward to addressing this and other issues in partnership with other states and the federal government.

MR. DEAL. Well, thank you both very much. I will begin the questions, and then turn to Mrs. Blackburn after that.

I think you have accurately summarized the problems. Years ago, when I was first elected to Congress, I became an active member of the Immigration Reform Caucus, and people kept asking me, well, Georgia is not a border State, why are you interested in this issue? I kept saying, come to my district and you would believe otherwise. That problem over the last decade has definitely magnified, and that's why as this hearing will now have its second segment in my congressional district in Dalton, Georgia, which is certainly one of those hubs where illegal immigration is very manifest. I think you are appropriate in your analysis there.

Senator, as you have characterized the three big categories where the impacts are felt most profoundly are in healthcare, in education, and in law enforcement. Obviously, the jurisdiction of our Health Subcommittee primarily restricts itself to that first inquiry, but the truth of the matter is, they are so integrated within themselves that you really can't separate one from the other.

Representative Rowland, I think that, hopefully, as we hear the second panel, and we will have Dennis Smith from CMS, who will expound upon some of the verification procedures that we have put in place, and he is implementing now through the regulatory process. I think you will be pleased to see that we are making some real progress.

As you know, on your issue of having some uniformity on driver's licenses, we took what I think is an important step with what we call the Real Idea Act. To say that if you are going to use a State driver's license for any Federal purpose, the one we commonly think of, since we travel so much going back and forth to Washington, is to board an aircraft that you must meet certain Federal criteria. That Act will be in the process of being implemented. I believe it will be, perhaps, one of the greatest boosts to your efforts here at the State level to change your State law, as you have both indicated you would like to do.

I am very impressed with your testimony. I'm very impressed with what you are trying to do at the State level. As you mentioned, my State of Georgia, the legislature last year took a monumental step in the direction of dealing with this issue, and maybe, quite frankly, now may be the most profound step by any State Legislature in recent times. So, I commend you for that. We will hear from my colleagues at the State level in Georgia next week. Just keep up the efforts, that's what I will say to you, and I will allow my colleague to have the remaining amount of my time.

Mrs. Blackburn.

MRS. BLACKBURN. Thank you so much, and I want to thank both of you for your interest in the issue, and then for coming before us today, and thank you for your well-prepared testimony.

Senator Ketron, I will say I have to agree with you in your closing remarks about laws. I think Ben Franklin, in his discussion of whether we were a democracy or a republic, noted the fact that the laws that we have certainly, and the requirement to obey the laws, was one of the reasons we were a republic, and I think that is a founding principle that the laws of the land, the Constitution, be obeyed and be upheld.

I do have a couple of questions that I want to ask, I would like to propose to you, and, Senator Ketron, the questions you outlined in your testimony are so appropriate, I think that they are questions that we are hearing here in the State of Tennessee, and I would like to ask that you submit to us the answers to those, because they are some of the questions, as I was making my notes during your testimony, I know that we had heard at one point from the TennCare Administration that they felt there was not a problem with illegal immigrants, because there were very few, if any, who were getting TennCare. And, I would be interested in your assessment of that, and then when you get quantifiable data

having that submitted to us for the record, and, of course, we will continue to talk with Mr. Gordon about that issue.

Would you care to respond to that?

MR. KETRON. Absolutely, Congressman.

I think everybody tries to sidestep that issue when it comes to illegal immigrants going into our emergency rooms, but it is a fact, and I'll be happy to try to retrieve that data if at all possible.

One of your colleagues I heard on a radio show some time back in the spring, Steven King, Congressman Steven King made a comment that we need to remove the Anchor Baby Provision in our country, like Canada has done 4 or 5 years ago, but that Anchor Baby Provision on a Federal level continues to allow illegal immigrants to come here and locks down, by putting that anchor in, it allows them to continue to use our healthcare services by going to the emergency room.

You know, we kicked off close to 300,000 people off of our TennCare Medicaid program, that had lived here all of their lives, but you let an illegal immigrant from whatever country outside of our country that is illegal come here and go into the emergency room, by law, Federal law, the hospitals have to pick up and pay for that, TennCare pays for that.

We have got to correct that situation, it's not fair to let those people come in front and go to the front of the line.

I talked to a lady just the other day in Lewisburg, Tennessee, just south of here. She immigrated from Portugal just a few years ago, and she was really upset of all the problems that she had to go through, the hassles, and waiting time, and going through Memphis, through Immigration Control down in Memphis, and then anybody else just comes in and they get to go in the front of the line.

MRS. BLACKBURN. Let me ask you this also. You mentioned the matricular consular cards were no longer accepted as an ID source. When was that change made?

MR. KETRON. We changed that, Representative, 2 years ago.

MS. ROWLAND. Two thousand and four.

MR. KETRON. Two thousand and four.

MRS. BLACKBURN. In 2004.

And, do you know if there has been a decrease in requests for medical care for illegal entrants since that time? You do not?

MR. KETRON. Not to my knowledge.

MRS. BLACKBURN. Okay. All right.

And, Representative Rowland, you mentioned several bills that had been supported this year that did not pass. Requiring citizenship or legal residence to receive a driver's license. Forbidding Certificates of Driving for illegal immigrants. Requiring citizenship proof prior to

registering to vote. Requiring driver's license exam to be taken in English only. Requiring citizenship verification for non-emergency healthcare services, and requiring Tennessee to join the Federal program for verification of work authorization.

So, to be certain that I understand you correct for the record, all of these were legislation pieces that were submitted but did not pass, they were bills that were introduced and moved forward in the Legislature but did not pass.

MS. ROWLAND. Congressman, that is correct. We had some success in the Senate with passing legislation. Every piece failed in the House, either in subcommittee, full committee, or in a vote on the floor.

MRS. BLACKBURN. Considering the situation as it is, then would you favor having some of those items, like the citizenship verification for non-emergency healthcare services, driver's license exam taken in English only, to receive reciprocity, the AMVA standards, citizenship proof prior to registering to vote, joining the Federal program for the verification of work authorization, would you consider receiving those as mandates, Federal mandates, on Tennessee State law in order to get them passed?

MS. ROWLAND. Our local governments do not like us putting mandates on them. We do not like receiving mandates when they are necessary. Above all, though, it is our responsibility as a government body in Tennessee to implement these. If it takes mandates to do that, I welcome the assistance. It is our responsibility to introduce common-sense legislation and protect the borders of the State of Tennessee, and if we fail in that effort to do that then it is your responsibility to step in as a Federal government and dictate to us what should happen in order to protect our borders.

MRS. BLACKBURN. Okay, thank you very much, and that's all the questions I have.

MR. DEAL. I want to assure those of you who are familiar with legislation that I've introduced at the Federal level, I did not put the good Senator up to talking about anchor babies. Since he did, let me tell you that I am the author of legislation that will do away with the birthright citizenship.

On that subject, it is one of those magnets, I believe, it is not probably as large a magnet as jobs themselves, but it, nevertheless, is a magnet. We are in a distinct minority in the world community now of nations that recognize birthright citizenship. By that I mean, if you are born on American soil, regardless of the circumstances whereby your parents got here, legally, illegally, or otherwise, you are considered a resident.

There are 135 countries in the world, all of Europe no longer recognizes that, and we are only one of 36, I believe now, that still continues to do that.

I believe it is an issue, and we do have legislation at the Federal level. We are gaining support. I think we are up to about 88 co-sponsors, we are gaining. I think it's an issue that, hopefully, we will address at the Federal level.

I'm very impressed with both of your testimonies, and we will make it, of course, a part of the record for this committee, and we thank you both for what you've done here today by presenting it, and also for what you will continue to do at your legislative level in Tennessee.

MRS. BLACKBURN. I have one more.

MR. DEAL. Yes, Mrs. Blackburn.

MRS. BLACKBURN. Mr. Chairman, if I may, looking back through my notes I did skip a question that I had for Senator Ketron. In his testimony he spoke about law enforcement, as he spelled out the three issues with the healthcare system, the education system, and law enforcement. The hearing that we did in San Diego, we heard from some of the sheriffs there, in Texas and in California, that the incarcerated population of some of their facilities as much as 80 percent of it would be an illegal population, illegal entrants. Do you have an idea of what the percentage of illegal entrants are in the incarcerated population?

MR. KETRON. Congressman Blackburn, this is off the cuff, but we did discuss this this past year. One of my colleagues, Senator Steve Southerland from Hamlin County up in Morristown, he came with a bill that was requesting some relief because his jail in his county, because of the large number, I think next to Senator Tracy who is here today, who has the largest population of illegal immigrants, up in Morristown he has the second largest, and their jail has become so over crowded, over 45 percent with illegal immigrants. They have lost their accreditation, and, consequently, when you lose your accreditation from the State then you receive less dollars in order to be reimbursed, so it's falling back upon the citizens of the community to help pay for that, albeit, many of those are not State offenses, but because of that the community, the county, is still having to pay for the healthcare, they are having to take them to dentist, or if they come in with TB, they have to now have a TB isolation chamber within the jail. They come in with no shots, no health criteria as far as inoculation coming into our country, and we do require that for other citizens who come here.

So, I think that is a problem, and I think if we were able to run some numbers we would find that in many areas across our State, that it's over 30 percent anyway.

MRS. BLACKBURN. Okay. Mr. Chairman, I would like to ask as he submits answers on the other questions that were posed that we have that information, not that it's pertinent to this subcommittee, but to the overall it definitely is, and I would appreciate the submission.

MR. DEAL. Without objection, it will be made a part of the record.

MRS. BLACKBURN. Thank you.

MR. DEAL. Thank you both.

MR. KETRON. And, do I send that back to your office, Mr. Chairman?

MR. DEAL. Either to Congresswoman Blackburn's office or to my office, either one will be sufficient.

Thank you both.

MR. KETRON. You are quite welcome.

MRS. BLACKBURN. Thank you.

MS. ROWLAND. Thank you, Mr. Chairman.

MR. DEAL. I will now ask our second panel if they would come forward.

Gentlemen, we are pleased to have you here, let me introduce you to the audience. First of all, we have Mr. Darin J. Gordon, who is the Deputy Commissioner of the Bureau of TennCare here in the State of Tennessee, and we have Mr. Dennis G. Smith, who is the Director of the Center for Medicaid and State Operations at Centers for Medicare and Medicaid Services, in Washington.

Gentlemen, we are pleased to have you here, and we'll start with you, Mr. Gordon, for your opening statement.

STATEMENTS OF DARIN J. GORDON, DEPUTY COMMISSIONER, BUREAU OF TENNCARE; AND DENNIS G. SMITH, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE & MEDICAID SERVICES

MR. GORDON. Thank you, I'd like to thank Congressman Blackburn and the Chairman for having us here today to provide testimony on this important issue.

Just to give you a little background on TennCare in our State, we are a program, Medicaid program, that looks very similar to other Medicaid programs. We serve low-income children, pregnant women, and the disabled. We serve, approximately, 1.2 million people across the State, and we operate with, approximately, a $7 billion budget. It should also be pointed out that we are also a State that functions with 100 percent managed care.

Today, TennCare does not provide eligibility entitlement benefits to Medicaid enrollees. As you are well aware, there are Federal laws prohibiting those entitlement benefits, as well as the fact that we have our Tennessee law that requires proof of residency within the State as well.

As you mentioned previously, some of the requirements in the DRA that added and gave specificity to the types of documents people can use as proof of citizenship, our State has been able to look at what we had been doing and make very minor modifications in order to comply with that requirement.

I would like to thank the Chairman and this committee for their help in clarifying some aspects of the DRA, with regards to the dually eligible individuals and those individuals with SSI, that helped tremendously, and we thank you for that.

We do also want to point out, as I'm sure you've heard from other States, there are still some limited circumstances in which individuals in, primarily, rural or mountain areas that aren't born in hospitals, in which case there are still some--these are U.S. citizens, there is just some further comments on how to better address proof of citizenship in those limited circumstances, and we appreciate the Committee and CMS' help in trying to get those clarifications.

The fact with the DRA coming out has not changed that illegal immigrants are not eligible for entitlement benefits on our program. I need to point out that there is a law, as has been mentioned on this point, that does require the State to provide reimbursement to our hospitals for the emergency care to those illegal immigrants that would otherwise have been eligible for our program if they had U.S. citizenship. We do not consider this reimbursement eligibility for our program, nor do we provide eligibility to our program just due to the fact that they are eligible, hospitals are eligible for the reimbursement for the services they provide.

It should also be noted that TennCare takes a strict interpretation of the definition of emergency services, as is required by this mandate. Medicaid only provides reimbursement for the emergency episode itself. We do not provide reimbursement to the providers for any follow-up care.

And, I should also point out that this is only reimbursement to hospitals for those illegal immigrants who fall into existing Medicaid categories, for example, if they are aged, blind, or disabled, or a pregnant mother, and meet income and resource requirements. So, it may not fully encompass, the reimbursement that we provide may not fully encompass other issues that hospitals see with regards to illegal immigrants.

Within our program, just to put it in perspective at the Tennessee level, looking at the month of July, and we cover about 1.2 million people as I said previously, in the month of July we provided reimbursement for 62, emergency services for 62 illegal immigrants to our State's hospitals. The amount of reimbursement for the services that these people received amounted to $1.7 million over the full treatment of their emergency condition.

Because of the very nature of emergency episodes, it should be pointed out, though, that single cases could easily eclipse the total reimbursement we pay for these 62 individuals. For example, an individual burned in a car accident could cost upwards of $2 million.

However, we primarily see reimbursements related to labor and delivery, that's primary. If you look at the illegal immigrants, the emergency services that we get requests for reimbursement for, it's primarily in that area. And, it's also important to point out, which was referenced earlier, is that that child, when born, is a U.S. citizen and is entitled to 12 months of Medicaid eligibility coverage from that point forward, and it's also important to emphasize in that instance the need to provide the neonatal care immediately following delivery to ensure that that child does not have complications that cost the State and the Federal government more money than it would have otherwise, if they had received that proper follow-up care.

I should also point out that, as I've mentioned earlier, that the hospitals do not receive reimbursement for any of those individuals that wouldn't have met Medicaid eligibility criteria. So, there will be some unreimbursed costs due to the fact that hospitals are unable to turn away those people seeking care in the emergency room that they do not receive funding from Medicaid on, and I'm sure the hospitals and other members of the panel will probably speak to that.

To remove funding from what Medicaid currently pays for, would again put additional unreimbursed cost burdens on the hospitals, even though ours is limited in the whole scope of what unreimbursed costs that hospitals incur, it is something to take into consideration.

I also need to point out that in our State we do not currently have a disproportionate share hospital payment, and I'm sure the hospitals will definitely speak to that. Usually, many States would use that to help offset some of that uncompensated care that those hospitals incur, including more than likely costs that they would incur related to treatment to those non-Medicaid-eligible illegal immigrants.

In conclusion, the Federal mandates placed on State Medicaid programs puts us in a precarious position of balancing the demand for the Federal government with fiduciary responsibility of the State of Tennessee. The State Medicaid program, we are in a difficult position,

as I see you all are as well. On one hand, we must comply with Federal requirements to pay for emergency care for illegal immigrants, and on the other hand we must live within the State's limited resources to address the healthcare needs of our own citizens.

Medicaid is a payer, not a direct healthcare provider. A s a result, the Federal mandates related to the illegal immigrant population further stretches limited State resources. The Federal government should examine ways to relieve some of these financial pressures these mandates place on States' healthcare systems, and I understand it's a difficult situation, I know we provide services only in emergency cases, but it's something that the States are further stretching their limited resources to try to accomplish.

Thank you.

[The prepared statement of Darin Gordon follows:]

PREPARED STATEMENT OF DARIN J. GORDON, DEPUTY COMMISSIONER, BUREAU OF TENNCARE

Good morning.

I would like to thank Congressman Blackburn and the members of the Energy and Commerce Committee for inviting TennCare to provide testimony on the impact of illegal immigration on our state's Medicaid program. It is a pleasure to be with you today.

TennCare is Tennessee's expanded Medicaid program, providing health care coverage to approximately 1.2 million Tennesseans with a $7 billion budget. Today, our program is much more like traditional Medicaid programs across the country, largely serving low-income children and pregnant women and the disabled.

Current Medicaid eligibility includes a requirement that an individual prove U.S. citizenship and Tennessee state residency before Medicaid entitlement benefits are available. Illegal immigrants are not eligible for full Medicaid entitlement benefits in Tennessee. Under federal law (42 U.S.C.A. §1396b(v)) no payment may be made to a State for medical assistance furnished to an illegal immigrant. An illegal immigrant is an immigrant who is not lawfully admitted for permanent residence.

There is one exception in federal law. Payment shall be made for care and services that are furnished to an illegal immigrant only if such care and services are necessary for the treatment of an emergency medical condition of the individual, and such care and services are not related to an organ transplant procedure. Therefore, TennCare provides reimbursement to hospitals for emergency healthcare services to illegal immigrants who would otherwise qualify for Medicaid.

According to federal regulations, the term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

Emergency Medicaid coverage is initiated in Tennessee when an application is filed with the state Department of Human Services. Typically, the emergency has already occurred and Medicaid is reimbursing the hospital for the emergency treatment costs

associated with the care already provided. An illegal immigrant receiving emergency medical services must meet the same income and resource standards as any other Medicaid enrollee. Examples of emergencies that trigger eligibility are childbirth, car accidents, heart attacks and stroke. The reimbursement of emergency services is covered for the time the qualified individual is admitted to the hospital only. No follow-up treatment or care is paid for by Medicaid.

Using state and federal funds to pay for emergency healthcare for illegal immigrants places real burdens on state governments in addition to the entire healthcare delivery system. Our program's experience can offer some insight into the effects of illegal immigration in Medicaid programs and its effects on Tennessee's health care providers.

Tennessee's Medicaid program experience has been that this federal mandate involves an extremely small number of individuals compared to our program's total population of 1.2 million people. For example, in July 2006, TennCare was required under federal mandate to pay for 62 illegal immigrants' emergency care services. The total combined cost for these 62 individuals was approximately $1.7 million.

However, it is also important to note that because of the nature of an emergent episode, one individual's cost can easily exceed the cost of treating these 62 individuals in any given month. In addition to these month-to-month cost fluctuations, there is also the potential for overall increases in emergency care costs for illegal immigrants should the illegal immigrant population continue to grow.

The vast majority of illegal immigrants who receive emergency Medicaid are pregnant mothers entering the hospital emergency room in active labor. The children are born U.S. citizens and immediately qualify for full Medicaid benefits for the first year of their lives. The cost of providing coverage for labor and delivery services for these illegal immigrants must be weighed against the fact that the provision of this service may reduce birth complications and subsequent costs that the Medicaid program would incur caring for an infant with health problems resulting from such complications.

Medicaid programs must also recognize the circumstance from which hospital providers cannot escape. Federal emergency medical treatment and active labor act (EMTALA) regulations require hospitals to provide emergency medical treatment to anyone regardless of ability to pay or citizenship status. The cost of providing uncompensated care to illegal immigrants today is offset by required Medicaid reimbursement for a small subset of that population. Medicaid does not reimburse hospitals for emergency care provided to all illegal immigrants, but only for those who meet all other Medicaid eligibility criteria except citizenship.

Therefore, hospitals are bearing the total cost of uncompensated emergency care to illegal immigrants that do not qualify for Medicaid reimbursement. To remove the funding that providers receive from the Medicaid program would result in additional unreimbursed costs for hospitals.

In many states, disproportionate share hospital payments (DSH) are used to offset unreimbursed cost to hospitals. DSH payments are federally matched dollars that help offset the cost of uncompensated healthcare provided by hospitals. When TennCare was created in 1994, Tennessee's DSH allotment at the federal level was removed because it was believed the program would be able to cover the uninsured population and remove most, if not all, of the charity care experienced by the hospitals. However, due to rapid growth, the program quickly closed to the uninsured without a reinstatement of DSH payments to hospitals.

Now that TennCare is aligned with more traditional Medicaid programs, we believe that DSH payments are once again appropriate mechanism for uncompensated care reimbursement to hospitals. Tennessee does not have the flexibility that almost all other Medicaid programs have in offering a mechanism to help offset increases in uncompensated care. TennCare is allowed to offer a fixed amount in essential access

payments (EAP) to a limited number of hospitals treating the majority of Medicaid enrollees.

This limited supplemental pool plan does not afford Tennessee hospitals the means to address the escalation of uncompensated care costs that DSH allotments allow other states. Healthcare utilization, the decline in private sector health care benefits, in addition to a number of other factors, leave hospitals facing an ever increasing uncompensated care burden and no mechanism to fairly address the increased costs to Tennessee.

Finally, Medicaid programs often receive criticism from taxpaying citizens who are concerned that state funds are directed away from providing healthcare assistance to legal residents and toward paying for illegal immigrant emergency care. The federal mandate places state Medicaid programs in a precarious position of balancing the demands of the federal government with a fiduciary responsibility to Tennessee taxpayers. Ultimately, all taxpaying U.S. citizen and health insurance consumers bear the healthcare costs to provide these services for illegal immigrants. Tax dollars are spent to provide direct reimbursement to hospitals for emergency Medicaid for those illegal immigrants who qualify for such assistance, while the costs of caring for other illegal immigrants are passed on to consumers indirectly in the form of higher costs for healthcare services that ultimately results in increased health insurance premiums.

In final summary, as a state Medicaid program we are in a difficult position. On one hand, we must comply with the federal requirement to pay for emergency care for illegal immigrants and on the other hand, we must live within the state's limited resources to address the healthcare needs of our own citizens. Medicaid is a payer, not a direct healthcare service provider.

As a result, the federal mandates related to the illegal immigrant population further stretches limited state resources. The federal government should examine options to relieve some of the financial pressures these mandates place on states' healthcare systems.

Thank you.

MR. DEAL. Thank you.

Mr. Smith.

MR. SMITH. Thank you very much, Mr. Chairman. It's a pleasure to be with you today, and I thank Mrs. Blackburn for inviting me back to Tennessee. It's a great pleasure to be with you here today.

I do have a full statement for the record that has been submitted, and I'd like to take my time just to really kind of reflect on what we've heard here this morning. And first, I was taken by Mrs. Blackburn's remarks about confronting these real problems and finding solutions, and I want to commend you for doing exactly that, because when you have faced a problem you took it on and you found solutions.

For 20 years now, an individual applying for Medicaid had to declare whether or not they were a citizen or a legal alien, in order to receive Medicaid. For Medicaid, you were required to provide a Social Security number.

Ten years ago, in welfare reform, confronted the issue of legal aliens coming to the country and getting immediately on public assistance programs. Applications actually being filled out in the country prior to

even getting to the United States, applications for our public programs, getting on SSI, getting on Medicaid. Congress put a stop to that.

Now, if you are a legal alien coming to the United States, you cannot be eligible for Medicaid for a 5-year period of time. The individual who brought you here has agreed in bringing you to the United States to be responsible for your care, including for your healthcare. So, we found a solution to a problem that was very, I think, important to do.

In the Balanced Budget Act of 1997, Congress responded by providing over $100 million over a 4-year period of time to assist States with the cost of providing emergency room services to undocumented aliens, regardless of their Medicaid eligibility.

In the Medicare Modernization Act, again, Congress saw a problem, worked with the Administration, provided $1 billion over a 4-year period to provide direct payments to hospitals for the cost of care that they were not otherwise going to be paid for.

And now, in the Deficit Reduction Act, finding the solution that, again, to the documentation of citizenship, I think being very important to the American public, to assure them that the integrity of the public programs, in fact, are being upheld.

But, it went beyond that in the DRA, provided $150 million to the States for transformation grants to help them to reshape their Medicaid programs, to help them to deal with some of the issues and problems that they face, and to modernize their programs, and a $50 million grant program, specifically, Mr. Chairman, putting in there for the States to help them to establish alternatives to emergency room care, and I think that that is a very important piece as well, as we do know that our hospital emergency rooms are over-burdened providing great quality of care, but at the highest cost, that is, the most inefficient way to provide healthcare services. We know this from States in a variety of different ways, again, finding those alternatives to the emergency rooms are very important.

So, I think that to begin with, to be commended for facing these challenges head on, and working together to find solutions.

I was also struck by the State Senator's remarks about how these things are interrelated. And again, in healthcare we often know, if you touch one part of healthcare you have touched all parts of healthcare, because they are interrelated, and interdependent.

I think the issue of immigration reform is very similar. The State Senator mentioned healthcare, but also corrections and education, and again, I think all of those things touching together do lead us back to those previous examples of doing comprehensive approaches, giving comprehensive solutions, and I want to end on that, that the Administration wants to work with you to find these comprehensive

solutions, but again, to also congratulate you for taking them on, and facing what is in front of us.

I will mention very quickly on citizenship documentation, again, I thank the Chairman for all of his work in that area. I think, again, we took a very balanced approach first and foremost protecting those American citizens who are eligible for Medicaid, to make certain that they do not lose their eligibility. There are many different ways to help establish their citizenship, and we are working with the States, having provided guidance to them, and our regulations help to protect their Medicaid eligibility for citizens who, in fact, are eligible.

These solutions, again, I think are very balanced. They work because we know they work in other areas. Our approach is, basically, the Social Security Administration's approach, how they authenticate an individual's identity, how they authenticate an individual's citizenship. These are not really new ways in terms of eligibility workers, eligibility workers who have worked for Social Security, worked in these other programs, are very familiar that you need to have an authentic document, you have to be able to have confidence in that document that is being presented to you, to have that, to be able to provide that eligibility.

That is why, again, we go through the hierarchy of documentation, to say this document is more reliable than that document. That's why those things are important, to assure that those documents are authentic. But, we do have other ways, again, to help preserve the ability for an individual who is currently on Medicaid to make certain there is time to find their appropriate documentation, so that their eligibility is not at risk.

Ways that the States have to share their databases to affirm citizenship and identity, States have a great deal of information about individuals. They are able to share that information, again, to preserve someone who is a citizen to make certain their Medicaid is not jeopardized.

So, I think we have taken a very balanced approach, but again, have assured the American people the integrity of the program. We worked with you on these different areas that we have discussed, and look forward to working with you on comprehensive immigration reform as well.

Thank you, Mr. Chairman.

[The prepared statement of Dennis Smith follows:]

PREPARED STATEMENT OF DENNIS G. SMITH, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE & MEDICAID SERVICES

Thank you for inviting me to speak with you about the impact of undocumented immigrants on the Medicaid program and the health care delivery system and express the

Administration's support for comprehensive immigration reform that increases border security, establishes a robust interior enforcement program, creates a temporary worker program, and addresses the problem of the estimated 11 to 12 million illegal immigrants already in the country.

Medicaid is a partnership between the Federal government and the states. While the Federal government provides financial matching payments to the states, each state is responsible for overseeing its Medicaid program, and each state pays a portion of its cost through a statutorily determined matching rate, currently ranging between 50 and approximately 76 percent. The Centers for Medicare & Medicaid Services (CMS), which oversees the Federal responsibility for Medicaid, ensures states enforce Medicaid eligibility requirements. Recently, CMS issued guidance and an interim final regulation to the states as part of the implementation of the Deficit Reduction Act of 2005 (DRA), which requires Medicaid applicants who declare they are citizens to document their citizenship and identity.

CMS, in regards to the broader health care system, also enforces regulations that require hospitals to medically screen and provide stabilizing treatment or an appropriate transfer to any person seeking emergency care, regardless of payment method or citizenship status.

Immigrants and Medicaid Eligibility

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) significantly changed the eligibility of non-citizens for Federal means-tested public benefits, including Medicaid and subsequently the State Children's Health Insurance Program (SCHIP). This change, however, did not alter eligibility for undocumented and nonimmigrant aliens, who generally remain ineligible for non-emergency Federal benefits. As a general rule, only "qualified aliens" may be eligible for Medicaid and SCHIP coverage. Qualified aliens include aliens lawfully admitted for permanent residence under the Immigration and Nationality Act. Refugees, those granted asylum, and victims of a severe form of trafficking (as certified by the Office of Refugee Resettlement of the Department of Health and Human Services) among several other categories also may be considered qualified aliens.

Under PRWORA, states are required to provide Medicaid to certain qualified aliens who otherwise meet the eligibility criteria of the state's Medicaid program, unless subject to a five-year bar. This five-year bar applies only to qualified aliens who entered the United States on or after August 22, 1996 with some exceptions. Typically the bar applies to lawful permanent residents and aliens granted parole for at least one year. Some qualified aliens are exempt from the five-year bar, including refugees, those granted asylum, and trafficking victims, among others. A qualified alien who is honorably discharged from the military; on active duty in the U.S. military; or the spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty in the U.S. military also is exempt from the five-year bar.

However, the five-year bar and other eligibility restrictions do not apply to aliens who are applying only for treatment of an emergency medical condition. Thus, all aliens – both qualified and non-qualified aliens (including undocumented immigrants) – may be eligible for treatment of an emergency medical condition, provided they otherwise meet the eligibility criteria (such as income level, for example) for the state's Medicaid program.

CMS Issues Guidance on Citizenship and Identity Documentation for Medicaid Eligibility

American citizenship or legal immigration status have, for many years, been a requirement for Medicaid eligibility. However, previously, in many states applicants

could assert their citizenship status by merely checking a box on a form. (A number of states have long required their applicants to document citizenship, including New York, New Hampshire and Montana.) The DRA now holds states financially responsible for Medicaid expenditures for individuals claiming to be United States citizens unless such individuals provide actual documentary evidence supporting their citizenship and identity. This new requirement applies to new applications for Medicaid eligibility and re-determinations beginning July 1, 2006.

In order to give states some initial guidance on the implementation of this provision, on June 9, 2006 CMS issued a State Medicaid Director letter. On July 12, 2006 the Department published an interim final regulation for states to implement this new requirement. Comments on the interim final rule are due on August 11, 2006. We expect to publish a final rule shortly.

The law requires that a person provide evidence of both citizenship and identity. In some cases, a single document will be enough to establish both citizenship and identity, such as a U.S. passport. However, if secondary documentation is used to establish citizenship, such as a birth certificate, the individual will also need evidence of his or her identity. Once citizenship has been proven, it need not be documented again with each eligibility renewal unless later evidence raises a question.

The law specifies certain forms of acceptable evidence of citizenship and identity and provides for the use of additional forms of documentation as established by Federal regulations, when appropriate. If an applicant or recipient presents evidence from the listing of primary documentation, such as a U.S. passport, certificate of naturalization, or a certificate of U.S. citizenship, no other information is required. When such evidence cannot be obtained, our regulations require the states to look to the next tier of acceptable forms of evidence. However, a state must first seek documents from the primary list before looking to the secondary or tertiary lists. Because individuals who receive Medicare and individuals who are on Supplemental Security Income (SSI) in a state using SSI for Medicaid eligibility purposes already have met certain documentation requirements, the regulation does not include new documentation requirements for these groups. This exemption reflects the special treatment of these groups in the statute.

At the time of application or re-determination, the state must give an applicant or recipient a "reasonable opportunity" to present documents establishing U.S. citizenship or nationality and identity. An individual who is already enrolled in Medicaid will remain eligible if he/she puts forth a good faith effort to present satisfactory evidence of citizenship and identity. Applicants who despite their good faith effort are unable to present documentation should be assisted by the state in securing these documents. States may use data matches with the State Data Exchange (SDX) or vital statistics agencies in place of a birth certificate to assist applicants or recipients to meet the requirements of the law. As a check against fraud, states are also required to use currently available capabilities to conduct a match of the applicant's name against the corresponding Social Security number that was provided. In addition the Federal government encourages states to use automated capabilities to verify citizenship and identity of Medicaid applicants. We specifically asked for public comment on whether there are other electronic data systems that should be identified to assist states in determining an individual's citizenship or identity.

As with other Medicaid program requirements, states must implement an effective process for assuring compliance with documentation of citizenship in order to obtain federal matching funds, and effective compliance will be part of Medicaid program integrity monitoring. In particular, audit processes will track the extent to which states rely on lower categories of documentation with the expectation that such categories would be used relatively infrequently and less often over time, as State processes and beneficiary documentation improve. When future automated capabilities to verify citizenship and identity of Medicaid applicants becomes available, states also will be

required to match for individuals who used third or fourth tier documents to verify citizenship and identity. In the meantime, states must ensure that all case records within this category are identified so that they may be made available to conduct these automated matches. States will receive the normal 50 percent match for administrative expenses related to implementation of the new law.

The law also requires that the Secretary develop an outreach program which is intended to educate individuals who are likely to be affected by the requirements of this provision of the law. CMS has already conducted numerous teleconferences with states and other organizations interested in this provision. In addition, we are developing an outreach plan that provides strategic direction and coordination for an integrated education and outreach program to inform states, Medicaid recipients, and others of these new documentation requirements. This initiative will be implemented to promote active and informed involvement by states and people with Medicaid in providing beneficiaries the necessary information about the new documentation requirements. The plan will ensure that all stakeholders know of the new requirements, understand the documents which satisfy these requirements, assist the streamlined implementation by states, and ensure continued uninterrupted access to Medicaid for citizens.

EMTALA

Regarding the broader health care system, CMS enforces the 1986 Emergency Medical Treatment and Labor Act (EMTALA). Under EMTALA, hospitals have obligations to any individual, regardless of citizenship, who requests treatment for a medical condition. EMTALA was designed to ensure that people will receive appropriate screening and emergency treatment regardless of their ability to pay.

CMS' regulations implementing EMTALA require that hospitals with dedicated emergency departments provide an appropriate medical screening examination to any person who comes to the hospital emergency department and requests treatment or examination of a medical condition. They also require that these hospitals provide an appropriate medical screening examination to any person who presents himself on hospital property requesting evaluation or treatment of an emergency medical condition. In both cases, a request may be made by another individual on behalf of the person for whom examination or treatment is sought, or a request can be considered to have been made if a prudent layperson believes that based on the behavior of the individual an emergency medical condition exists. If the examination reveals an emergency medical condition, the hospital must also provide either necessary stabilizing treatment or arrange for an appropriate transfer to another medical facility.

EMTALA applies to all Medicare-participating hospitals with dedicated emergency departments and applies to all individuals regardless of immigration status who present themselves requesting examination or treatment of a medical condition. Hospitals with specialized capabilities have a responsibility under EMTALA to accept appropriate transfers regardless of whether the hospital has a dedicated emergency department. A hospital that violates EMTALA may have its ability to participate in Medicare terminated and may be subject to civil penalties of up to $50,000 per violation. An individual who has suffered personal harm and any hospital to which a patient has been improperly transferred and that has suffered a financial loss as a result of the transfer are also provided a private right of action against a hospital that violates EMTALA.

Hospitals also are required to maintain lists of physicians who are on call for duty after the initial examination to provide necessary stabilizing treatment. Hospitals have discretion to develop their on-call lists in a way that best meets the needs of their patients requiring services required under EMTALA.

Under CMS' regulations, EMTALA does not apply after an individual has been admitted for inpatient hospital services, as long as the admission is made in good faith and not in an attempt to avoid the EMTALA requirements.

Section 945 of the MMA required the Secretary of Health and Human Services to establish a technical advisory group (TAG) to review EMTALA policy, including the regulations and interpretive guidance outlining hospitals' responsibilities under EMTALA. This TAG, which includes hospital, physician and patient representatives, has already met 4 times. The TAG will complete its deliberations and submit a report of its findings and recommendations to the Secretary by October 2008.

Conclusion

Thank you again for this opportunity to discuss the impact of undocumented immigrants on Medicaid and the health care system. I would also like to take this opportunity to once again express the Administration's support for comprehensive immigration reform. I would be happy to answer any questions you might have.

MR. DEAL. Thank you, Mr. Smith.

Let me sort of set the stage for my questions. For those of you who have not followed this discussion over the last decade or so, as we have dealt with the issues, especially those alluded to with Mr. Smith, Medicaid had been one of those areas where we really had not put the same kind of requirements in terms of verification of eligibility, as you alluded to that we are currently in, Social Security, SSI, and Medicare.

And, as you heard in my opening statement, we found as we started looking into this that 46 States, including the District of Columbia, making 47 major jurisdictions, used what was called "self declaration of eligibility." Now, let me just sort of walk you through, and I know the two gentlemen here at the table understand this in great detail, but for those of you in the audience let me walk you through what that really means.

For years, I had been hearing the complaints from my constituents that people that they thought probably were not eligible for Medicaid were showing up with Medicaid cards at the doctor's offices and other healthcare settings. I have somewhat facetiously made the comparison that it was the substitute for what we all used to hear about the complaints about Food Stamps with a person in front of them at the checkout line at the grocery store who had paid with Food Stamps and they thought that was an abused program, it now sort of migrated into the healthcare arena through Medicaid.

For years, I kept asking my people at the State level, and at the Federal level, do you verify the immigration status of people who apply for Medicaid? The answer kept being, yes, we do.

It took me a while to realize I was asking the wrong question. The first question is always, are you a citizen? There was no verification of your answer to that. You could say, yes, wee, si, whatever language you choose to use, if it was an affirmative response, there was no verification required, and that's what we call self-declaration of eligibility.

Now, I bet I could suggest to this audience that there are a number of Federal and State programs that have eligibility requirements, and if all

that was required to get on the rolls of receiving those benefits was for you to say you are eligible. I think you would say that would make a mockery of the system. That's what we had in Medicaid, and that's why the reforms that we put in place about requiring documentation of eligibility were so significant.

Why? Because what we found was, when States like mine asked the questions of individuals that appeared to be, perhaps, not eligible, they were accused of profiling. They were threatened with lawsuits by the Civil Rights Division, that if you do this and ask for documentation of only selected individuals who you suspect might not be a citizen, then you are violating the Civil Rights rules because you should treat everybody equally.

So, if you hear anybody complaining about the fact that grand momma doesn't have a birth certificate, she's been on Medicaid, and now they are going to kick her off. First of all, as Mr. Smith said, that's not true, and there are procedures to go by to get those proper documentations.

We've heard from the opponents of this solution that it is going to just be so cumbersome and difficult. I guess first of all, Mr. Gordon, I would ask you, since you are in the process and in the position of having to implement this reform, what has been your sense of being able to enforce this provision at the State level?

MR. GORDON. Actually, here in Tennessee at least, and, obviously, I can't speak to other States, but with our experience we currently contract with our State Department of Human Services that would do this for us.

Initially, there was some concern, but I believe the clarification around Social Security eligible individuals and the Medicare populations really relieved the vast majority of our concerns.

Speaking with the agency, the Commissioner of that agency, just yesterday, just following up and seeing how that's progressing, they had to modify some of their processes in how they retained the documentation and trying to do that through, just from a pure filing and imaging type process. But, other than that, they felt that this was something that they could implement and comply with.

MR. DEAL. Well, that's the experience that my State people are telling me as well.

Mr. Smith, let me ask you to amplify on this, and in so doing would you talk about the question that the Representative and the Senator alluded to for States like Tennessee that currently are still issuing driver's licenses without the verification of citizenship for the issuance of that license. How do States like that fit into the presentation of the necessary documentation for Medicaid eligibility? And, what validity, if any, do you place on documents like that kind of driver's license?

MR. SMITH. Yes, Mr. Chairman.

Again, to step back for a second, the States do the eligibility determinations for Medicaid. Many States, it is not the Medicaid agency actually doing the determination, but a Department of Social Services, or an enrollment broker, or someone else like that.

The guidance that we have given to the States is very specific, in terms of making certain the State understands that they need to rely on documents that are authentic and verifiable. The States should also be doing cross matches of Social Security numbers, to assure, again, that when you are presented with information the State is at risk to make certain that information, in fact, is correct, and that they are relying on documents that are correct and authentic.

So, if the State does not have confidence in any type of document, then they should be doing something else to move beyond that then to request something else.

There are documents, again, in the hierarchy, there are some documents that provide both citizenship and identity, like a passport, but in many cases, in most cases, States are going to be looking for probably a combination of documents, a birth certificate that provides the citizenship status, and another document that provides the identity. So, you need to look at both of them together.

But, the States can also do cross matching of their own databases, with other databases, with other States as well, but again, what we would be looking for in coming behind the State is, did you make the determination of eligibility on information that was authentic and that you had confidence that that was correct information.

So, a State should not accept information that they don't have confidence in. Again, we have said, do not accept copies. Do not--you know, there are, and again, this is not any different than guidance that Social Security uses, they would not accept a copy of a document. So, it lays out, I think, very clearly what the States should do in situations, if you are presented with information that you don't have confidence in you should be looking out for something else as well, you should be cross matching the Social Security number, et cetera.

MR. DEAL. In the letter you've sent to State Medicaid Directors, it goes into great detail about outlining the processes, the steps, and the kinds of documents that you would be looking for, for that verification. Is that right?

MR. SMITH. Yes, Mr. Chairman.

MR. DEAL. All right.

MR. SMITH. Yes, sir.

MR. DEAL. I don't think we need to go into all the details of that for purposes of this hearing, because it is an official document that has been sent to all State verification agencies.

I do think, though, however, it is going to require diligence. Both at the Federal level as you go behind and check States as to their verification and certification processes. My understanding is that if you find that they have not complied with this change in the law then they are subject to a penalty in the form of losing Medicaid matching money from the Federal government. Is that correct?

MR. SMITH. That's correct, Mr. Chairman. The law requires to participate, to get FFP from the Federal government, you must come into compliance.

But also, at the individual level, again, where you have an individual on an audit review, we will be looking for that information as well, that you've complied programmatically in implementing them, but also on an individual basis you want to make certain, as Darin alluded to, you have to make sure the file is complete also, to when they are looked behind, again, audits are generally a sample of files, whether it's eligibility or at a provider level, you are looking at a sample. So, you want to make certain that the file is complete, again, that you have relied on documents that are authentic and that you have confidence in.

MR. DEAL. As I understand it, there is a 12-month phase in on this program, so that people who are currently under the Medicaid program, that may not have the documentation that the new change in the statute requires. The States will have a 12-month period in order to provide that documentation. Is that correct?

MR. SMITH. It is correct for individuals, Mr. Chairman, in two different ways. One, if you are an applicant, if you are applying for the first time, then you need to provide the documents at tine of application.

But, in Medicaid, we also have what is called redetermination, so no less than every 12 months a State needs to redetermine that individual's eligibility. States vary in terms of that amount of time, and how frequently they redetermine. So, come September you are looking at all new applicants, and then those individuals that were up for redetermination in September, et cetera, as you move forward every month.

In terms of the individual, if they are on Medicaid currently, and again, we have exempted people on Medicare, we've exempted people on Social Security, they do not have to do this again. They do not have to--

MR. DEAL. Because they've already done that.

MR. SMITH. --that is correct.

But, if you are not in that exempt category, and you are on but you don't have the documents, then you have what is called a "reasonable opportunity." Again, the State will continue to have you enrolled into Medicaid, but give you a reasonable opportunity to provide that documentation, which again, is currently a standard in the Medicaid program.

MR. DEAL. Mrs. Blackburn, I will yield you whatever remaining balance of my time, plus your time.

MRS. BLACKBURN. Thank you, Mr. Chairman. I appreciate that.

I do have several questions for each of you.

Let me stay with this verification issue for right now, if I may. Mr. Gordon, let me come to you first. You said that you all, basically, are contracting with DHS--

MR. GORDON. That's correct.

MRS. BLACKBURN. --to handle all of this. So, they are handling your verification process, and what documents are they using to verify the citizenship, residency, income limits, et cetera, of those applying for TennCare?

MR. GORDON. Well now, based on the DRA, there's the list that are set forth that you go through the different phases.

MRS. BLACKBURN. Right, and I agree with your statement that clear definition of who is responsible for what is helpful, and I think the DRA did do that. But, prior to that, what were you doing?

MR. GORDON. They will use similar types of documents.

MRS. BLACKBURN. Okay.

MR. GORDON. The retention of those documents would be checked at the individual check for those types of documents.

MRS. BLACKBURN. Okay.

MR. GORDON. But, there are other circumstances in which case--

MRS. BLACKBURN. All right, and how are they obtaining the citizenship documents?

MR. GORDON. Whenever the individual comes in to be checked for verification, they are asked to bring proof.

MRS. BLACKBURN. Okay. So, they have to bring the originals, no copies?

MR. GORDON. I'm not clear whether or not it was at that point in time or at any point in time, whether or not it stipulated copy or original.

MRS. BLACKBURN. Okay.

MR. DEAL. But, it's clear now that the copy is now allowed, right?

MR. GORDON. That's correct.

MRS. BLACKBURN. Okay.

MR. DEAL. Excuse me.

MRS. BLACKBURN. Listen, that's great, and go ahead, Mr. Chairman, and add in. I think this is something that we have, it speaks to what we hear as a lot of the anecdotal information that we hear, and what we want to hear from you is what you are dealing with so that it helps us in the decision-making matrix.

Okay. So, and the reason I'm asking this, I had read and had kept an article that had run from the city paper here, where a woman, a Ms. Garner, with Department of Human Services, she's the Medical Policy Director and handles the TennCare enrollment, and speaking of the changes we were making in the DRA had said, well, it could backfire and harm our citizens who are really in need most. And, as you've heard the Chairman say, and as Mr. Smith has said, you've got your reasonable opportunity to go through and present. And so, it was interesting to me that that would be a first flush, and I was wanting to verify for the record what you had used, and then how you obtained what you had used.

MR. GORDON. And, as I stated, the types, similar documents were asked for, again, as I alluded to in my remarks, there are circumstances, and I believe that might have been what she was referring to in rural settings where individuals are not born in hospitals, in which case, in earlier years, but part of your clarification helped in that area.

MRS. BLACKBURN. Let me ask you this, we know that Georgia, New York, Montana, New Hampshire, have all had strict proof of citizenship for Medicaid eligibility, some for decades. And, they have not reported any problems with this. Do you have people from TennCare, and from DHS, talking with these other States to see what their best practices are, and what protocols they are using, and what template they are working from?

MR. GORDON. There are multiple State calls going on through various associations, which I'm sure you are familiar with, whether it be the NGA, or whether it be the State Medicaid Directors, that, basically, walk through this, and there's also some of those calls orchestrated by CMS themselves, in which case we participate.

MRS. BLACKBURN. Okay. Dr. Smith, I always appreciate your incites, let me say that, and I appreciate you diligence in working with us to find answers to whether it's Medicare or Medicaid, but any of the CMS web of services that exist. Let me ask you, Representative Rowland had spoken in her testimony about the verification process, and some of the concerns there. Would CMS endorse the use of the Employer Verification Program for verifying legal residency status? Would they, do you think they would endorse that/

If we look at having something that is a nationwide template, that can be used by the States, if we say the Federal government is going to address a part of this. If some of the States were to accept some things

that were mandated, if you will, would CMS endorse the use of that program?

MR. SMITH. I'm not familiar enough with the Employer Verification Program. I think this would be an Administration position, rather than a CMS position, and in the development of the guidance and the regulation to the States, we certainly had input from Homeland Security. I think this is an area that they are the ones who have the expertise in. But, I think it's consistent with, again, the discussions that are going on of having a reliable system that everybody knows and everybody understands that it's reliable, but again, it is one that is uniform as well, because it is difficult. You do it for, this program has its set of rules, another program has another set of rules. I think in this area there is a lot of discussion about how do you get this to--you have the confidence, but also easier to administer because everybody knows what those rules are.

MRS. BLACKBURN. So, basically, uniformity is what you are looking for, rather than a universal program.

MR. SMITH. I think that's correct.

MRS. BLACKBURN. Okay.

MR. SMITH. And again, that would be an Administration position.

MRS. BLACKBURN. All right, great.

I want--the reasonable opportunity for reverification, let me go to that for just a second. How long do you all allow at the State level for that?

MR. GORDON. We get 12 months of eligibility, and beyond that I'm not--

MRS. BLACKBURN. A full 12 months.

MR. GORDON. --that's how much eligibility you get. As far as the reasonable opportunity to show proof at that time of redetermination, I'm not sure exactly how much time we have allotted for that.

MRS. BLACKBURN. Okay. All right.

At the Federal level?

MR. SMITH. I think reasonable opportunity is generally 45 days.

MRS. BLACKBURN. Forty-five days.

MR. SMITH. But again, you are looking to the individual cooperating with you and helping you to find the documents that you are asking for.

MR. SMITH. Okay, so Tennessee is much more lenient than the Federal standard.

MR. SMITH. Well, in terms of the 12-month eligibility, that is a State decision of how long you are going to go out, but reasonable opportunity, these are sort of well established in the appeals and grievances decisions that Medicaid follows.

MRS. BLACKBURN. Okay, great.

Mr. Gordon, let's look at the TennCare expenditures for illegal immigrants, and you mentioned last month you had, is it $1.2 million, 62 individuals, $1.7 million in your testimony. So, has the State reported any TennCare expenditures for illegal immigrants to CMS, and were they only Section 1011 reimbursements, or how did that work?

MR. GORDON. In the $1.7 million, just to clarify, is all the care that we ended up reimbursing to the facilities for those 62 individuals.

MRS. BLACKBURN. Okay.

MR. GORDON. So, it didn't all $1.7 occur in the month of July, some of them may have had such conditions that may have spanned a little bit more than a month.

So again, it varies month to month. I think in many months we only see single digit numbers of individuals that providers are seeking reimbursement for.

I would tell you that, I would say on an annual basis you'd be looking at probably about $15 million total annually.

MRS. BLACKBURN. So, $15 million is what you are billing back to CMS for illegal immigrant healthcare.

MR. GORDON. For the emergency services.

MRS. BLACKBURN. Emergency?

MR. GORDON. Yes.

MRS. BLACKBURN. What about non-emergency that comes into--

MR. GORDON. We don't provide any non-emergency care.

MRS. BLACKBURN. Okay. All right.

And, that is all Section 1011.

MR. GORDON. I'm not familiar with Section 1011 with specificity.

MRS. BLACKBURN. Okay, emergency.

MR. GORDON. Yes.

MRS. BLACKBURN. That's emergency.

MR. GORDON. Yes.

MRS. BLACKBURN. Okay.

MR. SMITH. If I may, Mrs. Blackburn.

MRS. BLACKBURN. Yes, please, go ahead.

MR. SMITH. One thousand and eleven came specifically out of the Medicare Modernization Act.

MRS. BLACKBURN. Right.

MR. SMITH. So, that is all Federal dollars. The States aren't participating in that. So, CMS is directly reimbursing hospitals out of Section 1011, versus the emergency services reimbursed under Medicaid that I think the $1.7 Mr. Gordon was referring to is.

I also want to emphasize again, there is a definition of emergency services. So, going in for routine medical care would not qualify, and

also it would be for an individual who would otherwise be eligible for Medicaid. So, those are constraints as well.

MRS. BLACKBURN. Well, and that's why I was coming back to Mr. Gordon on the non-emergency, because the anecdotal that we are hearing, and we can talk about this with the hospitals in a few minutes, is that there is a good bit of that non-emergency that is coming into those emergency rooms, and the Chairman spoke so well to that in his testimony, $340 for a routine emergency room, and then you are looking at the same thing could be treated for about $70 in a doctor's office, a physician's office. And, we continue to hear this.

Now, $15 million, and TennCare's budget now is--

MR. GORDON. Seven billion.

MRS. BLACKBURN. --$7 billion?

MR. GORDON. Yes.

MRS. BLACKBURN. You know, then that doesn't sound like a whole lot, and so we've got a little bit of discrepancy in what anecdotally we're hearing and what you are saying, well, go ahead, clarify.

MR. GORDON. One thing I would point out is, since we are only required to provide reimbursement in those emergency situations, that sometimes you do have situations that an individual presents at an emergency room that if in a normal circumstance that care could have been delivered at another setting the hospital will--an application will be sent in describing the emergency, we will have our Medical Director review that, and I will tell you, child delivery in an emergency room is probably not the most appropriate place for child delivery, yet that does occur and that is one of the areas that we are to cover.

MRS. BLACKBURN. Okay. Let me jump through a couple more questions. My time is up, and I realize that, and I do still have some questions.

Mr. Gordon, Georgia is beginning to check W2s, to verify income for applying for Medicaid. Is Tennessee doing something similar?

MR. GORDON. We have, historically, checked with our labor and wage files that we collect in the State, for checking the income.

MRS. BLACKBURN. Okay.

MR. GORDON. As well as other data matches.

MRS. BLACKBURN. Let me ask you this, too. I know we've heard a good bit about this anecdotally, but in how many cases did people who were applying for TennCare claim that their official documents were unavailable? And, what were the main reasons for that unavailability? And then, in your reverification, how do you go back and check to see if those are truly unavailable? Could you give me an idea of that?

MR. GORDON. Well, I tell you, similar to what I was hinting toward earlier, especially, and again, most of it being addressed by covering

most of those that are aged, that you have situations, as far as percentage, I couldn't tell you that off the top of my head, but I would tell you that it's situations where individuals were born, had delivered children with midwives or something usually earlier on in rural areas, in the mountain areas of our State, in which case some of those documents that were listed are not always available.

Based on the DRA, we'll have to encourage those people to go through the process of trying to obtain some of those documents. Otherwise, they cannot be eligible for our program, period.

MRS. BLACKBURN. Okay. And then, going back to your payouts, out of TennCare's $7 billion, how much was paid out for emergency or temporary TennCare for those who were either ineligible for the program, or couldn't pay for the care, or couldn't find their documentation?

MR. GORDON. Again, we've always required some documentation for U.S. citizenship. So, we wouldn't have let them on if they didn't have some documentation. It may not have been included in the current list that's in the DRA, but we've required some proof of documentation.

MRS. BLACKBURN. And, do you have any idea of what percentage of that was for illegal immigrants?

MR. GORDON. No, because we wouldn't have let you on if you were not able to produce some proof of citizenship.

MRS. BLACKBURN. Okay.

MR. GORDON. So, we wouldn't have had any expenditures if you were--again, going back to requiring that they prove something, while it may not be on the DRA list, but we used other sources of documentation. So, again, with the list we'll be asking more specific questions.

MRS. BLACKBURN. Okay. Has TennCare ever used documentation not accepted by CMS or Social Security to document citizenship?

MR. GORDON. Actually, one of the things, I think, let me, under the DRA, what was previously being accepted, and I think this is not unique to Tennessee, I think it's safe to say in many States, there wasn't one set standard on what should be considered acceptable for citizenship.

So, we were looking for different types of documents, again, some of which didn't fit with the list currently today.

I would tell you, seeing that we use Department of Human Services that also interacts with Medicare and Social Security on a regular basis, that might be part of why our transition may not be as difficult as others who are used to some of those processes, and have incorporated some of those processes in determining eligibility for other programs that people may be eligible for.

MRS. BLACKBURN. Okay. Mr. Smith, anything to add?

MR. SMITH. I think we've, again, the importance of what the DRA did to instill the confidence that public programs are truly being used appropriately by U.S. citizens, protecting those who are most vulnerable, those on Medicare, those on SSI, are exempt from it. I think we achieved that balance, and again, I think the experiences that I've described in looking at this in a comprehensive approach sort of leads us down that path again, because I think we were very successful, and again, you all are to be commended for coming up with the solutions that you offered, whether in 1011 or the other special payments to meet the needs that we have.

MRS. BLACKBURN. Let me ask you this, Mr. Smith, before I leave you. Looking at the 1011 payments, and Mr. Gordon might have a little bit on this, too, and we heard from our State Senator and our State Rep, and finding a solution on how to address this funding issue has to be a partnership situation with your local, State and Federal government, clearly defining, clearly working through this process.

So, Representative Rowland had said every town is a border town, so what about our local health departments, are you hearing from local health departments, does TennCare hear from them, about the impact on them? Does CMS hear from them saying, what about Section 1011, can these local health departments access some of those funds? Hence, those are Federal funds that are going directly to the hospitals and the care centers.

MR. SMITH. I think this is an area, in particular, that we are still learning from and having the discussion with the hospitals.

For example, the billion dollars that Congress put in for the hospitals to meet this need, in some respects hospitals said, well, we don't want to get into verification of someone's status. So, we need to continue to talk with the hospitals about how to strike the balance.

The billion dollars is specifically for undocumented, and it's not for people who are not undocumented. It's not supposed to be just for anyone who walks in to the emergency room. So, the billion dollars has a very specific purpose.

Hospitals have to tell us how they are using that in a way that, again, we know that the billion dollars that Congress put in there is being used for what it was intended for.

So, I think that dialogue is still continuing. Many hospitals are, hospitals, for example, have taken on proxies in terms of using Social Security numbers, whether or not that is completely accurate or not is, again, still part of the dialogue. I think the General Accountability Office has been looking at 1011 also.

So, I think you did the right thing, but how it's implemented and executed I think still takes a little bit of dialogue between CMS and the hospital.

MRS. BLACKBURN. And, I appreciate that, because listening to Mr. Gordon, it seems that what I'm hearing him say is, well, TennCare feels we don't really have a problem with illegal immigration. We had $1.7 million that was paid out in one month, and about $15 million total for a year for these services, many of which are child births. Am I correct in restating that, sir?

MR. GORDON. Except for the fact that I consider $15 million a lot of money, but other than yet, yes.

MRS. BLACKBURN. Well, I do, too. I consider it to be an incredibly large amount of money.

Looking at TennCare's budget of $7 billion, and then you start saying this is where our problem is, then my question is, if you all feel you do not have a problem with illegal immigration, and you are, basically, saying we have set some processes in place so this is not a problem, but we are hearing from our local governments that emergency rooms are full, that our health clinics, our community health centers are full, we've got a disconnect somewhere.

And, what I want to do is figure out where this disconnect is. Every dollar a taxpayer spends is a lot of money.

MR. GORDON. And, I think maybe where some of that disconnect may come from is the fact again, we only cover those people that would--we only reimburse hospitals for those people that would otherwise have been eligible for our program. That is not a very broad category. So there, and again, I think hospitals will be better prepared to speak to that.

MRS. BLACKBURN. One more question for you, and I have way over stayed my time, and we do have other panels, I would like to know if you have reverified or are in the process of reverifying individuals currently on TennCare going back to when TennCare was put in place in January, '95, and then coming up through the time that Tennessee exercised the additional leniencies in its driver's license policies, and coming forward with the DRA. And, you can submit this in writing, I'm not going to put you on the spot to submit it right now, but I think, Mr. Chairman, it would be helpful for us to know what kind of reverification process you all plan to engage in to ensure CMS and the citizens, that those that are on the program, on TennCare, are legally in the country and are the individuals that are to be on that program.

MR. GORDON. Absolutely.

MRS. BLACKBURN. Thank you. I appreciate it.

Mr. Chairman, I yield back, and thank you for your consideration.

MR. DEAL. Let me just follow up very quickly.

Mr. Gordon, I'm sure you are not totally surprised, since your verification process did require some evidence of citizenship, but the documents don't correspond, as you indicated to the current standard. I'm sure you are not going to be totally surprised to find that many of those documents you were relying on were fraudulent and forged documents. You are not going to be surprised by that, are you?

MR. GORDON. I would have no way of knowing whether or not they were or weren't.

MR. DEAL. The reason I say that is, that document fraud is one of the biggest problems that we have in this country in every program. I think that's what the challenge that Mr. Smith and his agency has is to try to get back to non-forgible documents. Have that as the basis for certification of eligibility, and that's going to require cooperation at both the State and the Federal level, working together to achieve that goal.

One final question, Mr. Smith, is it not true that if Mr. Gordon, the Representative, or anyone from the State of Tennessee or any other State, wishes to make further comments that you are still in the comment period with regard to some of these issues?

MR. SMITH. Mr. Chairman, you are correct, but we only have one more day.

MR. DEAL. Oh, good thing I asked the question today then.

MR. SMITH. Yes, sir, and we have received comments.

MR. DEAL. Well, good. Thank you.

Thanks to both of you for being here.

MR. DEAL. I'll call our third panel to the front.

This panel is Mr. Richard Flores, who is Vice President of Revenue Cycle at LifePoint Hospitals here in Brentwood, Tennessee, Mr. Bob Duncan, who is Vice President for Advocacy and Government Relations of Methodist Healthcare-LeBonheur in Memphis, and Mr. Gary Perrizo, who is the Director of Patient Accounting, Department of Finance, at Vanderbilt University.

Gentlemen, we are pleased to have you here, and we will hear your opening statements beginning with Mr. Flores.

STATEMENT OF RICHARD FLORES, VICE PRESIDENT OF REVENUE CYCLE OPERATIONS, LIFEPOINT HOSPITALS, INC.; BOB DUNCAN, VICE PRESIDENT FOR ADVOCACY AND GOVERNMENT RELATIONS, METHODIST HEALTHCARE-LE BONHEUR CHILDREN'S MEDICAL CENTER; AND GARY PERRIZO, DIRECTOR OF PATIENT ACCOUNTING, VANDERBILT UNIVERSITY MEDICAL CENTER

MR. FLORES. Thank you, sir.

Good morning, I'm Richard Flores, Vice President of Revenue Cycle Operations at LifePoint Hospitals here in Brentwood, Tennessee. Thank you for inviting me to testify today.

LifePoint owns seven rural hospitals located across Tennessee. The local hospital is often one of the largest employers in the community, along with a great number of family-owned farms. The south middle part of the State, where several of our hospitals are located, is well known for its tree nurseries. Needless to say, there are quite a few uninsured people living in these areas.

Our hospitals are ready and willing to serve the people who live in their communities. Many of them come to the emergency rooms because they do not have insurance and they have no other place to go to get care. Some of these individuals may be undocumented immigrants.

As you know, the Federal Emergency Medical Treatment and Active Labor Act, called EMTALA, requires hospitals to treat anyone who comes through the door, regardless of their immigration status. This Federal law prohibits hospitals from asking anyone who comes into the emergency room any financial information until they are medically screened. By that time, they have become our patients. It would be an impossible task for hospitals to determine a patient's legal status prior to providing care due to Federal rules and regulations.

Tennessee hospitals are experiencing unprecedented uncompensated care levels, which includes charity care as well as bad debt. Tennessee claims data show a continuing increase in uninsured volumes. From calendar year 2004 to calendar year 2005, the cost to Tennessee hospitals of treating the uninsured in the emergency room increased by $144 million. In 2005, the unreimbursed TennCare cost, combined with the cost of charity care, bad debt, and medically indigent care, reached over $1 billion.

Due to the 2005 TennCare disenrollment changes, LifePoint Hospitals in Tennessee experienced a reduction of $10.2 million in TennCare gross revenues in the first 6 months of 2006 versus the same period in 2005. During that same period, we experienced an increase of $5.3 million in self-pay gross revenues. Similarly, TennCare emergency room visits declined 23 percent while self-pay emergency room visits increased 42 percent. Please keep in mind that rural hospitals have far fewer referral options, such as indigent clinics, than our urban hospital counterparts.

Tennessee's Medicaid program is similar to other States, with the exception of having access to a disproportionate share of hospital allotment, commonly referred to as DSH. Access to a DSH allotment would allow Tennessee's hospitals the ability offset the ever-growing

costs of providing services to those without insurance. We should be allowed to have Tennessee's hospital on a level playing field with all other hospitals in the country, since we are one of only two hospitals that do not receive a DSH payment.

I would like to acknowledge and thank Congresswoman Blackburn for supporting Tennessee's hospitals' effort to secure a permanent DSH payment for Tennessee hospitals.

Now, Tennessee's DSH payment should be consistent with DSH payments received by other States with a similar number of enrollees. Without it, hospitals may downsize, potentially reduce, or even eliminating important healthcare services to support the communities, especially in rural areas.

I want to thank you for the opportunity to explain the uninsured and uninsurables, how they are impacting our hospitals and emergency room utilization. We strongly urge you to consider approving Tennessee's request for a permanent DSH payment, since it will help offset the constantly increasing amount of uncompensated care that hospitals are providing for the people who live in their communities.

Thank you.

[The prepared statement of Richard Flores follows:]

PREPARED STATEMENT OF RICHARD FLORES, VICE PRESIDENT OR REVENUE CYCLE, LIFEPOINT HOSPITALS

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Tennessee's DSH payment should be consistent with DSH payments received by other states with similar numbers of enrollees. Without it, hospitals may downsize, potentially reducing or eliminating important healthcare resources that support their communities, especially in rural areas.

Thank you for the opportunity to explain how the uninsured and uninsurables are impacting our hospitals and emergency room utilization. We strongly urge you to consider approving Tennessee's request for a permanent DSH payment since it will help offset the constantly increasing amount of charity care that hospitals are providing for the people who live in their communities.

Thank you.

MR. DEAL. Thank you. Mr. Duncan.

MR. DUNCAN. Thank you, sir. Good morning, I'm Bob Duncan, Vice President of Advocacy and Government Relations for Methodist Healthcare-LeBonheur Children's Medical Center in Memphis, Tennessee. Thank you for inviting me to be here and the opportunity.

Before I begin my formal testimony, I would like to recognize and thank Representative Blackburn for her concern, commitment, and support for Le Bonheur Children's Medical Center. She has been a leader in bringing greater access and quality healthcare to the children of Tennessee and the surrounding States. Thank you, Congressman Blackburn.

The mission of our hospital, like other institutions in Tennessee, is to take care of people in our community who are sick, injured, or entered the world with severe medical problems. When admitting a patient or tending to a sick child or newborn with life-threatening conditions, it does not matter whether they are documented or undocumented immigrants, uninsured individuals, people on commercial plans, or those enrolled in TennCare. Our number one priority is to provide healthcare services to all the people who need it. We are obligated to do so.

As you know, Tennessee's Medicaid program, TennCare, has just completed a fairly significant restructuring. As a result of the changes, TennCare is now similar to the other States Medicaid programs. While we support many of the changes that occurred, Tennessee hospitals continue to see growth in uncompensated care.

In fact, in 2005 Tennessee's hospitals provided over $1 billion in uncompensated TennCare, charity care, and bad debt, an amount that is expected to increase this year and well beyond. Many of the uninsured will continue to seek primary and emergency care through hospital emergency rooms.

This past year our system alone had approximately $47.5 million in charity write offs, $8 million of this coming from our emergency room.

We believe that the Federal government, along with State government, has a role in paying for charity care. Hospitals are not paid what it costs them to provide care to uninsured individuals and charity patients. In 2004, 48 of Tennessee's 130 acute care hospitals were losing money. Another seven hospitals had operating margins below 2 percent. As a result, over 42 percent of Tennessee's hospitals are at financial risk. As you can see, we need your help to remedy this situation.

As Richard mentioned, Tennessee is now one of only two States that does not have a permanent Medicaid disproportionate share hospital payment to help offset uncompensated care costs for charity and TennCare patients. Tennessee had a Medicaid DSH program prior to the implementation of TennCare in 1994. The State gave up that DSH program under the assumption that TennCare's coverage of the expansion populations would drive charity care levels down, thereby eliminating the need for the DSH payments. This never proved true, however, and charity care costs were back at pre-TennCare levels in 2000.

It is imperative that Tennessee's hospitals obtain a permanent Medicaid DSH payment to help offset at least some of the costs providers incur caring for charity and TennCare patients. We'd like to thank you again for this opportunity to tell you our concerns about caring for some of the most vulnerable people in our community and appreciate your interest in addressing the issue of uninsured care and finding solutions.

Thank you, have a good day.

[The prepared statement of Bob Duncan follows:]

PREPARED STATEMENT OF BOB DUNCAN, VICE PRESIDENT FOR ADVOCACY AND GOVERNMENT RELATIONS, METHODIST HEALTHCARE-LEBONHEUR CHILDREN'S MEDICAL CENTER

Good morning! I am Bob Duncan, vice president for advocacy and government relations at Methodist Healthcare-Le Bonheur Children's Medical Center in Memphis, Tennessee. Thank you for inviting me to testify today.

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The mission of our hospital, like other institutions in Tennessee, is to take care of people in our community who are sick, injured or entered this world with severe medical problems. When admitting a patient or tending to a sick child or newborn with life-threatening conditions, it does not matter whether they are documented or undocumented immigrants, uninsured individuals, people on commercial plans or those enrolled in TennCare. Our number one priority is to provide healthcare services to all the people who need it. We are obligated to do so.

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In 2005, Tennessee's hospitals provided over ***$1 billion*** in uncompensated TennCare, charity care and bad debt, an amount that is expected to increase this year and beyond. Many of the uninsured will continue to seek primary and emergency care through hospital emergency rooms.

This past year, our system had approximately $47.5 million in charity write-offs. Included in this number is $8 million of ER charity care.

We believe the federal government, along with state government, has a role in paying for charity care. Hospitals are not paid what it costs them to provide care to uninsured individuals and charity patients. In 2004, 48 of Tennessee's 130 acute care hospitals were losing money. Another seven hospitals had margins below 2 percent. As a result, over 42 percent of Tennessee's hospitals are at financial risk. As you can see, we need your help to remedy this situation.

Tennessee now is one of only two states that does not have a permanent Medicaid disproportionate share hospital payment to help offset uncompensated care costs for charity and TennCare patients. Tennessee had a Medicaid DSH program prior to the implementation of TennCare in 1994. The state gave up that DSH program under the assumption that TennCare's coverage of the expansion populations would drive charity care levels down, thereby eliminating the need for the DSH payments. This never proved true, however, and charity care costs were back at pre-TennCare levels in 2000.

It is imperative that Tennessee hospitals obtain a permanent Medicaid DSH payment to help offset at least some of the costs providers incur caring for charity and TennCare patients. We thank you for the opportunity to tell you our concerns about caring for some of the most vulnerable people in our community and appreciate your interest in addressing the issue of uninsured care.

Thank you.

MR. DEAL. Thank you. Mr. Perrizo.

MR. PERRIZO. Thank you, Chairman Deal and Congresswoman Blackburn, for allowing me to testify in this important field hearing. I am Gary Perrizo, Director of Patient Accounting, at Vanderbilt University Medical Center, located here in Nashville.

I will summarize my testimony and request the full written testimony already provided be included in the records of this hearing.

MR. DEAL. It will be included.

MR. PERRIZO. Thank you.

I would like to explain how an illegal immigrant actually enters into the Vanderbilt system. Basically, through the emergency room or brought directly to our trauma center. If the patient is admitted, our registration staff will try to determine if the patient is a possible illegal

immigrant. If believed that they could be, the patient is referred to the Department of Human Services of the State of Tennessee. If DHS determines that it is an illegal immigrant, as I think we've already heard, the patient is enrolled in TennCare, but only for that single admission.

Vanderbilt will then receive payment from the TennCare MCO for the emergency admission at the TennCare contractual rates. Some recent data that we have assimilated is that so far in 2006, this calendar year, we have admitted 174 undocumented patients. This is a 17 percent increase over the same period last year.

One hundred twenty of this year's undocumented patients had been deemed illegal immigrants by DHS, and had been granted TennCare coverage. The reimbursement received, like all TennCare cases, is approximately 65 percent of the actual cost for services provided. This results in a loss to Vanderbilt of approximately $599,000 on these admissions thus far.

Forty-seven of the patients are under review by DHS at this time. If these patients are not granted TennCare coverage, the estimated loss will increase by another $755,000.

For the illegal immigrants that were admitted for this same period in 2005, more than 20 percent of those patients returned for non-emergency care, which was not covered by TennCare.

Another category of patients are the illegal immigrants that receive emergency room care but are not admitted, the treat and release population. Registration staff in an ER cannot determine if the patient is in the United States legally or illegally.

For visits from January 2005 through March of this year, 504 visits were made by possible illegal immigrants. The total unreimbursed cost of these visits is $858,000. This results in an estimated annual cost of unreimbursed care to illegal immigrants at Vanderbilt of $3.8 million.

Although this is significant, it pales in comparison to the overall uncompensated care Vanderbilt provides in this community. We are morally and legally bound to provide care in an emergency condition. This is consistent with our mission and consistent with the compassion of the just society in which we live.

Under Federal laws, like EMTALA, we are required to provide emergency care regardless of a patient's immigration status or ability to pay. The moral and legal requirements carry a significant price tag for hospitals and doctors, especially at our Nation's academic medical centers.

At Vanderbilt in the past 12 months, the cost of providing care to patients that are unable to pay topped $74 million.

I would like to briefly mention three concerns we have at Vanderbilt. First, the implementation of TennCare in 1994 resulted in the elimination

of the Medicaid disproportionate share payments. TennCare, though, has evolved where eligibility is functionally equivalent to traditional Medicaid in other sites in which a disproportionate share payment is made. It is imperative that Tennessee be provided with a disproportionate share payment allotment under Federal law.

Secondly, the House immigration bill would criminalize any caregiver who knowingly provides care to an illegal immigrant. We do not believe that the intent of this bill would have doctors and nurses stand by and not intervene to save a human life or prevent suffering. This would be a direct contradiction to the Federal EMTALA law.

Lastly, for many families, especially those of limited resources and ability, gathering the required documentation to enroll in TennCare could be a significant challenge. For women that are expecting a child, any delay in gathering the required documentation could result in delays in obtaining prenatal care. We believe that in the case of pregnancy, the law ought to allow prenatal care to begin while documentation is gathered and prepared.

I would like to thank Chairman Deal and Congresswoman Blackburn, and her support for Tennessee getting a DSH payment, and would answer any questions you might have.

Thank you.

[The prepared statement of Gary Perrizo follows:]

PREPARED STATEMENT OF GARY PERRIZO, DIRECTOR OF PATIENT ACCOUNTING, DEPARTMENT OF FINANCE, VANDERBILT UNIVERSITY MEDICAL CENTER

Thank you for the opportunity to testify at this important field hearing. My name is Gary Perrizo and I am the Director of Patient Accounting at Vanderbilt University Medical Center. I have been asked to discuss the impact of treating illegal immigrants on our medical center.

Let me begin by explaining how illegal immigrants enter our system. Primarily these individuals come to either our emergency department or they are transported to our trauma center. If it is necessary to admit an individual to the hospital, our registration staff makes an initial effort to determine citizenship/immigration status. If it is believed that the patient may be an illegal immigrant, the case is referred to the Tennessee Department of Human Services (DHS) for their review. If DHS determines that the patient is an illegal immigrant and is in need of hospitalization, the individual will be enrolled in TennCare for a single period of hospitalization and we will receive payment from a TennCare MCO for their emergent care at TennCare contractual rates. I can provide some data about Vanderbilt's recent experience with this category of patients.

For the period January 1, 2006 through August 6, 2006, Vanderbilt has admitted 174 undocumented patients, an increase of 17% over the same period last year. Thus far, DHS has determined that of these 174 patients, 120 were illegal immigrants and were granted TennCare coverage. The reimbursement received by Vanderbilt for these cases (as is true of all TennCare cases) is approximately 65% of the actual costs incurred in treating these patients, resulting in a net loss to the Vanderbilt of approximately $589,000 over the past 7 months. The remaining 47 patients have been determined to have no resources with which to pay for their care and we are awaiting a DHS determination of

their eligibility for coverage under TennCare. If no reimbursement is obtained for these 47 undocumented admissions, the estimated loss will increase by $755,000. For 7 admissions, other insurance coverage for the undocumented patients was obtained through workers compensation or other programs and that provide full reimbursement to Vanderbilt.

For illegal immigrants who had received emergency admissions at Vanderbilt in 2005, more than 20% returned for follow-up care that was not covered by the TennCare program and those costs are not included in our estimates above.

Now let me discuss a second category of patients -- illegal immigrants who are seen for emergency care but not admitted to the hospital. Typically the registration staff in an emergency room have no way of knowing or tools to determine if a patient is in the United States legally or illegally. Of the visits between January 1, 2005 and March 31, 2006, 504 are possible illegal immigrants based on the information provided at registration. The total unreimbursed cost of these visits to the Medical Center is approximately $858,000.

Based on these figures, I estimate that our annual cost of unreimbursed care for services provided to illegal immigrants is about $3.8 million. It is a significant contribution but pales in comparison to the overall price tag that Vanderbilt bears in providing uncompensated care within our community.

We are morally and legally obligated to provide care for anyone who is in urgent need. It is consistent with our mission and it is consistent with the compassion of the just society in which we live. Under other federal statutes, particularly EMTALA, we are required to provide emergency care to all who present themselves at our emergency department, regardless of their citizenship/immigration status, and regardless of whether they have insurance coverage or the ability to pay.

But that moral commitment and legal requirement to care for those in need has come to carry a significant price tag for hospitals and doctors alike especially those at our nation's academic medical centers. At Vanderbilt in the past 12 months alone our cost for providing care to individuals who were unable to pay for that care topped $74 million. While only a small fraction of our charity and indigent care patients are undocumented, we have seen a steady growth of undocumented patients paralleling the growth of our immigrant population in general.

Let me briefly mention three specific issues of concern to Vanderbilt. First, since the establishment of TennCare in 1994, Medicaid Disproportionate Share Payments were eliminated under the state's Section 1115 Waiver. TennCare has evolved, however, so that eligibility for coverage is functionally equivalent to traditional Medicaid programs in other states that receive DSH payments. As such it is imperative that Tennessee be provided with a DSH allotment under federal law.

Second, the House immigration bill would criminalize any caregiver who knowingly provides care to an illegal immigrant. We do not believe that the drafters of this bill intended to have doctors and nurses stand by and not intervene to save a life or prevent suffering. To do so would be repugnant to our values as a nation and to our oaths taken as providers. It is also in direct contradiction to the federal EMTALA law.

Finally, for many families, especially those of limited means and those who may or may not have strong language and cultural skills, gathering and preparing the necessary documentation to establish their eligibility for TennCare or immigration status could from time to time present challenges. For a woman who has recently discovered she is expecting a child, the inevitable delays in assembling documentation may result in delays in securing appropriate pre-natal care. We believe that in the case of pregnancy, the law ought to allow pre-natal care to begin while documentation is prepared. The avoided costs of precise pre-natal care are well documented in literature. The principle that should guide in the case of a pregnant woman ought to be to treat first and sort the rest out later.

Thank you for the opportunity to present to this committee and this chance to comment on such an important topic. I am happy to answer any questions you or members of the Committee may have.

MR. DEAL. All right, thank you gentlemen.

First of all, let me pick up, Mr. Perrizo, with some of your comments. Your concern, as I understand it, is that you think the House version of the immigration reform would criminalize anyone who would provide medical care. Let me assure you that that is not my understanding. It is an issue that, in light of your comment, we will certainly go back and review. It is, I'm sure, not the intent of anyone to do that, because there you would have, as you point out, a conflict between the requirements of EMTALA, I don't think, let me assure you, is the intent of the House of Representatives.

I think the intent of the House of Representatives is that we stop having a wink and a nod on this issue of illegal immigration. It's going to require institutions such as hospitals to be cooperative in that effort.

As was pointed out earlier by Mr. Smith, I believe it was this $1 billion that we authorized under the MMA to pay for uncompensated care for illegal immigrants. I haven't heard the latest, but what I have been told is that, as he indicated, most hospitals are not particularly interested in that. They would just as soon not apply for those funds because it requires them to submit information and documentation that says we are eligible for this amount of money under this billion dollars that's been allocated.

The point I would make to you is, that if we are going to make these reforms is that we all have to work together cooperatively, and you are an important link in that chain.

I recognize, and I think I know Mrs. Blackburn and I both recognize, that EMTALA is one of the real problem points and pressure points for hospitals. As Mr. Flores pointed out, without some changes to that, by the time you go through the screening process in the emergency room you might as well go ahead and treat the patient, because the time and the effort that you've expended is already a considerable amount of what you would do, perhaps, anyway.

One of the things that we try to do under the DRA, in fact there was a provision that I fought for hard and fast, and we got it through the House. We could not get it through the conference committee because the Senate would not agree to it, was a provision that I think would put a common-sense approach to this. It says that if it is very obvious early on that this is not an emergency room matter, it is a non-emergency presentation, that the hospital and the doctor in charge would have the authority to divert that individual to a non-emergency room setting.

As you point out, many rural areas don't have the opportunity for those non-emergency room settings, but many do, and many more will have. In fact, tonight I am speaking to what is now the largest free medical clinic in the State of Georgia, and one of the ten largest in the entire United States, which is in my hometown. My hometown of Gainesville, Georgia is not any thriving metropolis, and, quite frankly, it's not nearly as large as the community where we sit here today. But, my medical community and my hospital, in fact, my local hospital has over the last 3 years donated a million dollars to this free medical clinic that accepts no governmental money, neither Federal, State, nor local.

So, I think we have to encourage those kind of things, but the key to a diversion, as I know all of you know, and as I know my doctor friends certainly recognize, is there has to be some liability protection for making that decision, because you are not going to always be 100 percent correct.

In our legislation that we passed in the House, and Mrs. Blackburn was helpful in getting that through our Committee and then through the House version, provided that kind of protection for those in the emergency room who will make that diversionary decision.

As I said, unfortunately, it did not survive in the final version, but I think we have to revisit issues like that, because we can do all the good things that I think we've probably talked about. I think in general there is agreement that we ought to mean what we say when we pass a law that says that this is a program that is taxpayer supported and it's intended for our citizens, and not intended for anybody else. We ought to mean that, and to enforce it. There are going to be some pressure points, but it does require all of us to work cooperatively, because when it is enforced in that regard what's going to be the logical consequence? The emergency room is going to be the point of presentation.

What that says to me is that we just don't throw up our hands and say, oh, well, it didn't work, it simply says, it emphasizes the importance of our entire immigration structure and the enforcement of those coming into our country, so that we don't have these problems developing as an after-the-fact consequence.

So, I want to tell you that we do appreciate what hospitals do. You provide valuable services. We are very cognizant of the fact that the EMTALA situation needs to be revisited. Quite frankly, I don't know that there is the political will to do it, because the alternatives have not fully matured yet.

However, as a part of the DRA, we had $50 million that was there to encourage and help provide grants for these alternative clinics to be developed. So, I'm sure that our State representatives and senators, and, hopefully, governmental officials in the State of Tennessee, are taking a

close look at that grant program, because those alternative sites will in large part be part of the answer that is there.

Now, that's not to say that you don't have to develop a pattern in patience, and you all recognize that very well. If they consider your emergency rooms to be their medical home, they are going to continue to show back up there.

So, part of the process is an education process that I'm sure many of you are already doing to educate people as to alternative sites that are less costly than your emergency rooms.

Does anyone want to comment about that aspect of it?

MR. PERRIZO. I'll say a few words on that.

Yes, we realize that at Vanderbilt, as a matter of fact, our faculty staff, nurses, et cetera, actually help support by working, et cetera, at three clinics here in Nashville that are unfunded, as what you were talking about.

MR. DEAL. Right. Well, in fact, every State, according to my study, now has at least one free clinic, and many states like mine have as many as 30, I believe is the latest that we've seen. I think that is sort of the wave of the future, to help take some of this pressure off of what you are experiencing in your emergency rooms, and that is the most expensive point of presentation in the whole healthcare system.

So, I'm not going to take anymore of the time, and defer the remaining amount of my time to your Congresswoman, who does such a good job.

MRS. BLACKBURN. Thank you, Mr. Chairman.

Let's go back to talk about the DSH payments for just a minute, to be certain that everyone who is watching this hearing, and those who are in the room, understand that when Tennessee decided in '94 that they were going to move to the TennCare program, and do under Section 1115, their managed care program, they decided to not have the DSH payments. They forewent those payments, and I think we need to understand that, that that was an Administration decision at that point in time.

The other part is, TennCare is an Executive Order program in this State. Representative Rowland and Senator Ketron, and their colleagues in the General Assembly, cannot go in and pass a law and change that. The same thing, we can't go in and pass a law and change the TennCare program. That is a State program, and I want to be certain that everyone understands that premise as we move forward in our discussion.

So, with that understanding, going back to '94, and you can give this answer to me in '94 dollars and we can run it out, or you can give it to me in today's dollars, so to each of you, for the hospitals that you have

referenced, I would ask you, before TennCare how much money did you get in Medicaid and Medicare DSH payments? Any idea?

MR. PERRIZO. I can't say for 1994, but in today's dollars we have estimated that our DSH payment would be approximately $39 plus million.

MRS. BLACKBURN. Thirty plus--

MR. PERRIZO. In today's dollars.

MRS. BLACKBURN. --did you say million?

MR. PERRIZO. Million, Thirty plus million.

MRS. BLACKBURN. Since we are talking in millions and billions today, and very seldom in dollars and cents today, I want to be certain that we get that correct for our record.

Thank you, Mr. Perrizo.

MR. DUNCAN. I don't have those numbers on the top of my head, but it would be roughly half that estimate.

MRS. BLACKBURN. Half that estimate. Okay, so you are saying about $15 million.

MR. DUNCAN. Yes.

MRS. BLACKBURN. That's what you would have received in the DSH payments.

Mr. Flores, any idea? I don't think LifePoint was even in existence in '94.

MR. FLORES. We were not, not until 1999. However, I did want to point out that based on CMS' own estimates, Tennessee's DSH allocation would have been $447 million in 2003. However, the State and CMS were able to provide $100 million in essential access payments to hospitals that year, which is approximately 22 percent of what we would have gotten had we received the DSH payment.

MRS. BLACKBURN. Okay. Let's move to the essential access hospital payments, the EAH payments. So, this is what you all currently get. So, why don't you tell me how much you are receiving each year.

And, Mr. Perrizo, we'll start with you on the EAH payments.

MR. PERRIZO. I don't know at this time.

MRS. BLACKBURN. You don't know.

MR. PERRIZO. I could get you that information.

MRS. BLACKBURN. Perfect.

Mr. Duncan?

MR. DUNCAN. Approximately, $8 million.

MRS. BLACKBURN. Eight million. All right.

Okay, Mr. Flores?

MR. FLORES. Likewise, I would have to provide that.

MRS. BLACKBURN. Okay, if you will provide that.

And then, also provide for me in that number how that is broken down between the emergency and the non-emergency care, because if TennCare is saying they really don't have a problem with the illegal immigration issue and the verification issue, and one of the promises, if you will, of TennCare was to be that you would solve the problem of charity care at the hospitals. You would at least be receiving something for the amount of charity care that you provided.

Of course, what we have seen is that it seems, and what we are hearing from your testimony is, the emergency care is increasing every single year at an increasing percentage than the year prior.

Everyone is nodding in agreement on that.

So, we can say that no longer holds forth, that premise of TennCare did not work, and the essential access payments are not meeting the needs that you would have from a DSH payment, and offsetting this.

Okay. Another thing that I would like to know as we look at this funding mechanism from the hospitals, and, Mr. Chairman, if I may, I see Mr. Becker, and I know that other hospitals are represented, I think that this may be a point that we would want to look at as we talk about managed care programs, looking at what percentage of the total budget the EAH and the DSH payments contribute, Medicare DSH payments, looking at what percentage of your total budget, your operating budget every year, what reliance there is upon those payments.

So, as you submit your figures, let's submit that one also, so that we can be comparing apples to apples, and oranges to oranges, as we move forward in this discussion.

Mr. Flores, coming back to you, I think in your testimony you said that the primary emergency service was pregnancy and delivery?

MR. FLORES. No, but it was in testimony before.

MRS. BLACKBURN. Was that the prior testimony? Okay. All right. We've got too many sheets of paper around here.

What I would like to know from you all is the most common types of emergency and non-emergency ER, what you all are seeing in your hospitals, where the greatest pressure comes, because one of our concerns is the misuse of emergency room services and the increasing costs of that misuse to the taxpayer, and the fact that that misuse then does prohibit access, timely access, to citizens who are there to use those services.

Okay. Another question, just looking at--before we leave the DSH payment, when Tennessee made the decision to forgo the DSH payments in lieu of a restructured Medicaid payment, via TennCare, those extra dollars, does TennCare itself keep those dollars, or are those coming to you all via another revenue stream or another avenue? Are you seeing any increased revenue stream via TennCare funding?

MR. PERRIZO. No.

MRS. BLACKBURN. Mr. Perrizo, you are not.

MR. PERRIZO. No.

MR. DUNCAN. No.

MRS. BLACKBURN. Mr. Duncan, you are not.

MR. FLORES. No, ma'am.

MRS. BLACKBURN. You are not, okay, so we've got money just in thin air somewhere. Okay.

Physicians assistants and nurse practitioners in the ER, are you all extensively using those in the ER as you staff?

MR. PERRIZO. Yes.

MRS. BLACKBURN. You are. Okay. Is that a successful practice? Okay, it keeps some of the costs down?

MR. PERRIZO. Yes, it does. In some of our clinics that I was referring to earlier, are with nurse practitioners, very intensively, for primary care types of items.

MRS. BLACKBURN. You know, I'm hearing of some States and local governments that are beginning to send non-emergency care that is coming to the ER to clinics. Is that a practice that you all are considering?

MR. PERRIZO. We are actually trying to refer them to the right site for their service.

MRS. BLACKBURN. Okay, and you are doing the referral to the appropriate site and type caregiver.

MR. PERRIZO. Correct.

MRS. BLACKBURN. Correct. Okay. Mr. Duncan?

MR. DUNCAN. Doing the same thing. We have the church health center there, or the community help loops.

MRS. BLACKBURN. Okay, the community help centers?

MR. DUNCAN. Yes.

MRS. BLACKBURN. You are referring, okay.

And, are you doing that in Shelby County as well as in the outlying counties?

MR. DUNCAN. I couldn't speak to the outlying counties, because our hospitals are all located in the Shelby County, other than Fayette.

MRS. BLACKBURN. Okay, one other question on the verification status, because we've heard from our elected officials, and then TennCare and CMS, about verifying an individual's status. And, looking at the verification and then the reverification status through the documentation, I know that it would be very difficult to ask a patient about their immigration status before receiving care, but my question to you would be, as they continue in your care do you have a period of time in there where you ask a patient their immigration status or ask for

documentation and paperwork as you are doing your paperwork? Do you all ever ask for that status?

Mr. Perrizo?

MR. PERRIZO. On the in-patient side, those patients I was referring to earlier, the 174 undocumented, our financial counselors actually work with the patients and/or their families while they are in house to try to obtain that information. That's how we are able to actually say someone is undocumented. We don't know if they are illegal.

MRS. BLACKBURN. Okay. So, you actually begin to move through that before you send them to DHS.

MR. PERRIZO. Correct.

MRS. BLACKBURN. To make their determination.

MR. PERRIZO. Yes, ma'am.

MRS. BLACKBURN. So, you would probably have a little bit of disagreement with Mr. Gordon then, when it comes to whether or not they are providing care for those that are in here illegally.

MR. PERRIZO. Well, we are already providing the care, it's just will we get reimbursed.

MRS. BLACKBURN. Right, their payment for it. They had a total of $1.7 million in July for 62 patients, and you all, so far this year, have had 174 patients, 120 were illegal, and about 65 percent of the actual cost incurred in treating these patients, that was a $589,000 loss over a seven-month period.

MR. PERRIZO. Correct.

MRS. BLACKBURN. Now, okay, you have that kind of loss over that period of time, and you, as one single facility in this State, have that type loss, and we hear from TennCare that they've got 62 people within a month, 62 individuals that are within this service, how do you go back and recoup those dollars? Are you cost shifting to the private sector? You are not getting a full reimbursement on your TennCare. We know what your Medicare reimbursement rate is, so how does a facility like Vanderbilt, you are the Director of Patient Accounting, and you've got to look at that bottom line, how do you square those numbers and recover and cover that type loss?

MR. PERRIZO. Well, as we were speaking earlier, the uncompensated care, not only at Vanderbilt, but in the State of Tennessee, is a problem. Not just from the illegal immigrants, but from the general uninsured and under-insured population.

A facility has no choice but to either raise their rates, renegotiate their contracts and shift those losses to the insurance companies paying those providers' bill, or the private pay sector that can afford it are charged more.

MRS. BLACKBURN. I appreciate that. You know, we are hearing from some of those that oppose addressing the illegal immigration issue, that there is not a problem, or that no problem exists, and we don't--but, I think that exactly what you are saying indicates there is a problem, there is a disconnect, between what is verified, what we hear from our entities as being verified and people that are on Medicaid, the care that is being delivered, we see that your charity care increases every single year, and somebody is going to pay the bill. And, it is many times going to be those private pay.

So, I would say that this refutes that argument that there is no problem, there is a problem and a pressure to the system.

Anything either of you would like to add to that? No.

Mr. Chairman, thank you.

MR. DEAL. Well, thank you, and on that latter point, I think we all recognize that as we see the number of uninsured in our country rise, anything that puts pressure to drive up the cost of private health insurance is necessarily going to increase the number of uninsured, because the insurance policy becomes even more unaffordable. So, this is one of those factors that drives up the cost of private insurance and, therefore, necessarily, increases the number of total uninsured in our country. So, it is a problem.

I want to thank you gentlemen for being here. We appreciate your testimony.

This concludes the panels that were scheduled to testify here today. As I indicated at the outset, this is a field hearing of the Health Subcommittee of the Energy and Commerce Committee, and as such we operate under the rules of that Committee, just as if we were holding this hearing in our chambers in our meetings rooms in Washington, D.C. As a result of that, it does not allow us, unfortunately, to have audience participation.

I'm sure Mrs. Blackburn and I will both be here for a little while, for those of you who may wish to follow up with anything with us personally.

This is the first of two hearings. The second will be in Dalton, Georgia, at 10:00 a.m. next Tuesday, the 15th, at the Trade Center there. In light of that, we will now stand in recess until that hearing resumes next Tuesday.

Thank you all.

[Whereupon, at 12:09 p.m., the committee was adjourned.]

EXAMINING THE IMPACT OF ILLEGAL IMMIGRATION ON THE MEDICAID PROGRAM AND OUR HEALTHCARE DELIVERY SYSTEM

THURSDAY, AUGUST 15, 2006

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The committee met, pursuant to notice, at 10:00 a.m., in the Lecture Hall, Northwest Georgia Trade and Convention Center, 2211 Dug Gap Battle Road, Dalton, Georgia, Hon. Nathan Deal [member of the committee] presiding.

Members present: Representatives Deal, Norwood, and Solis.

Staff Present: Brandon Clark, Policy Coordinator; Katherine Martin, Professional Staff Member; Chad Grant, Legislative Clerk; and Amy Hall, Minority Professional Staff Member.

MR. DEAL. We will call the Subcommittee to order. This will be the second session of hearings that began last week in Nashville, Tennessee, a meeting of the Health Subcommittee of the Energy and Commerce Committee of the House of Representatives.

My name is Nathan Deal, I have the opportunity to chair that Subcommittee and I am pleased to have two of my colleagues here today, who I will introduce when it is appropriate for them to give their opening statements.

Let me just sort of give a general overview of the process that will be followed. This is a hearing, just as if it were a hearing in Washington, D.C., in our committee rooms there. It will be a panel of witnesses that are going to present testimony followed by questions from the Members of Congress who are here today. That is the format that we will follow and we will proceed and I will recognize myself for an opening statement at this time.

The topic which we are examining is: Examining the Impact of Illegal Immigration on the Medicaid Program and our Healthcare Delivery System.

Today, we are going to hear from three panels of distinguished and expert witnesses about the impact that illegal immigration is having on our healthcare delivery system and to get their perspective on a few

recent legislative provisions that were produced by this Committee in an effort to help address this ever-growing problem.

There are well over 11 million illegal aliens currently residing in the United States and the fact that this number is rapidly growing every day. We allow our borders to remain unsecured and our immigration laws unenforced. I think there has been no question that the problem of illegal immigration is one of the most important topics and policy debates that is currently taking place before Congress.

I stand with my Republican colleagues in the House in support of the legislation that we passed just recently, which is a strong immigration bill that I believe does what most of the American public expects and deserves. We want to strengthen our borders and enforce our immigration laws. As any healthcare providers will tell you, and you will hear from some here today, an ounce of prevention is worth a pound of cure. Unfortunately, it is clear that some on the other side of the issue have no plan for securing our borders and no plan for stopping the flood of illegal immigration that is so negatively impacting our public safety, our children's schools, and our healthcare system.

In 1996, Congress responded to the will of the people and passed the Illegal Immigration Reform and Immigration Responsibility Act. One of the main provisions of this legislation was to limit all Federal benefits, including Medicaid coverage, to those who are lawfully in the United States. Of course, people on the other side of this issue opposed that provision back then because they believed that your hard-earned tax dollars should go to pay for healthcare for people who are illegally in our country. It is a lot of the same people today who are now opposing the efforts to ensure that only citizens get access to taxpayer funded benefits. The most unfair thing about what our opponents are advocating is that an illegal immigrant on Medicaid would almost certainly have a better healthcare benefits package than what is available to most taxpayers who are actually paying for those Medicaid benefits.

Of course, we are not just sitting back and waiting on a single comprehensive legislative solution to pass both houses of Congress. We intend to address this problem whenever and wherever we can. To help address the negative impact of illegal immigration on our healthcare system, the Energy and Commerce Committee produced two important provisions in the Deficit Reduction Act of 2005, which is commonly referred to as the DRA. One of the provisions which I authored, along with my friend Congressman Charlie Norwood, who is with us today, and we fought to include in the DRA, was a provision that requires States to obtain documentary evidence that the person applying for Medicaid benefits is actually a United States citizen, as is required by law. This is not a new concept for government programs, since the Medicare and SSI

programs both require proof of citizenship for all beneficiaries. It is just that Medicaid has not been seriously reformed since the 1960s and was a little behind the times.

Before the enactment of this provision, the Inspector General of the Department of Health and Human Services found that 46 States and the District of Columbia allowed self-declaration of citizenship for Medicaid eligibility, and 27 of those States never verified any citizenship statements at any point. This means that people simply had to say that they were citizens, in whatever language they chose to say it in, and they would be eligible for thousands of dollars of taxpayer funded Medicaid benefits. That simply, in my opinion, was unacceptable.

Of course, the advocates on the other side of this issue fought very hard to prevent this provision from being included in the DRA. They fought very hard to defeat this needed legislation when it was being voted on by Congress. Now some of those same advocates are fighting just as hard to weaken this common-sense provision as much as possible. But it is my hope that those implementing this provision will stand firm on this very important issue.

Another provision that was included in the Deficit Reduction Act was a provision to allow States the flexibility to impose cost sharing on healthcare services furnished in an emergency room that a physician determines is not a real medical emergency, such as an ear infection or strep throat. To protect beneficiaries, this provision requires that an available and accessible alternative must be available to the beneficiaries and the treating hospital must refer the individual to the alternative site in order for the co-pay to be charged. Like the citizenship verification provision, this provision is designed to eliminate millions of dollars of waste in the Medicaid system by helping to ensure that Medicaid patients receive care in the appropriate setting. This provision also helps patients. Studies have also shown that patients who receive care in the appropriate setting have better healthcare outcomes. As we all know, the ER is not the best place to receive primary care services or preventive healthcare services.

Although this provision only applies to Medicaid beneficiaries, it will also help reduce some of the negative impact of illegal immigration who improperly utilize the ER. It provides $50 million in grant funding to the States to establish alternative non-emergency providers in communities across the United States.

In addition to the increased number of alternative non-emergency providers, this provision will also make hospital personnel more familiar and comfortable with referring non-emergency patients to the appropriate healthcare providers. It will also increase communication between ER personnel and these non-emergency providers. The logic behind this

provision is also simple. It costs approximately $340 to care for a non-emergency patient in the emergency department while it costs less than $70 to care for the same patient in a health clinic or a physician's office. That means that over five people can be treated in a physician's office for less money than one person can be seen in the emergency room. I believe this is a common-sense approach to reforming the Medicaid program, and it was in serious need of reform.

As always, I am looking forward to a more cooperative and productive conversation on this topic today and to working with my colleagues to come up with additional effective solutions to the problems that I am sure we will hear addressed in this hearing today.

Again, I would like to thank the witnesses on the panels that will testify and we look forward to hearing your testimony.

I would like at this time to recognize my colleague from California. She is a Congressman from the Los Angeles area, I believe, and we are pleased that she would travel so far to be with us here today, the Honorable Congresswoman Hilda Solis, and she is recognized for 5 minutes for her opening statement. Ms. Solis.

[The prepared statement of Nathan Deal follows:]

PREPARED STATEMENT OF THE HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

- The Committee will come to order, and the Chair recognizes himself for an opening statement.
- This morning will hold the second session of a two-day field hearing entitled "Examining the Impact of Illegal Immigration on the Medicaid Program and Our Healthcare Delivery System."
- Today, we will hear from three panels of distinguished and expert witnesses about the impact that illegal immigration is having on our healthcare delivery system and get their perspective on a few recent legislative provisions that were produced by this Committee in an effort to help address this ever-growing problem.
- Given that there are well over 11 million illegal aliens currently residing in the United States and the fact that this number is rapidly growing every day that we allow our borders to remain unsecured and our immigration laws to remain unenforced, there is no question that the problem of illegal immigration is one of the most important public policy debates currently before Congress.
- I stand with my Republican colleagues in House in strong support of enacting an immigration reform bill that does what the American people expect and deserve.
- We want to strengthen our borders and enforce our immigrations laws. Because as any healthcare provider will tell you, an ounce of prevention is worth a pound of cure.
- Unfortunately, it is clear that those on the other side of the issue have absolutely no plan for securing our borders and no plan for stopping the flood of illegal immigration that is so negatively impacting our public safety, our children's schools, and our healthcare system.
- In 1996, Congress responded to the will of the people and passed the "Illegal Immigration Reform and Immigrant Responsibility Act," and one of the main

provisions of this legislation was to limit all Federal benefits, including Medicaid coverage, to those who are lawfully in the United States.

- Of course, people on the other side of this issue opposed this provision back then because they believed that your hard-earned tax dollars should go to pay for healthcare services for people that are in your country illegally.
- And it is a lot of these same people that are now opposing our efforts to ensure that only citizens get access to taxpayer funded benefits.
- The most unfair thing about what our opponents are advocating is that an illegal immigrant on Medicaid would almost certainly have a better healthcare benefits package than what is available to most of the taxpayers who are paying for those Medicaid benefits.
- Of course, we are not just sitting back and waiting on a single comprehensive legislative solution to pass both Houses of Congress. We intend to address this problem whenever and wherever we can.
- To help address the negative impact of illegal immigration on our healthcare system, the Energy and Commerce Committee produced two important provisions in the Deficit Reduction Act of 2005, which is commonly known as the "DRA."
- One of the provisions that I authored and fought to include in the DRA was a provision that requires States to obtain documentary evidence that the person applying for Medicaid benefits is actually a U.S. citizen, as required by law.
- This is not a new concept for government programs, since the Medicare and SSI programs both require proof of citizenship for all beneficiaries. It's just that Medicaid hadn't been seriously reformed since the 1960's and was a little behind the times.
- Before the enactment of this provision, the Inspector General of the Department of Health and Human Services found that 46 states and the District of Columbia allowed self-declaration of citizenship for Medicaid eligibility, and 27 of those States never verified any citizenship statements at any point.
- This means that people simply had to say that they were citizens, in whatever language they chose to say it in, and they would be eligible for thousands of dollars of taxpayer funded Medicaid benefits.
- This was simply unacceptable.
- Of course, the advocates on the other side of this issue fought very hard to prevent this provision from being included in the DRA and they fought very hard to defeat this needed legislation when it was being voted on by Congress.
- And now, these same advocates are fighting just as hard to weaken this common-sense provision as much as possible, but it is my hope that those implementing this provision will stand firm on this important issue.
- Another provision we included in the Deficit Reduction Act was a provision to allow States the flexibility to impose increased cost-sharing on healthcare services furnished in an emergency room that a physician determines is not a real medical emergency, such as an ear infection or strep throat.
- To protect beneficiaries, this provision requires that an available and accessible alternative must be available to the beneficiary and the treating hospital must refer the individual to that alternative site in order for the co-pay to be charged.
- Like the citizenship-verification provision, this provision is designed to eliminate millions of dollars of waste in the Medicaid system by helping to ensure that Medicaid patients receive care in the appropriate setting.
- This provision also helps patients. Studies have also shown that patients who receive care in the appropriate setting have better healthcare outcomes.
- As we all know, the ER is not the best place to receive primary care services or preventative healthcare services.

- Although this provision only applies to Medicaid beneficiaries, it will also help reduce some of the negative impact of illegal immigrants improperly utilizing the ER by providing $50 million in grant funding to the States to establish alternative non-emergency providers in communities across the United States.
- In addition to the increased number of alternative non-emergency providers, this provision will also make hospital personnel more familiar and comfortable with referring non-emergency patients to the appropriate healthcare providers. It will also increase communication between ER personnel and these non-emergency providers.
- The logic behind this provision is also simple. It costs approximately $340 to care for a non-emergency patient in the emergency department while it costs less than $70 to care for the same patient in a health clinic or physician's office.
- That means over five people can be treated in a physician's office for less money than one person can be seen in the ER.
- Again, I believe that this is a common-sense approach to reforming a Medicaid program that is in serious need of reform.
- As always, I am looking forward to having a cooperative and productive conversation on this topic today and to working with my colleagues to come up with effective solutions to the problems addressed at this hearing.
- Again, I would like to thank all of our witnesses for participating today. We look forward to hearing your testimony.
- With that, I would like to recognize The Honorable Congresswoman from California, Ms. Solis, for 5 minutes for an opening statement.

MS. SOLIS. Thank you very much, Mr. Chairman, and good morning also to the panelists and to the audience.

I represent the 32nd Congressional District in Los Angeles, and yes, it was quite a challenge coming into your district here, but I felt very welcomed and yesterday, I spent some time in the area of Dalton to see how prosperous and how this community is thriving. So my hat is off to the mayor and to the citizens here for the economic building that I see going on here in your community.

On behalf of the Ranking Member John Dingell and my other Democratic colleagues on the Committee, I want to thank the community of Dalton for hosting this very important meeting today.

Today's hearing is delaying and distracting the American people from the real issues at hand--the refusal of the Republican Congress and President Bush to enact comprehensive reform. Instead, my counterparts want to blame immigrants for driving up the cost of healthcare--in my opinion, a false claim. The overwhelming majority of evidence shows that immigrants, regardless of status, use less healthcare services than U.S. citizens. In 2003, healthcare costs by U.S. born citizens were more than double that of immigrants. For example, although emergency rooms are one of the few available healthcare venues for the undocumented, immigrants use emergency rooms less than non-immigrants, only 6.3 percent of non-citizens used hospital emergency services in 2003, compared to 31.8 percent of U.S. citizens.

The real problem with our health system is not immigrants, but the fact that the system is broken. Too many uninsured. In America alone, 46 million Americans lack any form of healthcare coverage, 6 million more than when President Bush took office in 2001. Too little funding for community care and folks on the other side of the aisle have consistently tried to cut funding for healthcare programs. Too few jobs that offer healthcare benefits. The number of employers offering coverage, as we know, has declined significantly over the last few years.

If Georgia had an influx of New Yorkers, Oklahomans, or Californians, rather than Mexicans, Koreans, or Salvadorans, the problem it is facing would still be similar. That is because the root of our healthcare problems remains unchanged. Many businesses cannot afford healthcare insurance. Many low-wage workers cannot afford to purchase insurance, even if it is offered. And many of our healthcare organizations are not receiving the Federal support they need to provide quality care. Forcibly removing immigrants from the U.S. or inhumanely denying them needed healthcare will not solve the healthcare problems. In fact, providing a legitimate pathway to allowing immigrants to work hard to earn their citizenship will provide them with better health insurance options and better incomes to afford insurance, possibly reducing the number of uninsured.

The contributions of undocumented immigrants and the benefits they provide to the U.S. economy more than balance the meager healthcare resources which they are eligible to receive. In fact, the Social Security Administration has reported $56 billion in earnings that are often attributed to immigrants, earnings that help to generate $6 billion to $7 billion to the Social Security tax revenue, and an additional $1.5 billion in Medicare taxes.

More than 60,000 immigrants serve currently in active duty in our U.S. armed forces, including more than 35,000 who are green card holders, they are not U.S. citizens.

Undocumented immigrants contribute at least $300 billion to the U.S. gross national product annually.

In this politically contentious time, we must not lose sight of the issue at hand. Our primary obligation as elected officials is to protect the American people and to protect our borders. If Republicans had not repeatedly defeated our efforts to enhance border security over the last 4 years, there would be 6,600 more Border Patrol agents, 14,000 more detention beds, and 2,700 more immigration enforcement agents along our border than now exist. Apprehension of undocumented individuals at the border has dropped by 31 percent under President Bush, compared to President Clinton's record. And in 2004, folks, only three employers were fined for work site immigration violations--only three.

Republicans control the White House, the Senate, and the House of Representatives. And yet, due to the in-fighting on the other side of the aisle, in my opinion, they have failed to pass an immigration bill.

My colleagues on the other side of the aisle must stop stalling and help us deliver real immigration reform that provides security at our borders, helps to enhance the process so that individuals can work here that need to work here to help communities like Dalton continue to thrive.

And I would ask for that courtesy, that we have a civil discussion about this issue.

And again, I want to thank the panelists and the Chairman and the folks here in Dalton for inviting me to be here at this very important hearing.

Thank you very much, yield back.

MR. DEAL. Thank you. It is my pleasure now to introduce my colleague, who joins my district from the 9th District of Georgia, the Honorable Charlie Norwood, who is also a member of our Health Subcommittee.

MR. NORWOOD. Thank you very much, Mr. Chairman. I appreciate you having this hearing, and especially appreciate you having this hearing in Georgia.

We welcome our great panel of witnesses and it is a great delight to see so many Georgians participating in this today. Unlike in Washington when we have these, I cannot understand half the people in the audience, but I can understand most everybody in this room. So welcome, we are happy to see you here.

I want to, Mr. Chairman, if I may, re-remind myself of what this hearing is. This hearing is not about immigrants, this hearing is about illegal immigrants--

[Applause.]

MR. NORWOOD. --who are breaking our laws by entering our country, who are breaking our laws by using bogus papers, who are breaking our laws by trying to get onto Medicaid that is designed by the American taxpayer to help the American citizens, not foreigners who are in our country illegally.

[Applause.]

MR. NORWOOD. Mr. Chairman, illegal aliens are placing a huge burden on our health system, we all know that. While illegal aliens enjoy these benefits, we have Americans that are forced to bear the entire cost of their healthcare in their own family. Take Medicaid as an example. The State of Georgia admitted they legally spent $88 million on emergency services for illegal aliens in 2005, $88 million. This demonstrates just how widespread the problem is in Georgia, since we

really actually have no idea how much was actually spent on all of the services for illegal aliens any more than we have any idea how many illegal aliens use hospital services. The reason we do not is hospitals simply do not question people and ask them are you a citizen or not. So any numbers thrown out here today regarding that, of course, are bogus because nobody, including me, knows the answer to that.

Illegal aliens are not supposed to get routine Medicaid benefits. That has been the law of this land since 1986. That is not something we have just dreamed up yesterday. It is the law of the land. The problem is that in recent years, CMS encouraged self-declaration, which allowed people to be accepted as U.S. citizens simply because they said so. And we wonder why States are seeing their Medicaid expenses soaring. According to the Inspector General over at Health and Human Services, 46 States and the District of Columbia allow self-declaration of U.S. citizenship for Medicaid. That is against the Federal law to do that. I will put that in simple terms. An illegal alien could have walked into 46 States and the District of Columbia and say that they were a citizen and no one asked any other questions, 27 States did not verify citizenship at any point, even after benefits were provided.

We changed that through Section 6082 of the Deficit Reduction Act, and I am very pleased that we did. Now the supporters of open borders will say that the old way of business was just fine, they might argue that 44 of these States require evidence of citizenship if statements seemed questionable. Were those States approving profiling based on accents and appearances? I have no clue how a reasonable person could conclude someone is illegal without asking for proof of citizenship.

Now I am not interested in discriminating against anyone, that is exactly why we should ask for documents from everyone that applies for Medicaid benefits. Remember what we are doing. A person comes in and says I need free healthcare. I want the citizens of America to furnish me healthcare, that is what you are asking for. Is it too much for us to ask could you please identify yourself, could you please determine if you are a citizen before the taxpayers of this country pay for your healthcare and Medicaid that is better than many citizens, working American citizens have in their own healthcare? I do not think it is too much.

I am also proud that CMS implemented this provision in a way that will see that citizens are accommodated. If you are on Medicare, you have met the standard. If you are on Social Security disability, you have met the standard. If you can produce one of dozens of documents to prove citizenship and identify, you have met the standard. We are also talking about emergency care. This provision does not even touch EMTALA. We will get into that, I am sure.

Nine groups of qualified illegal aliens have qualified for Medicaid, including permanent residents, battered alien women, and victims of human trafficking.

Mr. Chairman, what we faced was the outright theft of healthcare benefits for the low-income Americans by illegal aliens. We have heard the falsehood that illegal aliens only take jobs that American do not want. Are we now also saying they are only taking healthcare benefits that Americans do not want? The U.S. citizens that are losing Medicaid coverage will tell you they really need and want those benefits.

Mr. Chairman, I am glad this field hearing will further allow each party to declare where they stand--on the side of their low-income constituents, or on the side of the illegal aliens. Maybe some folks have no problem pandering to civil violators who add to our crimes by swindling taxpayers; maybe they do not understand that the match system and State balanced budgets limit how much money there is to go around. Fewer poor American citizens get Medicaid because illegal aliens get Medicaid. It is just that simple. Our provision, and what Georgia did even before we enacted it, will bring integrity back to our certification system for Medicaid.

And with that, Mr. Chairman, I thank you for the time.

[Applause.]

MR. DEAL. Thank you.

I will now ask our participants in the first panel if they would please come to the podium.

I am pleased to introduce some distinguished members of the Georgia State Senate, who have already been alluded to as leaders in an immigration reform package that passed the legislature of our State. In the estimation of most who have looked at the package of legislation that you gentlemen helped pass, it makes Georgia really the leader on this whole issue in the country, and we appreciate your efforts.

We have a third panelist who has been invited and was expected to be here and--

MS. SOLIS. He is here, I believe he is here.

MR. DEAL. Oh, he is?

MS. SOLIS. Mr. Thompson.

MR. DEAL. All right.

First of all, I would like to introduce the Honorable Casey Cagle, who is a Member of the Georgia State Senate and represents the area on the eastern side of my Congressional District of Hall and Jackson Counties. Then, of course, the real leader of the legislation in the State General Assembly, the Honorable Chip Rogers from Atlanta, Georgia, and the Honorable Curt Thompson, who is also a Member of the State Senate from Atlanta. Gentlemen, we are pleased to have all of you here

today, I look forward to your testimony and each of you will be given 5 minutes to make oral presentations. Your written testimony has already been made a part of the record. We will begin with you, Mr. Cagle.

STATEMENTS OF THE HON. CASEY CAGLE, MEMBER, GEORGIA STATE SENATE; THE HON. CHIP ROGERS, MEMBER, GEORGIA STATE HOUSE OF REPRESENTATIVES; AND THE HON. CURT ROGERS, MEMBER, GEORGIA STATE SENATE

MR. CAGLE. Thank you, Mr. Chairman and members of the Committee. It is indeed an honor to be before you today in a wonderful part of our State here in Dalton, and I appreciate you taking the time and the sacrifice to hear our comments today.

The impact of illegal aliens on our healthcare system represents one of the most important physical challenges facing Georgia. However, I would say at the outset, the real issue at hand here is not the cost of healthcare at all. Instead, it is the failure of the Federal government to properly secure America's borders.

As Americans, we are a Nation of immigrants. No one wants to deny individuals who obey the law and follow the process an opportunity to have a shot at the dream of American citizenship. All we are saying is that those who choose to break the law and come here illegally should not receive taxpayer benefits as a result of doing so. Americans do not assume that we can illegally enter other countries and require them to give us benefits. We are simply asking the citizens of other nations to follow the same rules.

Unfortunately, Federal policies for the last several decades have encouraged foreign citizens not to follow the rules. Our unsecured borders have resulted in millions of citizens of other countries coming to America illegally. And these foreign nationals often need or want a broad range of social services when they arrive in individual States. This situation leaves State governments holding the bag for a problem that the Federal government has, quite candidly, utterly failed to solve.

I would therefore begin my remarks by urging Congress, in the strongest possible terms, to seal our borders. Unless and until we have secure borders and an immigration system that makes sense, any solution we find on social services or service issues such as healthcare will be a mere Band-Aid.

Senator Isakson, Congressman Deal, and Congressman Norwood have shown strong leadership on this front and I hope they are successful in encouraging their colleagues to put border security first.

Having said that, the issue of dealing with the impact of illegal aliens on the healthcare system is a significant one for Georgia. At its heart, the issue is one of basic fairness. Every day, citizens across Georgia find ourselves facing major healthcare problems that strain our financial resources. Maybe it is a young child being diagnosed with a cancer that is only covered at 80 percent by their healthcare plan. Or perhaps it is a senior citizen being forced to sell all of their worldly possessions in order to obtain affordable long-term care. Perhaps it is a family canceling a summer vacation in order to cover a sudden rise in insurance premiums. The bottom line is that for many everyday Georgia citizens, affordable healthcare coverage is rapidly becoming unreachable. After providing for their families, paying their taxes, and doing everything else that good citizens do, these working families find themselves unable to qualify for government-funded healthcare; yet, unable to pay for private healthcare insurance.

Now think about what happens when the same family learns that healthcare costs in Georgia are being significantly increased by the cost of providing free or subsidized care to citizens of other nations who broke Federal law to come here. The response from everyday Georgians is outrage. Our citizens are outraged because this kind of system is patently unfair.

We work hard every day to pay taxes and we deeply resent seeing those taxes siphoned off to provide free healthcare to aliens who come here illegally. I realize there are some people in Congress who think our outrage at this situation is wrong. I would just say that perhaps these folks would feel differently if they were forced to give up their taxpayer-funded health benefits and experience first hand the strain that rising healthcare costs put on Georgia families every day.

Based on the feedback I get from my constituents every day, I commend those in Congress who are working to ensure the taxpayer-funded Medicaid system benefits only individuals who are in American legally. Taking reasonable steps to reduce the burden illegal aliens place on Medicaid significantly and our hospitals generally is a virtual necessity in order for our State to maintain a sound financial footing.

Of course, the challenge here is identifying individuals who are here illegally in the context of providing healthcare. We obviously do not want to have any kind of system in place that makes it difficult for individuals with urgent healthcare needs to receive emergency treatment. We can and must ensure that our hospital facilities continue to offer lifesaving stabilization and care to anyone who arrives at their doors, regardless of how they got there. However, when our emergency rooms become primary care facilities of last resort for the non-urgent medical needs of illegal aliens, we have a problem. And the only way to solve

that problem is to take steps to identify illegals and prevent them from obtaining free medical care paid for by American citizens.

At this point, the challenge becomes identifying illegal aliens prior to healthcare delivery. More than anything else, this represents the most contentious part of this debate. Because identifying members of a population that explicitly seeks to hide their identity represents a very difficult challenge. However, I believe we can and should meet that challenge by putting a basic identification system in place to ensure taxpayer-funded benefits are going only to legal citizens.

An argument frequently raised is that requiring citizenship verification for Medicaid benefits requires paperwork that can be difficult to fill out. In response to that argument, I would simply say getting any kind of healthcare in our current system involves often complex paperwork. We can and should focus on streamlining that paperwork, but to argue that illegal aliens from other nations deserve a process that is easier to handle than American citizens is absurd.

Individuals on Medicaid are receiving a valuable commodity from the Government. And asking for basic identification as a prerequisite represents a common sense policy supported by the vast majority of Georgia citizens. We require identification in order to drive a car, rent a movie, or purchase alcohol. There is simply no legitimate public policy reason not to make the same requirement a basic threshold for receiving taxpayer-funded healthcare.

In summary, I urge Congress to act immediately to seal our borders and ensure that the only individuals in our country are those who come here legally. Until we can achieve this goal, I strongly support efforts to prevent illegal aliens from receiving non-emergency health benefits paid for by hospitals themselves or taxpayer-funded.

Thank you, Mr. Chairman, members of the Committee.

[Applause.]

MR. DEAL. Thank you, Senator Cagle.

Senator Rogers, you are recognized for 5 minutes.

[The prepared statement of Casey Cagle follows:]

PREPARED STATEMENT OF THE HON. CASEY CAGLE, MEMBER, GEORGIA STATE SENATE

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Americans do not assume that we can illegally enter other countries and require them to give us benefits. We are simply asking the citizens of other nations to follow the same rules.

Unfortunately, federal policies for the last several decades have encouraged foreign citizens not to follow the rules. Our unsecured borders have resulted in millions of citizens of other countries coming to America illegally. And, these foreign nationals often need or want a broad range of social services when they arrive in individual states. This situation leaves state governments holding the bag for a problem that federal government has abjectly and utterly failed to solve.

I would therefore begin my remarks by urging Congress in the strongest possible terms to seal our borders. Unless and until we have secure borders and an immigration system that makes sense, any solution we find on social service issues such as health care will be a mere band-aid. Senator Johnny Isakson, Congressman Nathan Deal and Congressman Charlie Norwood have shown strong leadership on this front, and I hope they are successful in encouraging their colleagues to put border security first.

Having said that, the issue of dealing with the impact of illegal aliens on the healthcare system is a significant one for Georgia. At its heart, the issue is one of basic fairness.

Every day, citizens across Georgia find ourselves facing major healthcare problems that strain our financial resources. Maybe it's a young child being diagnosed with a cancer that's only covered at 80% by a health plan. Or, perhaps it's a senior citizen being forced to sell all of their worldly possessions in order to obtain affordable long term care. Perhaps it is a family canceling a summer vacation in order to cover a sudden rise in insurance premiums.

The bottom line is that for many everyday Georgia citizens, affordable healthcare coverage is rapidly becoming unreachable. After providing for their families, paying their taxes and doing everything else that good citizens do, these working families find themselves unable to qualify for government funded healthcare, yet unable to pay for private health insurance.

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Based on the feedback I get from my constituents every day, I commend those in Congress who are working to ensure the taxpayer funded Medicaid system benefits only individuals who are in America legally. Taking reasonable steps to reduce the burden illegal aliens place on Medicaid specifically – and our hospitals generally – is a virtual necessity in order for our state to maintain a sound financial footing.

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However, when our emergency rooms become primary care facilities of last resort for the non-urgent medical needs of illegal aliens, we have a problem. And, the only way

to solve that problem is to take steps to identify illegals and prevent them from obtaining free medical care paid for by American citizens.

At this point, the challenge becomes identifying illegal aliens prior to health care delivery. More than anything else, this represents the most contentious part of this debate, because identifying members of population that explicitly seek to hide their identities represents a very difficult challenge. However, I believe we can and should meet that challenge by putting a basic identification system in place to ensure taxpayer funded benefits are going only to legal citizens.

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We require identification in order to drive a car, rent a movie, or purchase alcohol. There is simply no legitimate public policy reason not to make the same requirement a basic threshold for receiving taxpayer funded health care.

In summary, I urge Congress to act immediately to seal our borders and ensure that the only individuals in our country are those who come here legally. Until we can achieve this goal, I strongly support efforts to prevent illegal aliens from receiving non-emergency health benefits paid for by hospitals themselves or taxpayer funds.

Thank you.

MR. ROGERS. Thank you, Mr. Chairman and members of the Committee. Thank you for allowing me to address you today on what I believe is the most important domestic issue facing the United States; and that is the impact of our unsecured borders on the citizens of this Nation.

While many questions surrounding illegal entry into our Nation are debatable, I would like to start my testimony with a few that are not.

The United States government has an obligation to secure our borders for its citizens. Any entry into the United States through a point other than a legal port of entry is a violation of these borders. Likewise, any foreign national remaining in the United States for a time beyond the granted legal stay is in violation of our Nation's immigration laws.

Now why would a foreign national enter the United States through a means other than a legal port of entry or remain in the United States for a time in excess of his or her legal stay? I believe the answers are many, but fall mainly into two easily defined categories--employment and taxpayer-supported benefits. Therefore, any proposal that seeks to fulfill the responsibility of the United States government to secure our borders must include measures to eliminate the attraction of illegal entry.

With respect to the enforcement of employment laws, the Department of Homeland Security has all but stopped any effort to uphold the current law. The number of companies fined for hiring illegal workers dropped from 417 back in 1999 to just 3 in 2004. The result of

this failure to enforce the law has been millions of additional illegal aliens present in our Nation. Many, but not all, of these illegal aliens are hired by criminal employers and invariably use taxpayer-funded services that are reserved for United States citizens and persons lawfully present in the United States.

This brings us to the second necessary area of enforcement--taxpayer-supported benefits. While the Federal government is charged with the constitutional duties of national defense and the general welfare of this Nation, it is the States and the local governments that primarily administer taxpayer supported benefits. When considering the demands on our social safety net brought on by the presence of illegal aliens, it is clear that the financial impact is actually much greater on the States and the local governments. It is fact the States that pay for those particular services that are most demanded by illegal populations, including education, law enforcement, and today's topic, healthcare services.

You will likely hear from many witnesses today that can debate the financial impact of illegal immigration. Economists are easily found who will confirm that illegal immigration is in fact a significant financial drain on our economy. You may find a few who actually believe that the importation of millions of unskilled and uneducated laborers is actually good for our system. But regardless of the financial numbers, the question to be asked by elected officials is not whether it is profitable, but is it fair.

Current Federal law, Title 8, Chapter 14, Sections 1611 and 1621, clearly define that a person not lawfully present in the United States is ineligible to receive almost all taxpayer-funded benefits. The few exceptions include emergency services and medical services to treat the symptoms of communicable diseases. In other words, the Federal law establishes the threshold of eligibility to receive taxpayer-funded benefits for non-U.S. citizens.

This, I believe, brings us to the critical question that must be answered if you believe illegal aliens should receive taxpayer-supported benefits. And that is, if a foreign national, who is in violation of U.S. immigration law is granted the right to receive taxpayer-funded benefits without meeting eligibility requirements, then why is the same exception not extended to American citizens?

In the State of Georgia, we have a wonderful program designed to pay for health insurance for children of poor families. This program is known as Peachcare. Should I, as a U.S. citizen and a Georgia resident, be required to meet the eligibility requirements to receive this benefit? Clearly the answer is yes. The failure to enforce this eligibility requirement means that I will receive taxpayer-supplied heath insurance for my children at the expense of those who do legally qualify.

What about a U.S. citizen from the State of Alabama? She he or she be required to meet the eligibility requirements of Georgia residency before receiving Georgia Medicaid benefits? Clearly again, the answer is yes. And again, the failure to enforce this eligibility requirements results in fewer benefits for legally eligible Georgians.

So if we have established the fact that U.S. citizens from Georgia and any other State must meet the eligibility requirements to receive taxpayer benefits, then how can we possibly suggest that a foreign national illegally present in the United States should not also meet those same eligibility requirements.

Unlike the Federal government, most States, including Georgia, have a balanced budget requirement. And under a balanced budget requirement, when a taxpayer benefit is given to an ineligible recipient, then by definition that benefit must be denied to an eligible recipient.

Let me illustrate this in real life terms. In Georgia today, there are 12,700 children with severe physical disabilities, adults with mental retardation, and frail and elderly citizens who are on a waiting list for community-based services. These are 12,700 legal U.S. citizens who already qualify for our help, but are being denied because of a lack of funding. Each time a dollar is given to a person who does not qualify to receive it, that same dollar cannot be given to one of these 12,700 Georgians who are currently on the waiting list.

One final example of the inequities created by ignoring our immigration law; it is called the priority group 8g. Military veterans may be familiar with this designation. The Veterans' Administration annually places our United States veterans into distinct categories so as to determine who will receive medical care. This despite the fact that this medical care to which I refer was already promised these veterans upon their agreeing to serve our Nation's armed forces. The current group 8g is no longer eligible to receive the promised care because veterans in this group had the audacity to go out and make more than $31,000 back in 2004, and they had no service-related ailments.

Yet at the same time, a foreign national may illegally enter the United States, present no documentation to verify lawful status or income, and immediately receive those taxpayer-funded medical care services that should have gone to the United States veterans that are in group 8g. This bring me back to my earlier question: Is the current policy fair?

One of the eligibility requirements to receive non-emergency taxpayer-supported healthcare benefits is to be lawfully present in the United States. This would lead one to believe that surely the individual States are verifying the lawful status prior to giving away the taxpayers' money. Sadly, the answer is no, they are not.

Only four States--Montana, New York, New Hampshire, and I am proud to say Georgia--require proof of citizenship to receive Medicaid benefits.

However, there is good news. Under the newly enacted Deficit Reduction Act, the requirement for proof of citizenship to receive Medicaid benefits is now going to be enforced nationwide. Additionally, this new law will remove the misguided policy of deducting indigent care expenses for illegal aliens from the States' Medicaid funds. Georgia thanks you for this legislation.

Is the Deficit Reduction Act good public policy? Clearly, it is. As a taxpayer, we must all have the simple expectation--the simple expectation--that our taxpayer dollars are being used for only a lawful purpose. When false identification or lack of verification allows taxpayer dollars to be diverted to ineligible recipients, it is not a lawful purpose.

In Georgia, we have gone one step further. Under the new Georgia Security and Immigration Compliance Act, we will begin verifying the eligibility of all adult applicants for all taxpayer-supported benefits.

Let me be very clear here, the State of Georgia does not establish the criteria for qualifying for benefits. With respect to illegal aliens, Congress and President Bill Clinton established those criteria in 1996. Under Georgia law, we will simply verify eligibility. We will do so using the SAVE program that is offered to us by the United States Citizenship and Immigration Services. This electronic verification system will allow us to almost instantly verify the eligibility of any alien seeking taxpayer-supported benefits.

The requirement in Georgia to verify eligibility will ultimately mean that taxpayer benefits go to only those who meet the eligibility requirements. Does this mean the State will save money? Not necessarily. But what it will mean is that Georgians can trust that their taxpayer dollars are only going to persons legally eligible to receive them.

Finally, I will address the specific issue of taxpayer-supported non-emergency healthcare benefits to illegal aliens. Please note--and this is very important--you will hear a number of witnesses refer to a denial of healthcare rather than a denial of taxpayer-supported healthcare benefits. I believe characterizing this issue as simply a denial of healthcare is completely and totally inaccurate.

Any person, regardless of legal status, may purchase healthcare without the assistance of the taxpayers. Millions of American citizens do that each and every week. Additionally--and I address this to our medical professionals in the audience--any doctor or medical facility can simply give away their medical care. There is no requirement that they

force somebody to pay for it. Again, free medical care can be found all across this Nation.

The question we are faced with today is very simple. If a person, legal or illegal, asks the taxpayers of this Nation to pay for his or her medical care, do the taxpayers have a right to expect that that person be eligible to receive the benefits? As an elected official and as a taxpayer, I hope you would all agree the answer is yes.

Again, I thank you for allowing me the opportunity to appear before you today to discuss this important issue. I will be glad to answer any questions pertaining to illegal immigration or the new Georgia law which seeks to limit the impact of illegal immigration on our State.

[Applause.]

[The prepared statement of Chip Rogers follows:]

PREPARED STATEMENT OF THE HON. CHIP ROGERS, MEMBER, GEORGIA STATE HOUSE OF REPRESENTATIVES

Members of the Committee thank you for allowing me to address what I believe is the most important domestic issue facing the United States of America: the impact of our unsecured borders on the citizens of this nation.

While many questions surrounding the illegal entry into our nation are debatable, I would like to start my testimony with a few that are not.

The United States government has an obligation to secure the borders for its citizens. Any entry into the United States through a point other than a legal port of entry is a violation of these borders. Likewise, any foreign national remaining in the United States for a time beyond the granted legal stay is in violation of our nation's immigration law.

Why would a foreign national enter the United States through a means other than a legal port of entry or remain in the United States for a time in excess of his or her legal stay?

I believe the answers are many but most fall into two easily defined categories: employment and taxpayer-supported benefits.

Therefore any proposal that seeks to fulfill the responsibility of the United States government to secure our borders must include measures to eliminate the attraction of illegal entry.

With respect to enforcement of employment laws, the Department of Homeland security has all but stopped any effort to uphold current law. The number of companies fined for hiring illegal workers dropped from 417 in 1999 to just 3 in 2004.

The result of this failure to enforce the law has been millions of additional illegal aliens present in our nation. Many, but not all, of these illegal aliens are hired by criminal employers and invariably use taxpayer-funded services that are reserved for U.S. citizens and persons lawfully present in the United States.

This brings us to the second necessary area of enforcement: taxpayer-supported benefits.

While the federal government is charged with the constitutional duties of national defense and the general welfare of the nation, it is the states and local governments that primarily administer taxpayer-supported benefits. When considering the demands on our social safety net brought on by the presence of illegal aliens, it is clear that the financial impact is actually much greater on state and local governments.

It is in fact the states that pay for those particular services most demanded by the illegal population including education, law enforcement and, today's topic, health care services.

You will likely hear many witnesses debate the financial impact of illegal immigration. Economists are easily found who will confirm that illegal immigration is a significant financial drain on our economy. You may find a few who actually believe the importation of millions of unskilled and uneducated laborers is actually good for our system. But regardless of the financial numbers the question to be asked by elected officials is not whether it is profitable but rather "Is it fair?"

Current federal law, Title 8 Chapter 14 sections 1611 & 1621, clearly define that a person not lawfully present in the United States is ineligible to receive almost all taxpayer-funded benefits. The few exceptions include emergency services and medical services to treat the symptoms of communicable diseases.

In other words, the federal law establishes the threshold of eligibility to receive taxpayer-funded benefits for non-U.S. citizens.

This, I believe, brings us to the critical question that must be answered if you believe illegal aliens should receive taxpayer-supported benefits.

If a foreign national, who is also in violation of U.S. immigration law, is granted the right to receive taxpayer-funded benefits, without meeting eligibility requirements, then why is this same exemption not extended to American citizens?

In the state of Georgia we have a wonderful program designed to pay for health insurance for children of poor families. The program is known as Peachcare. Should I, as a U.S. citizen and a Georgia resident, be required to meet the eligibility requirements to receive this benefit? Clearly the answer is yes. The failure to enforce eligibility requirements means that I will receive taxpayer-supplied health insurance for my children at the expense of those who legally qualify.

What about a U.S. citizen from the state of Alabama? Should he or she be required to meet the eligibility requirement of Georgia residency before receiving Georgia Medicaid benefits? Again the answer is yes. And again the failure to enforce the eligibility requirements results in fewer benefits for legally eligible Georgians.

So if we have established that U.S. citizens from Georgia, or any other state, must meet eligibility requirements to receive taxpayer benefits, then how can we possibly suggest that a foreign national, illegally present in the United States, should not also meet eligibility requirements?

Unlike the federal government, most states, including Georgia, have a balanced budget requirement. Under a balanced budget requirement when a taxpayer benefit is given to an ineligible recipient then by definition the benefit must be denied to an eligible recipient.

Let me illustrate this in real life terms. In Georgia today there are 12,700 children with severe physical disabilities, adults with mental retardation, and frail and elderly citizens who are on a waiting list for community based services. These are 12,700 legal U.S. citizens who already qualify for our help, but are being denied because of a lack of funding.

Each time a dollar is given to a person who by law does not qualify to receive it, then that same dollar cannot go to help one of these 12,700 Georgians on the waiting list.

One final example of the inequities created by ignoring immigration law: it is called priority group 8g. Military veterans may be familiar with this designation. The Veterans Administration annually places our U.S. veterans into distinct categories so as to determine who will receive medical care. This despite the fact that the medical care to which I refer was promised to these veterans upon their agreeing to serve in our nation's armed forces. The current group 8g is no longer eligible to receive the promised care because veterans in this group made more than $31,000 in 2004 and had no service related ailments.

Yet at the same time a foreign national may illegally enter the United States, present no documentation to verify lawful status or income, and immediately receive taxpayer-funded medical care.

This brings me back to my earlier question, "Is it fair?"

One of the eligibility requirements to receive non-emergency taxpayer-supported healthcare benefits is to be lawfully present in the United States. This would lead one to believe that surely the individual states are verifying lawful status prior to giving away the taxpayers money. Sadly the answer is, no they are not.

Only four states, Montana, New York, New Hampshire, and I am proud to say, Georgia, require proof of citizenship to receive Medicaid benefits.

However, there is good news. Under the newly enacted Deficit Reduction Act the requirement for proof of citizenship to receive Medicaid is to be enforced nationwide. Additionally, this new law will remove the misguided policy of deducting indigent care expenses for illegal aliens from the states Medicaid funds.

Is Deficit Reduction Act good public policy? Yes, it is. As a taxpayer we must all have the simple expectation that our taxpayer dollars are being used for a lawful purpose. When false identification, or lack of verification, allows taxpayer dollars to be diverted to ineligible recipients, it is not a lawful purpose.

In Georgia we have gone one step further. Under the our new Georgia Security and Immigration Compliance Act we will begin verifying the eligibility of all adult applicants for taxpayer supported benefits.

Let me be clear, the state of Georgia does not establish the criteria for qualifying for benefits. With respect to illegal aliens, Congress and President Clinton established those criteria in 1996. Under Georgia law we will simply verify eligibility. We will do so using the SAVE program offered to us by the United States Citizenship and Immigration Services. This electronic verification system will allow us to almost instantly verify the eligibility of any Alien seeking taxpayer-supported benefits.

The requirement in Georgia to verify eligibility will ultimately mean that taxpayer benefits go only to those who meet the eligibility requirements. Does this mean the state will save money? Not necessarily. But it will mean that Georgians can trust their taxpayer dollars are going only to persons legally eligible to receive them.

Finally, I will address the specific issue of taxpayer supported non-emergency healthcare benefits to illegal aliens. Please note you will likely hear a number of witnesses refer to a denial of healthcare rather than a denial of taxpayer supported healthcare benefits. I believe characterizing this issue, as simply a denial of healthcare, is inaccurate.

Any person, regardless of legal status, may purchase healthcare without the assistance of the taxpayer. Millions of American citizens do so every week. Additionally, any doctor or medical facility can simply give away medical care. Again free medical care can be found all across our nation.

The question we are faced with today is simple, if a person, legal or illegal, asks the taxpayers to pay for his or her medical care, do the taxpayers have a right to expect the applicant to be eligible to receive the benefit?

As an elected official, and a taxpayer, I hope you would agree the answer is, yes!

Again, I thank you for allowing me the opportunity to appear before you today to discuss this important issue. I will be glad to answer any questions pertaining to illegal immigration or the new Georgia law, which seeks to limit the impact of illegal immigration on our state.

MR. DEAL. Senator Thompson, you are recognized for 5 minutes.

MR. THOMPSON. Thank you, Mr. Chairman and thank you all for coming down here. Some of you came farther than others.

I would just encourage this Committee to be looking at practical solutions to real problems, both when it comes to the crisis of illegal immigration as well as the crisis in healthcare that faces this country, in that pretty much my district, District 5, is ground zero for both.

I do represent Georgia's Fifth State Senate District situated along the interstate that comes from Gainesville where you will also hold a hearing, into Atlanta. We have some historic areas such as the picture postcard railroad depot and town square of Norcross, but primarily we live in suburbs begun during the 1970s when lots of Atlantans left their town after desegregation and lots of northerners left the rust belt after de-industrialization. Some of that rootless suburban population then moved again in the 1990s to points further out, taking with them some of the commercial infrastructure that had serviced them. What opened up was space for new residents making a home here or African-Americans finding a first home in the suburbs, urbanites fleeing the inflated home prices in Atlanta's bohemian quarter, and immigrants.

My district and the neighborhoods around it are home to as diverse a population as one finds in the southeast. In fact, it is the most diverse State Senate seat in the General Assembly here. In our schools, students speak some 120 languages when at home. I have to campaign in English, Spanish, Korean, Hindi, Vietnamese, and Mandarin in order to keep my seat. I have attended Romanian Orthodox churches, spoken at Hindu temples, danced Cumbia at a Colombian festival, and cut the ribbon at the opening of a high end Chinese shopping center. At dinnertime, I have menu options as rich as a Congressional aide living in Adams-Morgan. I go home this evening to a wife who was born in Colombia and I am here to tell you that diversity works.

When that first wave of suburbanites left for the exurbs in the 1990s, they took along with them some of the commercial infrastructure that had serviced them. We lost jobs, storefronts stood vacant, dollars for development went elsewhere. With declining political clout, our schools got fewer resources, traffic worsened, and we had a tough decade or so.

We have turned a corner. We have done the hard work to get the broader community to form a community investment entity called the Gwinnett Village Community Improvement District, to redevelop and market our international community. We have also become a draw to new investment with new major retail outlets catering to our diverse community's demands and plans for several major new urbanist live-work-shop-play centers including the Super Pearl and Super H centers as well as proposals for mixed use developments at Gwinnett Place Mall and at the Jimmy Carter Boulevard intersection with Interstate 85. Large investments are coming from overseas, including the Asian Village, investors seeing our community as a place where they can feel at home

and where they can prosper. Young professionals are relocating here to participate in our cosmopolitan lifestyle. The I-85 corridor is turning into a destination for consumers who appreciate our distinctive mix. Simply put, our turn-around is fueled by diversity that only immigrant communities can generate.

Do not mess this up for us.

Think of Vancouver, British Columbia, just north of Seattle, with a flourishing economy tied into the world market. Vancouver boomed when talented people and investors in Hong Kong wondered where they could go after the colony reverted back to Chinese Communist rule. Vancouver welcomed newcomers, made them feel at home like neighbors, and everybody got healthcare. It is important to make someone who is thinking of bringing talent and money and family into our community feel welcome. And in the real world, the modern world, part of that welcome is healthcare.

It is important to understand that immigrant communities are themselves diverse. Some are here legally, some are not. Some are in the twilight world because some bureaucrat has not had time to process the papers yet. And this diversity extends into families. Poppa has got a green card and does pretty well, momma works odd jobs because she does not have her papers, junior was not born here, so he may not get to go to college while sis carries a U.S. passport, having been born here. Mixed families are common. When politicians and activists gin up sentiments against the undocumented, it reverberates through any community, documented and undocumented, legal and illegal alike. Our global investors take notice.

That was the case earlier this year when our State legislature heatedly debated and eventually enacted an anti-immigrant bill designed to play on these sentiments to win elections while inciting fear in our communities and scaring away business investments. As a consequence, hard-working people in my district are afraid to get the health services they need. Many are afraid to take their citizen children for care and when they get sick enough, they will end up in the hospital emergency room and we all decry the over-crowding and cost of this emergency care, as though we had nothing to do with creating this.

One of the myths distorting the discussion about immigration is that the undocumented represent an unsustainable drain upon public resources. But that myth ignores the reality that these hard-working people are not only consumers of public services, but also contributors. A recent study by the Center on Budget and Policy Priorities, for example, finds that the Senate immigration bill, by creating a guest worker program,--that is the U.S. Senate immigration bill--expanding the number of family-sponsored and employment-based admissions, creating

a process for the undocumented and illegal immigrants to legalize their status, and requiring those seeking to legalize to pay back taxes for earlier years would significantly increase the number of legal immigrants filing Federal tax returns. The net effect of welcoming these new workers is Federal revenues enhanced by some $12 billion, more than offsetting the growth of entitlements.

That is the macro economic level. I am here to tell you about the micro. In my small part of the world, investment and consumer spending gravitates to us because of, and not in spite of, our mixed and diverse population. The prosperity that is just around the corner for us more than offsets the public sector investments required. It even offsets the consequences of the "white flight" of the 1990s.

That is what I am asking you not to mess it up.

Specifically, it is important to make some adjustments in the short term in the area of healthcare, because failure to act may have a corrosive effect on my community's social cohesion. The Federal government should let citizens who apply for Medicare to declare under penalty of perjury that they are citizens and who are making a good faith effort to secure their citizenship or identity documents, enroll in Medicaid while they are gathering their documents. This will ensure that pregnant women, children, and others who need timely medical care get it. There is no reason to delay preventive healthcare for children or prenatal care for women who are making a good faith effort to get their documents together. Moreover, States should have more flexibility in how to determine citizenship to help groups like foster care children, those affected by disasters and those whose birth certificates have been lost and so on.

Offering a legal pathway to earn citizenship can help immigrant workers get better jobs that offer employee benefits like health insurance, so that it can reduce the number of people who are uninsured. We should never criminalize a hospital or clinic that treats an illegal alien or undocumented worker without reporting the immigrant to law enforcement.

Why would failure to address these issues have a corrosive effect on my community's social cohesion? Recall the mixed nature of the community, where the web of personal connections crisscrosses the lines of documents. While the Deficit Reduction Act's provisions regarding verification of citizenship by Medicaid applicants were targeted at immigrants, they raise serious problems for U.S. citizens who are eligible for coverage, but will be adversely affected by the paperwork requirements, particularly children who are citizens but whose parents are undocumented. They are unlikely to have passports. They may not be verified by cross-matches with State vital records. Obtaining a birth

certificate can create a Catch-22 for families if a government issued photo ID is required, inasmuch as young children typically do not have such IDs.

Throughout our immigrant communities, people will know someone or know someone who knows someone for whom the process of obtaining and presenting the necessary documentation will delay healthcare coverage. For providers, who are often from the immigrant communities too, the financial impact can be very serious, by adding to the burden of uncompensated care, the bills of seriously ill citizens who are eligible for Medicaid, but whose coverage is delayed or denied as a result of the bureaucratic requirements. Delaying coverage while an expectant mother tries to meet the documentation requirements delays prenatal care and in some cases will deter the mother from obtaining prenatal care altogether.

For nearly 2 decades, the States and CMS have used presumptive eligibility so that mothers and babies could get care without delay while eligibility paperwork is completed. In Georgia, this has increased the number of women receiving timely, adequate prenatal care and has helped reduce infant deaths. The new law undercuts that approach by denying full Medicaid coverage until citizenship is documented, at least how it is done here in Georgia.

It is penny wise and pound foolish to delay prenatal care for American mothers because it will mean a more adverse pregnancy outcome, with increased expenditures for neonatal intensive care and in some cases, the care of children with lifelong disabilities. Furthermore, it is utterly senseless to make a new born citizen with undocumented mother whose births are covered by Medicaid apply separately for Medicaid as infants when other newborn citizens are deemed eligible for a year at birth. This will only mean that babies go without early preventive care and all of them need to be healthy.

The social cohesion of my diverse community rests upon the expectation that people from wholly different backgrounds can work hard side by side and build prosperity together. We have a stake in that prosperity. We live our aspirations, not our fears. But aspiration and harmony give way to fear and antagonism in a heartbeat when parents cannot get healthcare for a newborn, and then the downward economic spiral returns.

We live in a global economy. Investors can put their funds in Norcross, Georgia or Mumbai, India or Durango, Mexico or Sydney, Australia. Here at home, we live in a mobile society where consumers can choose where to spend their discretionary income. I want those investments to flow to Georgia and I want that purchasing power aimed at Norcross, Chamblee, Doraville, Lilburn, and Duluth. But that will not

happen if we do not adopt rational policies regarding immigration and healthcare that take full account of the benefits actually derived from a diverse and indeed global population.

[The prepared statement of Curt Thompson follows:]

PREPARED STATEMENT OF THE HON. CURT THOMPSON, MEMBER, GEORGIA STATE SENATE

I represent Georgia's 5th State Senate District, situated alongside the interstate that comes from Gainesville, where you will also hold a hearing, into Atlanta. We have some historic areas, such as the picture postcard railroad depot and town square of Norcross, but primarily we in the 5th live in suburbs begun during the Seventies, when lots of Atlantans left town after de-segregation and lots of Northerners left the Rustbelt after de-industrialization. Some of that rootless suburban population then moved again in the Nineties, to points further out, taking with them some of the commercial infrastructure that had serviced them. What opened up was space for new residents, and making a home here are African-Americans finding a first home in the suburbs, urbanites fleeing inflated home prices in Atlanta's bohemian quarter, and immigrants.

My district and the neighborhoods around it are home to as diverse a population as one finds in the Southeastern US. In our schools, students speak some 120 languages when at home. I campaign in English, Spanish, Korean, Hindi, Vietnamese and Mandarin. I've attended Romanian Orthodox Churches, spoken at Hindu Temples, danced Cumbia at a Colombian festival, and cut the ribbon at the opening of a high end Chinese Shopping Center. At dinnertime, I have menu options as rich as a Congressional aide living in Adams-Morgan. I go home this evening to a wife who was born in Colombia. I am here to tell you that diversity works.

When that first wave of suburbanites left for the exurbs in the Nineties, they took along with them some of the commercial infrastructure that had serviced them. We lost jobs. Storefronts stood vacant. Dollars for development went elsewhere. With declining political clout, our schools got fewer resources. Traffic worsened. We had a tough decade or so.

We have turned a corner. We've done the hard work to get the broader community to form a community investment entity called the Gwinnett Village Community Improvement District to redevelop and market our international community. We've also become a draw to new investment, with new major retail outlets catering to our diverse community's demands, and plans for several major new-urbanist live-work-shop centers including the Super Pearl and Super H centers as well as proposals for mixed use developments at Gwinnett Place Mall and at the Jimmy Carter Boulevard intersection with Interstate 85. Large investments are coming from overseas including the Asian Village, investors seeing our community as a place where they can feel at home and where they can prosper. Young professionals are re-locating here to participate in our cosmopolitan lifestyle. The I-85 corridor is turning into a destination for consumers who appreciate our distinctive mix. Simply put, our turn-around is fueled by diversity that only immigrant communities can generate.

Don't mess this up for us.

Think of Vancouver, British Columbia, just north of Seattle, with a flourishing economy tied into the world market. Vancouver boomed when talented people and investors in Hong Kong wondered where they could go after the Colony reverted to China. Vancouver welcomed newcomers. Made them feel at home. Like neighbors. And everybody got healthcare. It's important to make someone who is thinking of bringing talent and money and family into our community feel welcome. And in the real world, in the modern world, part of that welcome is healthcare.

It's important to understand that immigrant communities are themselves diverse. Some are here legally. Some are not. Some are in a twilight world because some bureaucrat hasn't had time to process papers yet. And this diversity extends into families. Poppa's got a green card and does pretty well, Momma works odd jobs because she doesn't have her papers, Junior wasn't born here so may not get to go to college, while Sis carries a US passport. Mixed families are common. When politicians and activists gin up sentiments against the undocumented, it reverberates throughout my community, documented and undocumented alike. Our global investors take notice.

That was the case earlier this year, when our State Legislature heatedly debated and eventually enacted an anti immigrant bill designed to play on these sentiments to win elections while inciting fear in our communities and scaring away business investments. As a consequence, hard-working people in my district are afraid to get health services they need. Many are afraid to take their citizen children for care. When they get sick enough, they will end up in the hospital emergency room, and we'll all decry the overcrowding, and costs of this emergency care, as though we had nothing to do with it.

One of the myths distorting the discussion about immigration is that the undocumented represent an unsustainable drain upon public resources. But that myth ignores the reality that these hard-working people are not only consumers of public services but also contributors. A recent study by the Center on Budget and Policy Priorities, for example, finds that the "Senate immigration bill, by creating a guest-worker program, expanding the number of family-sponsored and employment-based admissions, creating a process for undocumented immigrants to legalize their status, and requiring those seeking to legalize to pay back taxes for earlier years would significantly increase the number of legal immigrants filing federal tax returns." The net effect of welcoming these new workers is federal revenues enhanced by some twelve billion dollars, more than offsetting growth of entitlements. Moreover, offering a legal pathway to earned citizenship can help immigrant workers get better jobs that offer employee benefits like health insurance. Thus, it can reduce the number of people who are uninsured.

That's the macroeconomic level. I'm here to tell you about the micro. In my small part of the world, investment and consumer spending gravitates to us because of and not in spite of our mixed and diverse population. The prosperity that is just around the corner for us more than offsets the public sector investments required. It even offsets the consequences of the "White Flight" of the Nineties.

That's what I'm asking you not to mess up.

Specifically, it is important to make some adjustments in the short term in the area of healthcare, because failure to act may have a corrosive effect on my community's social cohesion. The federal government should let citizens who apply for Medicaid, who declare under penalty of perjury that they are citizens and who are making a good faith effort to secure their citizenship or identity documents, enroll in Medicaid while they are gathering their documents. This will ensure that pregnant women, children and others who need timely medical care get it.

There is no reason to delay preventive health care for children if their families are making a good faith effort to get their documents together. Likewise, it is penny-wise and pound-foolish to delay treatment for a chronic condition while waiting for documents. Furthermore, it is utterly senseless to make newborn citizens with undocumented mothers whose births were covered by Medicaid apply separately for Medicaid when other newborn citizens are deemed eligible at birth for a year of coverage. This will only mean the babies go without the early preventive care all of them need to be healthy. Finally, states should have more flexibility in how to determine citizenship to help groups like foster care children, those affected by disasters, those whose birth certificates have been lost, and so on.

Why would failure to address these issues have a corrosive effect on my community's social cohesion? Recall the mixed nature of that community, where the web of personal connections crisscrosses the lines of documentation. While the Deficit Reduction Act's provisions regarding verification of citizenship by Medicaid applicants were targeted at immigrants, they raise serious problems for U.S. citizens who are eligible for coverage but will be adversely affected by the paperwork requirements, particularly children who are citizens but whose parents are undocumented. They are unlikely to have passports. They may not be verified by cross-matches with state vital records. Obtaining a birth certificate can create a "Catch 22" for families, if a government-issued photo ID is required, inasmuch as young children typically do not have such IDs.

Throughout our immigrant communities, people will know someone or know someone who knows someone for whom the process of obtaining and presenting the necessary documentation will delay healthcare coverage. For providers, who are often from the immigrant communities, too, the financial impact can be very serious, by adding to the burden of uncompensated care the bills of seriously ill citizens who are eligible for Medicaid, but whose coverage is delayed or denied as a result of the bureaucratic requirements.

The social cohesion of my diverse community rests upon the expectation that people from wholly different backgrounds can work hard side by side and build prosperity together. We all have a stake in that prosperity. We live our aspirations, not our fears. But aspiration and harmony give way to fear and antagonism in a heartbeat when parents cannot get healthcare for a newborn. And then the downward economic spiral returns.

We live in a global economy. Investors can put their funds into Norcross, Georgia, or Mumbai, India, or Durango, Mexico, or Sydney, Australia. Here at home, we live in a mobile society where consumers can choose where to spend their discretionary income. I want those investments to flow into Georgia. I want that purchasing power aimed at Norcross, Chamblee, Doraville, Lilburn, Lawrenceville, and Duluth. But that won't happen if we don't adopt rational policies regarding immigration and healthcare that take full account of the benefits actually derived from a diverse and indeed a global population.

MR. DEAL. Thank you, Senator.

[Applause.]

MR. DEAL. I will ask the audience to cooperate. I left my gavel at home today, but I still have my knuckles to rap. So please cooperate with us. This is an important hearing and there obviously are differences of opinion.

I will begin the questioning, followed by my colleagues. If you will set the timer, we will have 5 minutes in which to--you want to do 10 minutes? Okay, 10 minutes.

First of all, Senator Thompson, I want to agree with you that diversity works. But diversity in this country has always been founded on the rule of law, as you are very well aware. What at least some of us are saying here today, is that diversity, as long as it conforms to the law, is a very good thing. The problem we have is the presentation you have made, as I would characterize it, is that the facts are sometimes stubborn things, but the law is also sometimes a stubborn thing. So sometimes the easiest thing to do is to ignore the law. Many of the examples that you

cited in your testimony are examples where we have just ignored the law and nobody has done anything about it.

So let me just put it in a very simple question to you then. Do you believe that taxpayers should pay for all healthcare that may be required, emergency and non-emergency, for anybody who is on American soil, regardless of their legal status?

MR. THOMPSON. What I believe is that we have a healthcare crisis. And in my district, it is more about the fact that--

[Audience comment.]

MR. THOMPSON. It is more about the fact that most--and my district has a high percentage, probably the highest percentage, of uninsured I am told of any district in the State. And that is because the jobs in my district do not offer health insurance. They are in construction, they are in service industries. That is true whether they are in hotels, they are in restaurants, they are in places--the best corporate citizen I have got is probably Starbucks. So that is true for legal and illegal. And so there is a problem there with a healthcare crisis.

What I did say in my testimony is that we need to be reasonable in what type of documentation we ask them to require, how long we give people to require it, and what presumptions go on. The courthouse in Carnesville burned I think in--it was before I was born, but after my mom was born. My own mom cannot obtain an original birth certificate and so by the definitions that are being set up, she would have trouble--and she is an American citizen as near as I can remember--

MR. DEAL. You all better watch out.

[Laughter.]

MR. THOMPSON. She would have trouble under the rules that are being set up. And that is why I have urged folks to adopt practical solutions to real world problems like the Senate Bill.

MR. DEAL. Let me say to you that I think you will be pleased when you hear the second panel's testimony with regard to that issue. I think you will find that the four States, including Georgia, that are now requiring and have required even before the Federal requirement went into place, that those problems are virtually non-existent. It is not one of those things that somebody says my birth certificate burned up somewhere, go home until you find it. State authorities, and I am sure you will hear from Mr. Ortiz who is head of our facility here in the State, that they are cooperative in getting those. I think those are strawman type arguments, quite frankly. I do not think they are realistic. I think that the facts do not sustain that.

Let me move to another area of your testimony that I think is certainly relevant, because part of the thrust of what we are talking about here today is part of what we have already done as we have all alluded to

in the Deficit Reduction Act of requiring citizenship verification as an eligibility requirement for Medicaid. As all of you have indicated, the State of Georgia, even before we did that, had already taken that step.

But also part of what these hearings are, and there are hearings by various other committees across the country, looking and comparing and contrasting the Senate-passed version of the immigration reform bill and the House-passed version of the immigration reform bill. And you alluded, Senator Thompson, appropriately I think, to one of those distinctions. And that is there are really two big distinctions, if we want to simplify it.

And that first one is a guest worker program that is included in the Senate bill that is not in the House and an amnesty provision that is--or at least five different versions of amnesty--that are included in the Senate bill that there are none in the House bill.

Now one of your statements that caught my attention was the quote that I believe you quoted from another source. I cannot put my finger on it right now.

MR. THOMPSON. Center for Budget and Policy.

MR. DEAL. Yes, Center for Budget and Policy Priorities, in which they made the quote about the Senate immigration bill with a guest worker program expanding the number of family-sponsored and employment-based admissions, and it goes on to say they think that that is a good idea.

I asked this question to the panel that Congressman Norwood had in a hearing in Gainesville yesterday, and that is, for people to come into this country legally, we have sponsorship programs where someone can sponsor an individual to come in. Part of the 1996 Immigration Reform Act said that if you are a sponsor of an immigrant coming into this country, then you will have the responsibility of saying they will not become a charge upon the public services of the State or the Federal government. I asked the question if anyone had ever heard of a sponsor being held financially accountable for the expenses of an individual that they sponsored.

Have any of you gentlemen ever heard of that?

MR. CAGLE. No.

MR. ROGERS. No.

MR. THOMPSON. No.

MR. DEAL. You are in agreement with the panel yesterday. Nobody had ever heard of that. And that is what causes me some real concern, is if we are going to duplicate the language of an ineffective law in this new package that the Senate is proposing, I do not know how you would ever expect a hospital, for example, to know who the sponsor of an individual is, whether it be a private family type sponsorship or an employer-based

sponsorship, to hold them accountable for expenses, here in this context talking about healthcare.

Do you have a good idea as to how that might work?

MR. THOMPSON. How you might?

MR. DEAL. How you might hold either an employer or a family-based sponsorship accountable for the expenses so that these individuals who now are presenting themselves either at the ER or the general hospital or doctors' offices, do not become a charge upon public resources.

MR. THOMPSON. Well, I guess you are sort of calling for speculation and I am a lawyer, so I am probably good at doing that.

MR. DEAL. I am too and I know it when I see it.

[Laughter.]

MR. THOMPSON. Nor am I an expert. I do know that if you are legally here, you have certain documentation including a work authorization card. And again, I am not an expert from the Homeland Security Department, I am a State legislator from the Fifth District. But it would seem that you could somehow include in the documentation, the work authorization, who is responsible for what.

MR. DEAL. I think that is a very key element that we have to come to grips with some practical approaches to it. Either of you gentlemen have any suggestions? Because even though I personally do not think that the Senate version will ever pass the House of Representatives, at some point, the discussion will proceed to documentation. You know, how do you create a tamper-proof document, if you have an expanded guest worker program, how do you hold those who are the employer or sponsors of those individuals--how do you hold them accountable.

Did you all get into any of those kind of discussions at the State level? It probably was not necessary for you to do so. Senator Rogers?

MR. ROGERS. No, sir, Congressman Deal, we did not. And I think you hit on one of the multitude of problems with the Senate bill. I characterize it as not worth the paper it is printed on. Because it sets up a processing nightmare that could never be achieved. If we look at what we attempted to do in the 1986 amnesty and realize--and I think this is important for those in the audience to remember--that amnesty period just ended last year. It took 20 years to process three million. How long will it take us to process the 20 million that are here illegally today? No one knows. No one in this room may be alive at that point in time.

But it highlights again the processing problems that that bill contains and I think that the simple fact of the matter is, if you do not have the documentation on you, you cannot expect the taxpayers to pay for your medical care. If you want to pay for it out of your own pocket, have at it. But if you are expecting the taxpayers to pay for it, you have got to show

up with the documentation. I cannot even go rent a video unless I have the proper documentation. So clearly I should not be allowed to ask some other taxpayer to pay for my medical care because I am not willing to do so myself.

MR. DEAL. Well, and I do think--

[Applause.]

MR. DEAL. I do think that those are reasonable expectations that we have placed.

Part of any law--as you gentlemen know, you can pass laws, the important part sometimes is how they are implemented. And that has been the problem at the Federal level for many years, dating from 1986 or even in some cases even beyond that. And the failure to implement the laws that either the Federal government or the State government passes.

So I think it is going to be important for all three of you to have the responsibility of oversight at the State level of implementing--making sure that the Federal changes we have made and the State changes you have made are actually implemented. As one of you alluded to, the Federal legislation delegates to the State the responsibility of verifying eligibility for programs like Medicaid. So I would ask and hope that you will all--I am sure you will--follow up to make sure that what all of us do are actually being carried out and implemented in the next year or so.

My time has expired and I will now recognize Ms. Solis for 10 minutes.

MS. SOLIS. Thank you, Mr. Chairman.

First, I would like to just clarify that I do not believe anyone has proposed any legislation that I know of or that I am supporting that would actually repeal the provisions in the Medicaid plan, and that is to provide full services to U.S. citizens and to assist those that are in need of that service. I think all Americans, especially mothers and children that currently are uninsured, if they have to go through a bureaucracy to show proof of citizenship and maybe they, for example, just went through a flood like in Mississippi and Georgia, Katrina. What happens to those folks? Are you going to take their word that they are U.S. citizens or not? How are you going to verify that when every documentation is no longer in existence? That is number one.

Number two is I tend to agree with the statement that Mr. Rogers made regarding the State's role here. Yes, the States have been burdened with a lot of these additional costs in healthcare and other services, but I really believe that one of the things that I would ask State elected officials to do is to hold their elected Federal representatives accountable. And I agree that over the last few years, in fact just this past session, the members on the other side of the aisle, agreed to cut

back $28 billion in Medicaid for the next 10 years. You tell me how we are going to provide services for our elderly, for our disabled, and for those individuals that are unable to work that are U.S. citizens? How are we going to make up that revenue? Where are we going to cut from?

The other question I have is, we talk about law enforcement and incarceration, detaining of illegal immigrants. I have gone on record, as many Democrats have, to say that we need to beef up that particular fund. That we should not be asking our local municipalities, our local law enforcement officers, to have to dig into their budget to provide for Federal immigration enforcement. That is wrong. And this Administration and this particular Congress that is in control has not fully funded what I think are our first responders, the folks out in the field that really have been starved. And in Los Angeles County, we are faced with that dilemma right now. Our sheriff, Lee Baca, there has testified at many of these hearings regarding that particular issue.

Democrats, by the way, and I want to reiterate, had in the past proposed budget funding to fully fund more Border Patrol agents to the tune of, what was it I said earlier, at least 6000 more Border Patrol agents, to make sure that our borders were secure and that we do have adequate enforcement and that we do not burden our local law enforcement and local municipalities. So I agree that the Federal government needs to do more and I would ask that our elected officials do that.

Now I would like to go and ask some questions, please, to Senator Thompson. Senator Thompson, there are some in the room, and I believe across the country, that may think that legal and illegal immigrants are the source of our problems with respect to healthcare and the fact that rising costs continue to climb. While the number of uninsured increased--and I want to reiterate this--6 million people under this Administration that has been due primarily to loss of jobs and lack of job-based coverage. These are important issues that I think the public needs to be aware of, that in fact, we have more people that are not insured. And so you are going to have a system that is going to be burdened. You are going to see more people going to the trauma centers to use that type of healthcare service if they are not in any form available to get into a system that provides adequate coverage. There has not been enough local community clinics, in my opinion, that have actually been adequately funded. In many cases, in my own district, many have been closed. We need to do more for prevention so that we do not see these individuals reaching our trauma centers where the cost does tend to go up. But the focus there, in my opinion, is really about the uninsured, because many uninsured American citizens tend to over-utilize the

trauma unit centers in our hospital system. And we have not adequately funded those hospitals and reimbursement rates for that type of service.

If we are asking for an unfunded mandate, I think that is wrong. I think the Federal government should do more to provide adequate coverage so people do not come up to our hospitals and use that very precious system or unit of service that is so vital. If someone has a head injury or is in a car accident or falls off their motorcycle and has a dangerous accident there, the first step is to go to the emergency unit of a hospital. The cost can be enormous and yes, in many cases, the States are saddled with that. And I agree that we need to have Federal government play a bigger role and to provide coverage for that. Later today, I am sure we are going to hear from the hospitals about that particular burden.

But I wanted to ask you, Senator Thompson, if you could give us some constructive ideas discussed in Georgia to help lower the number of uninsured children. You talked about your particular district having a high number, but that is not an unusual case. That is somewhat typical of many, many cities in our country. And if you could elaborate on that.

MR. THOMPSON. Well, I guess one of things that is a possibility here is an expansion of the SCHIP program or Peachcare, fully funding it out and maxing that out. We do not take advantage of every Federal dollar, we basically leave dollars on the table. And doing what Illinois has done, expanding healthcare to all minors also. And there is actually a proposal out there called Peachkid that would basically do that. That is going to be probably the subject of the election down here in Georgia, but that is one issue that is coming up.

I do think that in general what you commented about was a funding issue, and what we often see, especially at the local level, is that the fed does not want to pay for it, so they pass it off on the State. The State does not want to pay for it, so they pass it off on the county. And that results in my county hospital, Gwinnett Medical, having a huge deficit, and ultimately the taxpayer pays for this emergency room care. If there were in fact more clinics and more money spent on clinics, more money spent on preventive care, we would not in fact have this option.

I understand the desire to strike out at people you feel may have broken the law, but you are doing it in a way that is costing you actually more money, the current system is actually going to cost us more money and because a county can only raise money from property taxes, it is going to cost more money to those who can least afford it, people who are more sensitive to property tax increases, which are low-income people in their first home or elderly people. While I understand the impulse, it is not sound economics, what we are doing.

MS. SOLIS. I wanted to ask you if you could make a comparison between the Georgia law that just passed that would require documentation for Medicaid and what that would mean for you if the Federal government comes in and says well no, you have to follow along our lines. Would there be some dramatic changes that would affect costs, medical costs?

MR. THOMPSON. I do not have specific figures, but other than it basically passes the buck because it funnels people to the emergency rooms, that is my concern. And so then you are going to have--and my own Gwinnett Medical Center is already running a huge deficit for that. I do not have a specific answer for you about those costs, no.

MS. SOLIS. One of the questions that I had is that when we begin to ask for documentation, especially for individuals, even children in foster care, you talked a little bit about that. Many foster care children, for whatever reason, may not have appropriate documentation with them, because they were assigned by a court, State, to be put in a foster home. And those documentations are not available because the parents, the blood relatives, are not in say in a position to want to do that, to cooperate. What does that mean for American children that should be eligible for even foster care assistance?

MR. THOMPSON. Well obviously, I mean we were talking about a cumbersome system that is not going to work and is not worth the paper that it is printed on. That is what you are basically setting things up and you are also setting it up--for instance, most kids are in foster care because of some emergency and it is going to be harder to process them through, it is going to increase the trauma to those kids. Ultimately, I mean we can be both--on a personal level, it is going to increase the trauma to those kids, but on a government level, it is going to ultimately increase costs to us because it is going to require additional services later on the back end to correct the problems created on the front end.

MS. SOLIS. And Senator Thompson, the State's children's health insurance program that you talked about, SCHIP, the Federal partnership that provides insurance for children and families with Medicaid level income, needs to be reauthorized, as you know, next year. Unfortunately, Congress adds new funding to the program, we will see a $1.8 million child loss in healthcare coverage over the next few years and the States will face a $10-12 billion shortfall just to maintain that level of funding. How will your State deal with that crisis or that issue that you will be faced with?

MR. THOMPSON. Well, I mean unless Congress acts, Georgia is going to run out of money, it is just that simple. And Peachkids is probably--or Peachcare, sorry--has probably been, after the Hope Scholarship, the most popular program we have enacted in my lifetime,

or at least in my voting lifetime. If that runs out of money, it is going to throw thousands of kids off healthcare and it is going to then result in more kids being in the emergency room, higher absentee rates in schools when kids have to stay home, it is going to result in lower test scores. I mean it is going to have a ripple effect that will be huge. Congress does in fact need to reauthorize this, absolutely.

MS. SOLIS. Thank you.

MR. DEAL. The gentlelady's time has expired. Thank you.

Mr. Norwood is recognized for 10 minutes for questions.

MR. NORWOOD. Thank you very much, Mr. Chairman. It appears that it falls to me to sort of work on the record just a little bit so that we end up here getting some truths out.

I want to start by pointing out that the Congress I think did a very good job in limiting the growth in Medicaid referred to earlier as deep cuts, when in fact really it was simply slowing down the spending. But how we did it did not come out either. The way we did it was to make sure that millionaires could not get rid of their assets so they could be on long-term care. So that is the other part of the sentence that I am sure Ms. Solis would have gotten to the next round.

[Laughter.]

MR. NORWOOD. I want to begin sort of with my discussion saying that Senator Rogers, I think the United States Senate immigration bill is worse than you described. I think it is the worst piece of legislation that I have seen in Washington, D.C. in 12 years. Should that become law--and it is not--

[Applause.]

MR. NORWOOD. --it makes citizens out of the 20 million illegal immigrants that are here, immediately invites them to bring their families into this country and make citizens. We estimate that that will bring another 20 million new people to America over the next 20 years, and by the turn of the century, that will be another 100 million people have come into this country.

Now the reason I point that out is that the purpose of this hearing is to talk about the fact that illegal immigrants are getting on our social systems and it is busting the bank now. Senator Cagle, what do you think would happen in Georgia over the next century if that many more new people came into the country legally, were made citizens, and immediately could get onto our social programs? Can Georgia stand that kind of thing?

MR. CAGLE. Well, no, it certainly cannot. And when you look at Georgia today, I will tell you at the outset that there is--we believe in immigration and we believe that there is a right way and a wrong way to

come to this country. And we cannot condone individuals that are coming here through illegal means.

When you look at Georgia today, you find that half of all births are being paid for by taxpayers of Georgia. We experienced a significant, $400 million, shortfall in Medicaid year after year until we made some real changes. When you look at really having an impact, it is only through eligibility and utilization to bring those costs into bear. We cannot continue to absorb these types of costs in Georgia. And Congress has got to act and it has got to act swiftly in order to preserve the future for our children.

MR. NORWOOD. Do you believe the first act should be to secure our border?

MR. CAGLE. There is no question.

MR. NORWOOD. Senator Rogers?

MR. ROGERS. That is your required duty and we all are anxiously awaiting that duty to be fulfilled.

MR. NORWOOD. Senator Thompson?

MR. THOMPSON. I believe you have to do both at the same time.

MR. NORWOOD. But you believe we need to secure our borders?

MR. THOMPSON. Absolutely.

MR. NORWOOD. And stop people from coming across our borders illegally.

MR. THOMPSON. Absolutely.

MR. NORWOOD. I am very happy to hear that.

By the way, in terms of correcting the record, you were talking about the SCHIP program. Georgia is a deficit State in SCHIP. We spend more in SCHIP monies than does the Federal government send us and allow us. Would you verify that, either one of you Senators?

MR. ROGERS. That is true.

MR. NORWOOD. And what you said was the opposite, and I am sure you did not mean to, but being a lawyer, you know--

[Laughter.]

MR. NORWOOD. No offense, Mr. Chairman.

[Laughter.]

MR. NORWOOD. You made a comment, Mr. Thompson, and I quote, "you feel may have broken the law." I presume you were talking to us or perhaps somebody on the panel, and you were saying that we feel they may be breaking the law by coming into our country, using bogus Social Security cards, et cetera, et cetera. Do you feel people who have come across our border from Saudi Arabia and India and Mexico, are they breaking our law, rather than "may be breaking"? Are they breaking our law?

MR. THOMPSON. I apologize, I do not know where I said "we feel" or "we may feel."

MR. NORWOOD. You said "you feel," you were talking to us--"you feel they may be breaking our law." Are they or are they not?

MR. THOMPSON. If they are using false documentation, that is--

MR. NORWOOD. Are they breaking our law by crossing our border illegally? Is that against the law?

Mr. Thompson. Yes, condemnation Okay, I just wanted to make sure. So it is not "may be breaking the law," they are breaking the law.

MR. THOMPSON. Well, that depends. Some people do have legal documentation to come here. They may do other things when they get here--

MR. NORWOOD. I am not talking about legal documentation, I am talking about people who slip across our border in the middle of the night. Turn on Fox News if you want to watch it. They are breaking the law.

[Laughter.]

MR. THOMPSON. And I appreciate your question, but I--

MR. NORWOOD. No offense, you have said they are breaking the law, it is not "may."

MR. THOMPSON. I have said that--

MR. NORWOOD. Yes or no.

[Laughter.]

MR. THOMPSON. Congressman, if you will allow me to answer the question or we can--

MR. NORWOOD. Yes or no would be great so I can go to some other questions. Do you believe people who cross our border without documents are breaking our laws?

MR. THOMPSON. That is against the law and that is not what I said. I said but having a false Social Security card does not necessarily mean they crossed the border illegally.

MR. NORWOOD. I did not say anything about that.

MR. THOMPSON. Well, that is what you are trying to insinuate.

MR. NORWOOD. I said that is another way they break the law.

MR. THOMPSON. I do also want that corrected for the record, Mr. Congressman.

MR. NORWOOD. All right, now Senator Rogers.

MR. ROGERS. Yes, sir, glad to answer a question.

MR. NORWOOD. We spend way too much money in Washington, very unwisely in my opinion. The difference is we get to print it. The problem is you do not get to print it over there in Atlanta, you have got to actually balance your budget. I want you to take just a minute again and talk about the budgetary limitations that we have in our State regarding

all programs, but particularly we are talking about social programs here, and why is it so important that we deal with this problem of making sure we spend our dollars for American citizens who deserve the taxpayers' dollars frankly, versus people who I think are criminals, who have come across our border, broken our laws using false documents, et cetera, et cetera. Would you do that budgetary thing just a minute for me?

MR. ROGERS. I will, sir, and I think what is clear, and sometimes I think in this great debate we lose focus of very simple facts. Congress is supposed to protect Americans, not people from other countries. Americans.

[Applause.]

MR. ROGERS. In Georgia, we are supposed to protect Georgians, not Alabamians, nor Floridians. So when I know there are 12,700 severely disabled children, elderly, frail people on a waiting list who already qualify for benefits and are being denied because we know that certain amounts of dollars go to people who are not eligible, then we have simply taken money from those who qualify, who are legal U.S. citizens and Georgia residents, and given it to people who are here illegally. That is not just a slap in the face to all of us, that is a direct slap in the face to the people who already legally qualify.

I want to follow up on something Congresswoman Solis said. She said she knows of no bill that seeks to repeal Medicaid provision. Well, of course not, if you make everybody legal, you do not need to repeal it, they will all get the benefit.

[Laughter.]

MR. ROGERS. The second thing--

[Applause.]

MR. ROGERS. --I know Congressman Deal and Congressman Norwood were here in 1996, I do not know if Congresswoman Solis was, but in 1996, I want to correct something. Title 8, Chapter 14, Sections 1611 and 1621, already declare exemptions for flood, as you brought up as an example. You do not have to have any documentation if you are injured in a flood or tornado or hurricane or anything, and for emergency foster care. So those exemptions are already built into the law.

Congressman Deal pointed out strawman arguments. I think oftentimes we get involved in these strawman arguments that are simply not part of what the law is. The law is very clear. If you have an emergency situation, whether it is a flood or foster care, you do not have to provide any documentation.

We are talking about people who are taking advantage of the system, who in many cases could pay for it out of their own pocket, but do not want to because they have the Government to pick up the tab for them.

MR. NORWOOD. I have got just a minute and, Senator Thompson, I need to ask you four or five questions. Please oblige me with yes or no and then I will maybe have time to get it all in.

How many people in your district?

MR. THOMPSON. One hundred fifty five thousand.

MR. NORWOOD. Yeah, 650,000 in mine and 8 million in Georgia. So I appreciate you trying to protect your district, but the rest of us also have to worry about the rest of the citizens and their attitude about this over the rest of the State.

Yes or no, please. Do you think enforcing our laws against civil violators is wrong?

MR. THOMPSON. No.

MR. NORWOOD. Do you believe that we should provide services to those who are illegally in the Nation even if it means there is less service for American citizens?

MR. THOMPSON. I think we need some comprehensive reform so that that does not happen, because that is--

MR. NORWOOD. And the answer is yes or no?

MR. THOMPSON. That is a strawman choice and I am not going to play that game.

MR. NORWOOD. Well, you can refuse to answer. I just want to know if you--

MR. THOMPSON. I have given you my answer, Mr. Norwood.

MR. NORWOOD. All right, so the answer is you do not.

You say that the people in your district--

MR. THOMPSON. I disagree.

MR. NORWOOD. --are afraid to get health services because of actions of the legislature. Now I think that we are going to hear from hospital representatives later who are going to testify there is no shortage of folks seeking uncompensated care. Do you disagree?

MR. THOMPSON. My hospital runs a deficit, but it does not change the fact that there are people not going to the hospital who need--and not going to the doctor because of this. Again, you are setting up a false choice.

MR. NORWOOD. Well, I know these questions are hard.

Lastly, many are afraid to take their citizen children for care. You say that in your document. Many are afraid to take their citizen children for care. Would you be good enough to furnish proof to this Committee that that is true?

MR. THOMPSON. If you would like, I can submit an affidavit.

MR. NORWOOD. I do want you to do that because every ER doctor I have ever talked to in this State say they do not have any problems with

the number of people coming in illegally using their emergency room. So proof would be greatly appreciated.

Sorry, Mr. Chairman, for going over.

MS. SOLIS. Mr. Chairman, before you excuse the panel, I would like to insert part of the Deficit Reduction Act of 2005 that was passed, the section, statute 120, Section 6036 "Improved Enforcement of Documentation Requirements," which states nothing specifically about floods or foster children. I would like that--ask unanimous consent to have that entered into the record.

MR. ROGERS. It is a different title, it's Title VIII, Chapter 14.

MR. DEAL. You may do so, but Senator Rogers was referring to the 1996 Act, as I recall.

Yes, without objection, that may be included in the record.

[The information follows:]

SEC. 6036. IMPROVED ENFORCEMENT OF DOCUMENTATION REQUIREMENTS.

(a) In General- Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended--

(1) in subsection (i), as amended by section 104 of Public Law 109-91--

(A) by striking `or' at the end of paragraph (20);

(B) by striking the period at the end of paragraph (21) and inserting `; or'; and

(C) by inserting after paragraph (21) the following new paragraph:

(22) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of subsection (x) is met.'; and

(2) by adding at the end the following new subsection:

(x)(1) For purposes of subsection (i)(23), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

(2) The requirement of paragraph (1) shall not apply to an alien who is eligible for medical assistance under this title--

(A) and is entitled to or enrolled for benefits under any part of title XVIII;

(B) on the basis of receiving supplemental security income benefits under title XVI; or

(C) on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

(3)(A) For purposes of this subsection, the term `satisfactory documentary evidence of citizenship or nationality' means--

(i) any document described in subparagraph (B); or

(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

(B) The following are documents described in this subparagraph:

(i) A United States passport.

(ii) Form N-550 or N-570 (Certificate of Naturalization).

(iii) Form N-560 or N-561 (Certificate of United States Citizenship).

(iv) A valid State-issued driver's license or other identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.

(v) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

(C) The following are documents described in this subparagraph:

(i) A certificate of birth in the United States.

(ii) Form FS-545 or Form DS-1350 (Certification of Birth Abroad).

(iii) Form I-97 (United States Citizen Identification Card).

(iv) Form FS-240 (Report of Birth Abroad of a Citizen of the United States).

(v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.

(D) The following are documents described in this subparagraph:

(i) Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.

(ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

(E) A reference in this paragraph to a form includes a reference to any successor form.

(b) Effective Date- The amendments made by subsection (a) shall apply to determinations of initial eligibility for medical assistance made on or after July 1, 2006, and to redeterminations of eligibility made on or after such date in the case of individuals for whom the requirement of section 1903(z) of the Social Security Act, as added by such amendments, was not previously met.

(c) IMPLEMENTATION REQUIREMENT- As soon as practicable after the date of enactment of this Act, the Secretary of Health and Human Services shall establish an outreach program that is designed to educate individuals who are likely to be affected by the requirements of subsections (i)(23) and (x) of section 1903 of the Social Security Act (as added by subsection (a)) about such requirements and how they may be satisfied.

MR. DEAL. And without objection, Senator Thompson, you may be allowed to submit further evidence to substantiate the statements that have been referred to.

Gentlemen, thank you very much for your service and thank you for being with us today.

[Applause.]

MR. DEAL. If the second panel will please take their seats. I am pleased to introduce our second panel and we do need to move along as expeditiously as possible since we have three panels here today. I am pleased to introduce the second panel of Ms. Jean Sheil, who is the Director of Family and Children's Health Program, Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services in Washington, D.C.; Dr. Alison Siskin, who is a specialist in immigration

legislation, Domestic Social Policy Division of the Congressional Research Service; and Mr. Abel C. Ortiz, who is Health and Human Services Policy Advisor, office of Governor Sonny Perdue of the State of Georgia.

Ladies and gentlemen, we are pleased to have you here and Ms. Sheil, we will begin with your testimony. You have 5 minutes.

STATEMENTS OF JEAN SHEIL, DIRECTOR, FAMILY AND CHILDREN'S HEALTH PROGRAM, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE & MEDICAID SERVICES; DR. ALISON SISKIN, SPECIALIST IN IMMIGRATION LEGISLATION, DOMESTIC SOCIAL POLICY DIVISION, CONGRESSIONAL RESEARCH SERVICE; AND ABEL C. ORTIZ, HEALTH AND HUMAN SERVICES POLICY ADVISOR, OFFICE OF THE GOVERNOR, STATE OF GEORGIA

MS. SHEIL. Thank you, Mr. Chairman, Chairman Deal, Dr. Norwood, and Ms. Solis, thank you for inviting me to speak with you today about Section 6036 of the Deficit Reduction Act entitled "Improved Enforcement of Documentation Requirements."

Medicaid is a partnership between the Federal government and the States.

MR. DEAL. Could you speak into the mic?

MS. SHEIL. Yes, sir. Is that better?

MR. DEAL. Yes.

MS. SHEIL. Okay. Medicaid is a partnership between the Federal government and the States. While the Federal government provides financial matching payments to the States, each State is responsible for overseeing its Medicaid program and each State pays a portion of its cost through a statutorily determined matching rate, currently ranging between 50 and approximately 76 percent. The Centers for Medicare & Medicaid Services, CMS, which oversees the Federal responsibility for Medicaid, ensures States enforce Medicaid eligibility requirements. Recently, CMS issued guidance and an interim final regulation to the States as part of the implementation of the Deficit Reduction Act which requires Medicaid applicants who declare they are citizens to document their citizenship and identity.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, also known as PRWORA, significantly changed the eligibility of non-citizens for Federal means-tested public benefits, including Medicaid and subsequently the State Children's Health

Insurance Program, SCHIP. This change, however, did not alter eligibility for undocumented and non-immigrant aliens, who generally remain ineligible for non-emergency Federal benefits.

Under PRWORA, States are required to provide Medicaid to certain qualified aliens who otherwise meet the eligibility criteria of the State's Medicaid program, unless subject to a 5-year bar. The 5-year bar applies only to qualified aliens who entered the United States on or after August 22, 1996, with some exceptions.

However, the 5-year bar and other eligibility restrictions do not apply to aliens who are applying only for treatment of an emergency medical condition. Thus, all aliens, both qualified and non-qualified, including undocumented immigrants, may be eligible for treatment of an emergency medical condition, provided they otherwise meet the eligibility criteria, such as income level, for example, for the State's Medicaid program.

American citizenship or legal immigration status have, for many years, been a requirement for Medicaid eligibility. However, as Dr. Norwood indicated, previously in many States, applicants could assert their citizenship status by merely checking a box on a form. The Deficit Reduction Act now holds States financially responsible for Medicaid expenditures for individuals claiming to be U.S. citizens unless such individuals provide actual documentary evidence supporting their citizenship and identity. This new requirement applies to new applications for Medicaid eligibility and redeterminations effective July 1.

In order to give States some initial guidance on the implementation of this provision, on June 9, CMS issued a State Medicaid Director Letter. On July 12, the Department published an interim final regulation for States to implement this new requirement. Comments on the interim final rule were due last Friday, August 11.

The law requires that a person provide evidence of both citizenship and identity. In some cases, a single document will be enough to establish both citizenship and identity. However, if secondary documentation is used to establish citizenship, such as a birth certificate, the individual will also need evidence of his or her identity. Once citizenship has been proven, it need not be documented again with each eligibility renewal unless later evidence raises a question.

The interim regulation provides a broad array of documents that are acceptable evidence of citizenship and identity. Individuals who receive Medicare and individuals who are on Supplemental Security Income are exempt from these documentation requirements.

At the time of application or redetermination, the State must give an applicant reasonable opportunity to present documents establishing U.S.

citizenship or nationality and identity. An individual who is already enrolled in Medicaid will remain eligible if he or she puts forth a good-faith effort to present satisfactory evidence of citizenship and identity. Applicants who, despite their good-faith effort, are unable to present documentation should be assisted by the State in securing these documents. CMS encourages States to use automated capabilities to verify citizenship and identity of Medicaid applicants. We specifically asked for public comment in the regulation on whether there are other electronic data systems that should be identified to assist States in determining an individual's citizenship or identity.

As with other Medicaid program requirements, States must implement an effective process for assuring compliance with documentation of citizenship in order to obtain Federal matching funds, and effective compliance will be part of Medicaid program integrity monitoring. When future automated capabilities to verify citizenship and identity of Medicaid applicants become available, States will also be required to match for individuals who used less reliable documents to verify citizenship and identity. States will receive the normal 50 percent match for administrative expenses related to implementation of the new law.

The law also requires that the Secretary develop, as soon as practicable, an outreach program which is intended to educate individuals who are likely to be affected by the requirements of this provision of the law. CMS has already conducted numerous teleconferences with States and other organizations interested in this provision. Fact sheets, posters, brochures are also available on our CMS website. In addition, we are developing an outreach plan that provides strategic direction and coordination for an integrated education and outreach program to inform States, Medicaid recipients, and others of these new documentation requirements. The plan will ensure that all stakeholders know of the new requirements, understand the documents which satisfy these requirements and assist the streamlined implementation by States, and ensure continued uninterrupted access to Medicaid for citizens.

Thank you again for this opportunity to speak with you on these new Medicaid program requirements.

MR. DEAL. Thank you. Dr. Siskin.

[The prepared statement of Ms. Sheil follows:]

PREPARED STATEMENT OF JENA SHEIL, DIRECTOR, FAMILY AND CHILDREN'S HEALTH PROGRAM, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE & MEDICAID SERVICES

Thank you for inviting me to speak with you about the impact of undocumented immigrants on the Medicaid program and the health care delivery system and express the Administration's support for comprehensive immigration reform that increases border security, establishes a robust interior enforcement program, creates a temporary worker program, and addresses the problem of the estimated 11 to 12 million illegal immigrants already in the country.

Medicaid is a partnership between the Federal government and the states. While the Federal government provides financial matching payments to the states, each state is responsible for overseeing its Medicaid program, and each state pays a portion of its cost through a statutorily determined matching rate, currently ranging between 50 and approximately 76 percent. The Centers for Medicare & Medicaid Services (CMS), which oversees the Federal responsibility for Medicaid, ensures states enforce Medicaid eligibility requirements. Recently, CMS issued guidance and an interim final regulation to the states as part of the implementation of the Deficit Reduction Act of 2005 (DRA), which requires Medicaid applicants who declare they are citizens to document their citizenship and identity.

CMS, in regards to the broader health care system, also enforces regulations that require hospitals to medically screen and provide stabilizing treatment or an appropriate transfer to any person seeking emergency care, regardless of payment method or citizenship status.

Immigrants and Medicaid Eligibility

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) significantly changed the eligibility of non-citizens for Federal means-tested public benefits, including Medicaid and subsequently the State Children's Health Insurance Program (SCHIP). This change, however, did not alter eligibility for undocumented and nonimmigrant aliens, who generally remain ineligible for non-emergency Federal benefits. As a general rule, only "qualified aliens" may be eligible for Medicaid and SCHIP coverage. Qualified aliens include aliens lawfully admitted for permanent residence under the Immigration and Nationality Act. Refugees, those granted asylum, and victims of a severe form of trafficking (as certified by the Office of Refugee Resettlement of the Department of Health and Human Services) among several other categories also may be considered qualified aliens.

Under PRWORA, states are required to provide Medicaid to certain qualified aliens who otherwise meet the eligibility criteria of the state's Medicaid program, unless subject to a five-year bar. This five-year bar applies only to qualified aliens who entered the United States on or after August 22, 1996 with some exceptions. Typically the bar applies to lawful permanent residents and aliens granted parole for at least one year. Some qualified aliens are exempt from the five-year bar, including refugees, those granted asylum, and trafficking victims, among others. A qualified alien who is honorably discharged from the military; on active duty in the U.S. military; or the spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty in the U.S. military also is exempt from the five-year bar.

However, the five-year bar and other eligibility restrictions do not apply to aliens who are applying only for treatment of an emergency medical condition. Thus, all aliens – both qualified and non-qualified aliens (including undocumented immigrants) – may be eligible for treatment of an emergency medical condition, provided they otherwise meet

the eligibility criteria (such as income level, for example) for the state's Medicaid program.

CMS Issues Guidance on Citizenship and Identity Documentation for Medicaid Eligibility

American citizenship or legal immigration status have, for many years, been a requirement for Medicaid eligibility. However, previously, in many states applicants could assert their citizenship status by merely checking a box on a form. (A number of states have long required their applicants to document citizenship, including New York, New Hampshire and Montana.) The DRA now holds states financially responsible for Medicaid expenditures for individuals claiming to be United States citizens unless such individuals provide actual documentary evidence supporting their citizenship and identity. This new requirement applies to new applications for Medicaid eligibility and re-determinations beginning July 1, 2006.

In order to give states some initial guidance on the implementation of this provision, on June 9, 2006 CMS issued a State Medicaid Director letter. On July 12, 2006 the Department published an interim final regulation for states to implement this new requirement. Comments on the interim final rule are due on August 11, 2006. We expect to publish a final rule shortly.

The law requires that a person provide evidence of both citizenship and identity. In some cases, a single document will be enough to establish both citizenship and identity, such as a U.S. passport. However, if secondary documentation is used to establish citizenship, such as a birth certificate, the individual will also need evidence of his or her identity. Once citizenship has been proven, it need not be documented again with each eligibility renewal unless later evidence raises a question.

The law specifies certain forms of acceptable evidence of citizenship and identity and provides for the use of additional forms of documentation as established by Federal regulations, when appropriate. If an applicant or recipient presents evidence from the listing of primary documentation, such as a U.S. passport, certificate of naturalization, or a certificate of U.S. citizenship, no other information is required. When such evidence cannot be obtained, our regulations require the states to look to the next tier of acceptable forms of evidence. However, a state must first seek documents from the primary list before looking to the secondary or tertiary lists. Because individuals who receive Medicare and individuals who are on Supplemental Security Income (SSI) in a state using SSI for Medicaid eligibility purposes already have met certain documentation requirements, the regulation does not include new documentation requirements for these groups. This exemption reflects the special treatment of these groups in the statute.

At the time of application or re-determination, the state must give an applicant or recipient a "reasonable opportunity" to present documents establishing U.S. citizenship or nationality and identity. An individual who is already enrolled in Medicaid will remain eligible if he/she puts forth a good faith effort to present satisfactory evidence of citizenship and identity. Applicants who despite their good faith effort are unable to present documentation should be assisted by the state in securing these documents. States may use data matches with the State Data Exchange (SDX) or vital statistics agencies in place of a birth certificate to assist applicants or recipients to meet the requirements of the law. As a check against fraud, states are also required to use currently available capabilities to conduct a match of the applicant's name against the corresponding Social Security number that was provided. In addition the Federal government encourages states to use automated capabilities to verify citizenship and identity of Medicaid applicants. We specifically asked for public comment on whether there are other electronic data systems that should be identified to assist states in determining an individual's citizenship or identity.

As with other Medicaid program requirements, states must implement an effective process for assuring compliance with documentation of citizenship in order to obtain federal matching funds, and effective compliance will be part of Medicaid program integrity monitoring. In particular, audit processes will track the extent to which states rely on lower categories of documentation with the expectation that such categories would be used relatively infrequently and less often over time, as State processes and beneficiary documentation improve. When future automated capabilities to verify citizenship and identity of Medicaid applicants becomes available, states also will be required to match for individuals who used third or fourth tier documents to verify citizenship and identity. In the meantime, states must ensure that all case records within this category are identified so that they may be made available to conduct these automated matches. States will receive the normal 50 percent match for administrative expenses related to implementation of the new law.

The law also requires that the Secretary develop an outreach program which is intended to educate individuals who are likely to be affected by the requirements of this provision of the law. CMS has already conducted numerous teleconferences with states and other organizations interested in this provision. In addition, we are developing an outreach plan that provides strategic direction and coordination for an integrated education and outreach program to inform states, Medicaid recipients, and others of these new documentation requirements. This initiative will be implemented to promote active and informed involvement by states and people with Medicaid in providing beneficiaries the necessary information about the new documentation requirements. The plan will ensure that all stakeholders know of the new requirements, understand the documents which satisfy these requirements, assist the streamlined implementation by states, and ensure continued uninterrupted access to Medicaid for citizens.

EMTALA

Regarding the broader health care system, CMS enforces the 1986 Emergency Medical Treatment and Labor Act (EMTALA). Under EMTALA, hospitals have obligations to any individual, regardless of citizenship, who requests treatment for a medical condition. EMTALA was designed to ensure that people will receive appropriate screening and emergency treatment regardless of their ability to pay.

CMS' regulations implementing EMTALA require that hospitals with dedicated emergency departments provide an appropriate medical screening examination to any person who comes to the hospital emergency department and requests treatment or examination of a medical condition. They also require that these hospitals provide an appropriate medical screening examination to any person who presents himself on hospital property requesting evaluation or treatment of an emergency medical condition. In both cases, a request may be made by another individual on behalf of the person for whom examination or treatment is sought, or a request can be considered to have been made if a prudent layperson believes that based on the behavior of the individual an emergency medical condition exists. If the examination reveals an emergency medical condition, the hospital must also provide either necessary stabilizing treatment or arrange for an appropriate transfer to another medical facility.

EMTALA applies to all Medicare-participating hospitals with dedicated emergency departments and applies to all individuals regardless of immigration status who present themselves requesting examination or treatment of a medical condition. Hospitals with specialized capabilities have a responsibility under EMTALA to accept appropriate transfers regardless of whether the hospital has a dedicated emergency department. A hospital that violates EMTALA may have its ability to participate in Medicare terminated and may be subject to civil penalties of up to $50,000 per violation. An individual who has suffered personal harm and any hospital to which a patient has been improperly

transferred and that has suffered a financial loss as a result of the transfer are also provided a private right of action against a hospital that violates EMTALA.

Hospitals also are required to maintain lists of physicians who are on call for duty after the initial examination to provide necessary stabilizing treatment. Hospitals have discretion to develop their on-call lists in a way that best meets the needs of their patients requiring services required under EMTALA.

Under CMS' regulations, EMTALA does not apply after an individual has been admitted for inpatient hospital services, as long as the admission is made in good faith and not in an attempt to avoid the EMTALA requirements.

Section 945 of the MMA required the Secretary of Health and Human Services to establish a technical advisory group (TAG) to review EMTALA policy, including the regulations and interpretive guidance outlining hospitals' responsibilities under EMTALA. This TAG, which includes hospital, physician and patient representatives, has already met 4 times. The TAG will complete its deliberations and submit a report of its findings and recommendations to the Secretary by October 2008.

Conclusion

Thank you again for this opportunity to discuss the impact of undocumented immigrants on Medicaid and the health care system. I would also like to take this opportunity to once again express the Administration's support for comprehensive immigration reform. I would be happy to answer any questions you might have.

MS. SISKIN. Thank you. Thank you, Chairman Deal, Congresswoman Solis, and Congressman Norwood for the invitation to appear before you today. I am Alison Siskin, a specialist in immigration legislation at the Congressional Research Service.

As discussed previously, currently, non-citizen eligibility for Federal Medicaid benefits largely depend on their immigration status and whether they arrived or were on the program's rolls before August 22, 1996, the enactment date of the Welfare Reform Act. Nonetheless, all aliens, regardless of status, who otherwise meet the eligibility requirements for Medicaid are eligible for emergency Medicaid. Unauthorized aliens are ineligible for full Medicaid but may qualify for emergency Medicaid.

Due to the eligibility of non-citizens for emergency Medicaid, many have questioned the impact of non-citizens on emergency departments. Although some have pointed to unauthorized aliens as a key contributor to the problem of emergency departments, the reality is more complicated. According to research, use of emergency rooms varies significantly across communities and studies have found that communities with more non-citizen residents generally have lower rates of emergency department use than communities with fewer non-citizen residents.

In 2003, Congress enacted the Medicare Prescription Drug Improvement and Modernization Act, which contains a provision, Section 1011, that provides reimbursement to States for emergency care afforded to unauthorized aliens. For each fiscal year, fiscal year 2005

through fiscal year 2008, the provision appropriates $250 million, which is used to pay local governments, hospitals, and other providers for the cost of furnishing emergency health services to unauthorized aliens.

In February 2006, as we have discussed, Congress enacted the Deficit Reduction Act. Prior to the Deficit Reduction Act, as a condition of an individual's eligibility for full Medicaid benefits, States were required to obtain a written declaration under penalty of perjury stating whether the individual is a U.S. citizen. States were only required to obtain documentary evidence for an individual who declared that they were not citizens or nationals.

As a result of the changes made by Section 6036 of the Deficit Reduction Act, States now must obtain documentary evidence of both citizenship and identity from individuals who declare that they are U.S. citizens or nationals in order to receive Federal reimbursement for Medicaid services provided to these individuals. This requirement applies to initial determinations and redeterminations of eligibility made on or after July 1, 2006. The requirement does not change the Medicaid documentation requirement or rules for non-citizens.

At least three States have said that they will postpone implementation of the citizen documentation requirements because they need more time to prepare new policy guidelines, train eligibility workers, and advise Medicaid beneficiaries. Two lawsuits have also been filed to challenge these requirements.

With the restriction for non-citizens on Medicaid eligibility, one question that arises is the extent to which non-citizens have private insurance. The literature has consistently found that non-citizens have higher uninsurance rates than native born and naturalized U.S. citizens and these differences remain when controlling for factors such as poverty, education, and labor force participation. However, there is no consensus on the impact of non-citizens on the overall U.S. uninsured population. For example, one report for that non-citizens accounted for 59 percent of the increase in the uninsured population from 1994 to 2003.

Nonetheless, another commission study found that the impact of non-citizens on the uninsured population depended on which years were analyzed and grouped together, concluding that immigration trends are not responsible, in large part, for the increase in the number of uninsured.

Due to high uninsurance rates among unauthorized aliens and their ineligibility for Medicaid, several studies have focused on the health-related cost of unauthorized aliens.

Since it is extremely difficult to get accurate data on unauthorized aliens, many studies make assumptions about the number of unauthorized aliens and their service usage. Some of these studies

survey immigrant communities and ask immigrant status, while others ask local agencies to estimate the cost of services provided to the unauthorized aliens, or others use proxies such as those who provide a false Social Security number, to determine who is an unauthorized alien. Each of these methods has strengths and weaknesses, and none provides a reliable estimate upon which researchers agree.

A 2004 study by the Government Accountability Office, GAO, concluded that since hospitals do not generally collect information on patients' immigration status, an accurate assessment of the impact of unauthorized aliens on hospitals' uncompensated care costs remain elusive. Over 95 percent of the hospitals which responded to the GAO survey used a lack of a Social Security number as the only method to identify unauthorized aliens. It is unclear whether this method over or under-estimates the amount of care provided to unauthorized aliens.

The GAO study also reviewed the reported Medicaid spending for the 10 States with the highest estimated unauthorized population and found that emergency Medicaid expenditures for the 10 States have increased over the past several years but remain less than 3 percent of each State's total Medicaid expenditures. Nonetheless, the study found that between 2000 and 2002, in 9 of the 10 States reviewed, the State's emergency Medicaid expenditures grew faster than the total Medicaid expenditures.

In sum, it is unclear what the true impact of unauthorized aliens is on Medicaid and the health delivery system.

Thank you once again for your invitation to be here today and I am at your disposal for any questions.

MR. DEAL. Thank you. Mr. Ortiz.

[The prepared statement of Dr. Siskin follows:]

PREPARED STATEMENT OF DR. ALISON SISKIN, SPECIALIST IN IMMIGRATION LEGISLATION, DOMESTIC SOCIAL POLICY DIVISION, CONGRESSIONAL RESEARCH SERVICE

Thank you Chairman Deal, Ranking Member Brown, and Distinguished Members of the Committee for the invitation to appear before you today to speak about the financial impact of unauthorized aliens on Medicaid and Health Delivery Systems. I am Alison Siskin, a Specialist in Immigration Legislation at the Congressional Research Service. My testimony today will focus on a discussion of the Medicaid eligibility of noncitizens, and two recent legislative initiatives, one to reimburse providers for the cost of uncompensated care provided to unauthorized aliens, and the other to require certain documentation for those applying for Medicaid. My testimony will conclude with a discussion of studies on uninsurance rates for noncitizens, and estimates of the uncompensated cost of providing health care for unauthorized aliens.

Currently, noncitizens' eligibility for federal Medicaid benefits largely depends on their immigration status and whether they arrived (or were on a program's rolls) before August 22, 1996, the enactment date of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Legal permanent residents (LPRs) entering

after August 22, 1996, are barred from Medicaid for five years, after which coverage becomes a state option. States have the option to use state funds to provide medical coverage for LPRs within five years of their arrival in the United States. Refugees and asylees are eligible for Medicaid for seven years after arrival. After the seven years, they may be eligible for Medicaid at the state's option. LPRs with a substantial (10-year) U.S. work history or a military connection are eligible for Medicaid without regard to the 5-year bar. LPRs receiving Supplemental Security Income (SSI) on or after August 22, 1996 are eligible for Medicaid since Medicaid coverage is required for all SSI recipients. Finally, in the case of LPRs sponsored for admission after 1997, the income and resources of their sponsor are "deemed" available to them when judging their eligibility. Nonetheless, all aliens regardless of status who otherwise meet the eligibility requirements for Medicaid are eligible for emergency Medicaid. Thus, unauthorized aliens are ineligible for Medicaid, but may qualify for emergency Medicaid.

Emergency Medicaid covers unauthorized aliens, nonimmigrants, and LPRs within the first five years of arrival for emergency conditions if they meet the other eligibility requirements of the program. Under the Emergency Medical Treatment and Active Labor Act, all Medicare-participating hospitals with emergency departments treat all medically unstable patients and women in active labor regardless of their ability to pay. Unauthorized aliens who are otherwise eligible for Medicaid except for their illegal status may receive "medical assistance under Title XIX of the Social Security Act ... for care and emergency services that are necessary for the treatment of an emergency medical condition (as defined in Section 1903(v)(3) of such Act) of the alien involved and are not related to an organ transplant procedure." This language from the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restates and carries forward a provision which had been enacted 10 years previously as an amendment to the Medicaid provisions of the Social Security Act.

Section 1903(v)(3) defines "emergency medical condition" as:

> a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in — (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part.

Like other Medicaid recipients, unauthorized aliens must demonstrate that they are state residents, and many are not (or are unable or unwilling to prove that they are). This is particularly true of unauthorized aliens requiring emergency hospital care during attempted illegal entries. To be eligible for emergency Medicaid, unauthorized aliens must also be poor and either aged, disabled, or members of a family with children. Working age single males, for example, are generally not eligible for any form of Medicaid regardless of their financial status or residence.

Due to the eligibility of noncitizens for emergency Medicaid, many have questioned the impact of noncitizens on emergency departments. Although some have pointed to unauthorized aliens as a key contributor to problems of emergency departments, the reality is more complicated. According to research, use of emergency care varies significantly across communities, and contrary to popular perception, studies have found that communities with more noncitizen (alien) residents generally have lower rates of emergency department use than communities with fewer noncitizen residents. (For example see, Peter J. Cunningham, "What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities," *Health Affairs-Web Exclusive*, Jul. 18, 2006, pp. W324-W336.)

In 2003, Congress enacted The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173), which contains a provision (known as section 1011) that provides reimbursement to states for emergency care afforded to unauthorized aliens. For each fiscal year, FY2005-FY2008, the provision appropriates $250 million of which:

- $167 million is allotted to states based on the percentage of unauthorized aliens residing in the state compared to the total number of unauthorized aliens in the United States; and
- $83 million is allocated to the six states with the highest percentage of unauthorized alien apprehensions for the fiscal year, based on the percentage of apprehensions in the state compared to the number of apprehensions for all such states.

P.L. 108-173 directs the Secretary of Health and Human Services (HHS) to pay local governments, hospitals, or other providers located in the state (including providers of services rendered through an Indian Health Service facility) for the costs of furnishing emergency health care services to unauthorized aliens during that fiscal year. Advanced payments will be made quarterly based on the applicants' projected expenditures.

In February 2006, Congress passed the Deficit Reduction Act (DRA, P.L. 109-171) which contains a provision requiring certain documentation for those applying for Medicaid who claim U.S. citizenship. Prior to the DRA, as a condition of an individual's eligibility for full Medicaid benefits, states were required to obtain a written declaration, under penalty of perjury, stating whether the individual is a citizen or national of the United States. States were only required to obtain documentary evidence from individuals who declared that they were not citizens or nationals.

In July 2005, the Inspector General (IG) for the Department of Health and Human Services released a report entitled, Self-Declaration of U.S. Citizenship for Medicaid. The report found that as of 2004, 47 states allowed self-declaration of U.S. citizenship for determinations of Medicaid eligibility, but 44 of those states required documentary evidence of citizenship if the statement seems questionable. Montana, New Hampshire, New York, and Texas did not permit self-declaration of citizenship for determinations of Medicaid eligibility. In addition, the report found that 27 states did not verify the accuracy of U.S. citizenship statements as part of their post-eligibility quality control.

While the IG noted that Centers for Medicare and Medicaid Services (CMS) had encouraged self-declaration in an effort to simplify and accelerate the Medicaid application process which resulted in rapid enrollment, self-declaration also could have lead to inaccurate eligibility determinations for those who provide false citizenship statements. Nonetheless, the report failed to identify the extent to which current Medicaid beneficiaries were ineligible based on citizenship or the extent to which eligible individuals failed to apply for Medicaid in states that require proof of U.S. citizenship as a condition of eligibility.

As a result of changes made by §6036 of DRA, states now must obtain documentary evidence of both citizenship and identity from individuals who declare that they are citizens or nationals of the U.S. (with certain exceptions) in order to receive federal reimbursement for Medicaid services provided to these individuals. This requirement applies to initial determinations and redeterminations of Medicaid eligibility made on or after July 1, 2006. The requirement does not change Medicaid documentation (or other) rules for noncitizens.

The CMS provided states with initial guidance on the Medicaid citizenship documentation provision in DRA on June 9, 2006. An interim final rule (the contents of which differ from CMS's initial guidance) was published in the Federal Register on July 12, 2006. The interim rule explains who is exempt from the documentation provision,

what types of documents and data matches may be used to prove citizenship (or nationality) and identity, and how states must comply with the new requirement.

At least three states (Ohio, California, and North Carolina) have said that they will postpone implementation of the Medicaid citizenship documentation requirement because they need more time to prepare new policy guidelines, train eligibility workers, and advise Medicaid beneficiaries. Two lawsuits have also been filed to challenge the requirement. In addition, according to a Medicaid official in Tennessee, the directions given to their Medicaid directors to implement DRA §6036 are almost identical to those in the federal letter sent to the states from CMS on how to implement the provision. The state did not have time to develop their own guidance as the CMS letter was sent several days after the provision was supposed to be implemented. The official noted that the provision has proven difficult to implement for children, especially those who are not yet school-aged.

With the restrictions for noncitizens on Medicaid eligibility, one question that arises is the extent to which noncitizens have private insurance. The literature has consistently found that noncitizens have higher uninsurance rates than native born and naturalized U.S. citizens, and these differences remain when controlling for factors such as poverty, education and labor force participation. For example, a Kaiser Commission study found that in 2003, 47% of noncitizens lacked health insurance compared to 15% of native born citizens. In addition, another Kaiser Commission study found that in 2003, 26% of low income children with noncitizen parents lacked health insurance while only 16% of low income children with citizen parents lacked health insurance. These findings are similar to a CRS study which used data from 2001, and found that noncitizens were three times more likely to be uninsured than U.S. citizens and naturalized foreign born individuals. Forty-four percent of noncitizens were uninsured compared to 17% of naturalized U.S. citizens and 12% of native born U.S. citizens.

Although there appears to be general agreement that noncitizens are more likely than U.S. citizens to lack health insurance, there is not a consensus on the impact of noncitizens on the overall U.S. uninsured population. For example, a report by the Employee Benefits Research Institute (EBRI) found that noncitizens accounted for 59% of the increase in the uninsured population from 1994 to 2003. Similarly, another study found that by applying the uninsurance rates of unauthorized aliens in Los Angeles County to the entire country, unauthorized aliens accounted for one-third of the increase in the number of uninsured adults in the United States between 1980 and 2000.

Nonetheless, a Kaiser Commission study found that the impact of noncitizens on the uninsured population depended on which years were analyzed and grouped together. The Kaiser Commission study analyzed the uninsured population during three periods: 1994-1998; 1998-2000; and 2000-2003. The Kaiser Commission study found that when combining the data from 1998 through 2003, almost two-thirds of the increase in the uninsured population was due to noncitizens, but the result was largely driven by the reduction in the number of uninsured U.S. citizens between 1998 and 2000. In contrast, the report noted that in the 1994 to 1998 and 2000 to 2003 periods, most of the growth in the uninsured population was due to native born U.S. citizens. Seventy-four percent of the growth in the uninsured population between 1994 to 1998 was due to native born U.S. citizens while 10% was due to noncitizens. Likewise, between 2000 and 2003, 24% of the growth in the uninsured population was due to noncitizens, while 71% of the growth could be attributed to native born U.S. citizens. The Kaiser Commission study concluded that immigration trends are not responsible, in large part, for the increase in the number of uninsured. In addition, the researchers noted that, mostly due to the fact that noncitizens comprise a much smaller proportion of the population than U.S. citizens, noncitizens would have to fare dramatically worse than citizens to be responsible for the majority of the change in the uninsured population.

Due to high uninsurance rates among unauthorized aliens and their ineligibility for Medicaid, several studies have focused on the health-related costs of unauthorized aliens on state and local governments, and health care providers. It is very difficult to enumerate a population which is trying to avoid detection by the government. The main sources of socioeconomic information in the United States, the Current Population Survey (CPS), the Decennial Census of the Population (Census), and the American Community Survey, collected by the Census Bureau, ask citizenship status, but not immigration status. Thus, it is not possible to use these data sources in calculating the healthcare cost of unauthorized aliens.

Since it is extremely difficult to get accurate data on unauthorized aliens, many studies make assumptions about the number of unauthorized aliens, their service usage, and their revenue contributions. As a result, many studies which attempt to estimate the cost of health care for unauthorized aliens in the United States focus on limited geographic regions (e.g., border communities, states, or cities). Some of these studies survey immigrant communities and ask immigration status, while others ask for local agencies to estimate the cost of services provided to unauthorized aliens. Other studies use proxies, such as those who provided a false Social Security number, to determine who is an unauthorized alien. Each of these methods has strengths and weaknesses, and none provides a reliable estimate upon which researchers agree.

The following is a discussion of selected studies which estimate the cost of health care provided to unauthorized aliens. I have focused on studies completed during the previous 10 years. In addition, this is not an exhaustive review of the literature on the cost of health care for unauthorized aliens in the United States.

GAO Study (2004). In May 2004, the Government Accountability Office (GAO) released a study entitled *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs*. The study concluded that since hospitals do not generally collect information on patients' immigration status, an accurate assessment of the impact of unauthorized aliens on hospitals' uncompensated care costs "remains elusive." GAO surveyed 503 hospitals, but as a result of the low response rate to the survey, was unable to determine the cost of uncompensated care provided to unauthorized aliens. In addition, over 95% of the hospitals which responded to the survey used the lack of a Social Security number as the only method to identify unauthorized aliens. It is unclear whether this method over or under estimates the amount of care provided to unauthorized aliens.

The GAO study also reviewed the reported Medicaid spending for the 10 states with the highest estimated unauthorized populations: Arizona, California, Florida, Georgia, Illinois, New Jersey, New Mexico, New York, North Carolina, and Texas. Although states are not required to report to CMS the amount of Medicaid expenditures for unauthorized aliens, several states provided data or suggested to GAO that most of their emergency Medicaid expenditures were for services provided to unauthorized aliens. In addition, five of the states reported that more than half of emergency Medicaid expenditures were for labor and delivery services.

GAO found that emergency Medicaid expenditures for the 10 states have increased over the past several years but remain a small proportion, less than three percent, of each state's total Medicaid expenditures. Nonetheless, the study found that, between FY2000 and FY2002, in nine of the 10 states reviewed, the state's emergency Medicaid expenditures grew faster than the total Medicaid expenditures.

Impact of Illegal Immigration on Mississippi (2006). The Mississippi Office of the State Auditor estimated that $35 million of $504.6 million spent for uninsured healthcare services in 2004 may be due to unauthorized aliens. This number was estimated by using a finding from the RAND Corporation that 68% of unauthorized alien adults lacked health insurance. Importantly, the report noted that "because no data

regarding immigration status is collected, it is difficult to determine the accuracy of this estimate..."

Impact of Illegal Immigration on Minnesota (2005). The Office of Strategic Planning and Results Management for the State of Minnesota reported that in FY2005, unauthorized aliens cost Minnesota health assistance programs approximately $35.5 million, of which approximately $17.3 million was paid by the state. The cost included:

- $16.3 million, for Minnesota Emergency Medical Assistance, which covers all emergency services including labor and delivery, of which the state and the federal governments each paid 50% ($8.15 million).
- $15.5 million for Minnesota State Children's Health Insurance Program (SCHIP) which covers medical costs for pregnant women without other health insurance through the month of birth. The state paid 35% of the costs ($5.4 million) while the federal government paid 65% of the costs ($10.1 million).
- $3.7 million for Minnesota Medical Assistance program's state noncitizen pregnant women fund, all of which was paid by the state.

The High Cost of Cheap Labor: Illegal Immigration and the Federal Budget (2004). This study released by the Center for Immigration Studies uses the March Current Population Survey (CPS) and the decennial census, and relies on the methodology used in two other respected studies of the fiscal effects of immigration: (1) *The New Americans* (1997) by the National Research Council (NRC); and (2) *Immigrants in New York: Their Legal Status, Incomes and Taxes* (1998) by researchers at the Urban Institute. Unauthorized aliens are estimated by using socioeconomic characteristics to assign a probability to each respondent that the respondent is an unauthorized alien. The study uses households as the unit of analysis arguing, as in the NRC study, that the household is the primary unit through which taxes are paid and services used. It is important to note that although the head of the household is an unauthorized alien, it is possible that others in the household are legally present, or United States citizens.

The study noted that ascertaining the cost of unauthorized alien households presents complex fiscal questions, and estimated that on average, each household headed by unauthorized aliens cost the federal treasury $658 for Medicaid (including SCHIP) and $591 for medical care for the uninsured in FY2002. In comparison, the study estimated that in FY2002, legal alien headed-households, on average, cost the federal treasury $1,232 for Medicaid (including SCHIP) and $123 for medical care for the uninsured.

Care for the Uninsured Non-citizens: A Growing Burden on Florida's Hospitals (2003). Using case studies of 700 unauthorized aliens from 39 hospitals/health systems representing 56 hospitals or 26% of the acute care hospitals in Florida, the Florida Hospital Association reported that these 39 hospitals/health systems spent $40.2 million on care for unauthorized aliens. Three-quarters of the unauthorized alien patients incurred charges below $50,000, while 32 unauthorized alien patients incurred charges in excess of $250,000 each, totaling more than $21.4 million.

Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties (2002). In 2002, the United States/Mexico Border Counties Coalition released a study entitled Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties. The survey conducted statistical modeling by identifying sets of non-border communities that "capture essential characteristics of each border community with respect to the demand for emergency medical services." The researchers note the complexity of matching border communities with other communities, as the counties on the U.S./Mexico border are unique on many important dimensions, and this complexity may have impacted the results. The researchers then performed a linear regression, and assumed the differences between the border communities and the similar non-border communities could be attributed to unauthorized aliens. The study concluded that in

2000, $189.6 million was spent by hospitals in the Southwest border communities to provide uncompensated care to unauthorized aliens.

Health Care for Unauthorized Immigrants: Who Pays? (2001). The House Research Organization for the Texas House of Representatives asserted that the Harris County Hospital District estimated that between 1999 and 2001 it spent $330 million on health care for unauthorized aliens, of which $105 million was reimbursed by the federal government. The study failed to provide methodology for the estimate, and as a result, it is impossible to assess the validity of the estimate.

In sum, it is unclear what the true impact of noncitizens is on Medicaid and the health delivery system. Although noncitizens are more likely than citizens to be uninsured, it is not known to what extent noncitizens affect the overall uninsurance rate for the U.S.

Thank you once again for your invitation to be here today, and I am at your disposal for any questions you may have.

MR. ORTIZ. Thank you, Chairman Deal and members of the Energy and Commerce Committee for holding this field hearing today in Dalton, Georgia. I appreciate your leadership on this issue and am grateful to testify about Georgia's experience in implementing the Medicaid Citizenship Provisions of the DRA.

Medicaid has grown to become the second largest budget item in the State of Georgia, only behind public education. The people of Georgia have been very clear that they expect us to be good stewards of the State's resources and to be fair and just in dedicating those resources to those most in need.

Therefore, last December, Governor Perdue instructed the Georgia Department of Human Resources, the State agency that administers Medicaid enrollment, to institute more stringent documentation requirements for both citizenship and income eligibility.

As of January 1, 2006, applicants for Georgia's Family Medicaid program have been required to provide documents such as W-2 forms, pay stubs, or income tax returns before becoming eligible for benefits. The only exception to this policy is for pregnant women and their newborns, allowing them to receive immediate prenatal and postnatal care.

Federal law requires that taxpayer-funded benefits be limited to those who are lawfully in the United States and income verification requirements serve as an additional check for legal U.S. citizenship. As the Governor said in December, documentation verification reduces fraud in the taxpayer-funded healthcare system and ensures that Medicaid recipients are legal residents entitled to public assistance.

Since implementation, we have seen a sizable reductions in our caseload, which has been attributed to the combination of both more rigorous citizenship and income documentation requirements. This fact is strong evidence of fraud and abuse inherent under the previously allowed self-declaration prerequisite.

In January 2006, Congress passed the Deficit Reduction Act. This bill contains many of the Medicaid flexibilities that the Nation's governors have been asking for and I would like thank the Committee and Congressman Barton and Chairman Deal for working with the governors on this process.

The DRA Improved Enforcement of Documentation Requirements contained requirements largely similar to those document verification regulations instituted in Georgia on January 1.

In the implementation of citizenship verification requirements, the Governor made it very clear that first, all new document requirements needed to be in compliance with Federal law and regulation; second, that our State eligibility workers were to be dedicated to diligently assist citizens and qualified aliens to obtain the documentation necessary for Medicaid eligibility.

When an applicant lacks the proper documentation, our practice is to hold the application open for the maximum time period allowed by CMS regulation. During that time, eligibility workers will assist applicants to produce the satisfactory documentation.

In Georgia, 3000 caseworkers across 159 counties determine Medicaid eligibility. They have been trained to integrate these new regulations into their daily work, while continuing to provide supportive assistance to Medicaid applicants.

To ensure the efficient and successful eligibility determination for qualified applicants, Georgia has taken full advantage of additional flexibilities allowed under the DRA, such as cross-matching of State vital statistics; not requiring verification if the individual has already been deemed eligible for SSI or Medicare; presumptive eligibility for pregnant women and deemed newborn eligibility.

One thing we have noticed is that our increased focus on eligibility documentation is enhancing accountability across our system. When we communicate well with our consumers, more of them come to our front door of our system with the documents in hand ready and able to prove citizenship and verify their income. If they do not have the documentation when they come to the front door, we work diligently to ensure that they have the documentation in hand when they are determined eligible. We see this as a service to the citizens of Georgia.

In conclusion, the United States is a great country with great benefits. Our expectations are that those we serve should be eligible and we have a responsibility to verify that eligibility. We stand ready in Georgia to get the right work done the right way.

Thank you again, Chairman Deal, for your time and continued leadership on this issue.

[The prepared statement of Abel C. Ortiz follows:]

PREPARED STATEMENT OF ABEL C. ORTIZ, HEALTH AND HUMAN SERVICES POLICY ADVISOR, OFFICE OF THE GOVERNOR, STATE OF GEORGIA

Thank you, Chairman Deal, and Members of the Energy and Commerce Committee for holding this field hearing today in Dalton, Georgia. I appreciate your leadership on this issue and am grateful for the opportunity to testify regarding Georgia's experiences implementing the Medicaid Citizenship Documentation Provisions of the Deficit Reduction Act (DRA).

Medicaid has grown to become the second largest budget item in our state, behind only public education. The people of Georgia have been very clear that they expect us to be good stewards of the state's resources, and to be fair and just in dedicating those resources to people most in need.

Therefore, last December Governor Sonny Perdue instructed the Georgia Department of Human Resources, the state agency that administers Medicaid enrollment, to institute more stringent documentation requirements for both citizenship and income eligibility.

As of January 1, 2006, applicants for Georgia's Family Medicaid program have been required to provide documents such as W-2 forms, pay stubs, or income tax returns before becoming eligible for benefits. The only exception to the policy is for pregnant women and their newborns, allowing them to receive immediate prenatal and postnatal care.

Federal law requires that taxpayer-funded benefits be limited to those who are lawfully in the United States and the income verification requirement serves as an additional check for legal U.S. citizenship. As the Governor said in December, document verification reduces "fraud in the taxpayer-funded healthcare system and ensure(s) that Medicaid recipients are legal residents entitled to public assistance."

Since implementation we have seen sizable reductions in our caseload which we attribute to the combination of more rigorous citizenship and income documentation requirements. This fact is strong evidence of fraud and abuse inherent under the previously allowed "self-declaration" prerequisite.

In January 2006, Congress passed the Deficit Reduction Act (DRA). The bill contained many of the Medicaid flexibilities the Nation's Governors have been asking for and I would like to thank the Committee, Chairman Barton and Chairman Deal for working with the Governors in that process.

Section 6036 of the DRA, Improved Enforcement of Documentation Requirements, contained requirements largely similar to document verification regulations instituted in Georgia on January 1.

In implementing the citizenship verification requirement, the Governors' directions were clear: First, all new documentation requirements were to be in compliance with federal law and regulation and, second, our State Medicaid eligibility workers were directed to work diligently to assist any citizen or qualified alien in obtaining the documentation necessary for Medicaid eligibility.

When an applicant lacks the proper documentation, our practice is to hold that application open for the maximum time period allowed by CMS regulations. During that time eligibility workers will assist the applicant to produce satisfactory documentation.

In Georgia, 3,000 caseworkers, across 159 counties, determine Medicaid eligibility. They have been trained to integrate these new regulations into their daily work, while continuing to provide supportive assistance to Medicaid applicants.

To ensure the efficient and successful eligibility determination for qualified applicants Georgia has taken full advantage of additional flexibilities allowed under the DRA, such as:

- Cross-matching state vital statistics;

- Not requiring verification if the individual has already been deemed eligible for SSI and Medicare;
- Presumptive eligibility for pregnant women;
- Deemed newborn eligibility.

One thing we have noticed is that our increased focus on eligibility documentation is enhancing accountability throughout our system. When we communicate well with our customers, more of them are coming to the front door of our system with documentation in hand, ready and able to prove their citizenship and verify their income. If they don't have the documentation when they come in the front door, we work diligently to insure that they have the documentation in hand when they are determined eligible. We see this as a service to citizens of Georgia.

In conclusion, the United States is a great country with great benefits. Our expectations are that those we serve should be eligible and we have a responsibility to verify that eligibility. We stand ready in Georgia to get the right work done, the right way.

Again, thank you Chairman Deal for your time and continued leadership on these important issues.

MR. DEAL. Well, thank you all for your testimony. I think I have agreement from my panel members up here that we are going to limit our question time to 5 minutes for each of you since we are running a little behind our schedule and we have another panel that is coming up. And I will begin that.

First of all, as you mentioned, Dr. Siskin, prior to the DRA, we had a system in place that said you had to certify, subject to perjury, that you were a citizen and, therefore, eligible--or other category--that you were eligible for participation in Medicaid. Are you or any of the panel members ever aware of anybody who has ever been prosecuted for falsely certifying that they were eligible?

MS. SHEIL. I am not.

MS. SISKIN. Nor am I.

MR. ORTIZ. I am not.

MR. DEAL. Well, that is similar to the answers I got on the other question which I am going to ask you now too.

Under the 1996 Immigration Reform Act, where we said that if you want to sponsor someone to come into this country, you assume responsibility as a sponsor and to be responsible for the cost so they do not become a drain on our social welfare system. Are any of you ever aware of anyone ever being charged as a sponsor and sent a bill for the cost of their person they sponsored?

MS. SISKIN. Not for public benefits. There have been cases where somebody who was sponsored sued their sponsor for not providing support, but no one has gone after somebody for a public benefit, as far as I know.

[Laughter.]

MR. ORTIZ. I am not aware of anybody.

MS. SHEIL. I am not aware that anybody has been charged; however, in the eligibility determination process, eligibility workers should be collecting information on the income and assets of the sponsor and considering that income in developing their eligibility. But I do not know to what extent that is being done.

MR. DEAL. Even if we are collecting that information, how do we then effectively communicate it to places like public hospitals where they are faced only with the option of charging it off as uncollectible debt?

MS. SISKIN. Well, in the last 2 years, supposedly it is now being captured electronically in the SAVE system. Prior to that, you would have had to fill out a form with the former INS and now the Department of Homeland Security, requesting information on an alien sponsor. But I am not sure the hospitals have access to the SAVE system.

MR. DEAL. That is the problem, is it not? We have problems communicating within our own agencies and we collect all this information, sometimes do not share it within our own agencies, as we have all heard the story, but we certainly have not shared it with the people who are on the front line, who are incurring the costs and have no one to send a bill to.

That ties in with my concern about the expanded guest worker provisions of the Senate bill where it appears on their terms would be to repeat this same process, which I think is totally ineffective.

Let me though follow up with the electronic verification. Senator Rogers mentioned it I believe and you all have alluded to it.

Mr. Ortiz, are you at the State level using the electronic verification system and what does that tie you in to?

MR. ORTIZ. We are using it and we use our cross matches with our State vital records and then we use it to cross match with Medicare and Social Security.

MR. DEAL. And that is on the documentation for certification of eligibility?

MR. ORTIZ. Yes, it is.

MR. DEAL. Okay. Is it working pretty well so far?

MR. ORTIZ. We have not had any reports of any slow down in processing. Our workers have just completed training last week, it has been ongoing and they just completed it last week and we have had no reports of any problems gaining that information through the electronic system.

MR. DEAL. Ms. Sheil, since you are going to be responsible for the implementation of the new DRA provisions, have you had any real concerns that have surfaced in using the proper verification and documentation that the law requires?

MS. SHEIL. We have had numerous phone calls and training sessions with our State agencies and they understand the policies. I continue to answer questions about the policies, so I think that implementation for the vast majority is going very well.

MR. DEAL. And your testimony, Mr. Ortiz, alludes to this, and says it I think rather plainly, quite frankly, that if someone comes in and asks for Medicaid certification and they do not have their documents, you work with them to try to obtain those documents, if they are validly presenting themselves; is that correct?

MR. ORTIZ. That is true. And that has actually been true for many, many years. I have experience both as a hospital social worker, an economic social worker, a social worker in a mental health clinic, and also as a foster care supervisor; and through my many years of being a social worker, it has always been the eligibility worker and other social workers outside the system who help applicants get that type of information, because it has always been needed. So this is an ongoing enhanced version of that.

MR. DEAL. Thank you. My time has expired. Ms. Solis.

MS. SOLIS. Thank you.

Ms. Siskin, thanks for joining us here today on such short notice and I am sure we will hear a lot more about immigrants and supposedly their responsibility for the problems we are facing with the Nation's healthcare system. If I understand your testimony, the situation for me is not very clear and simple. For example, is it not true that looking at emergency department use by non-citizens, communities with higher numbers of non-citizen residents have lower rates of emergency department use than communities with more citizen residents?

MS. SISKIN. Yes, that is what the studies have found.

MS. SOLIS. And also, is it not true that communities with higher use of emergency departments also tend to have longer waiting periods for patients seeking medical appointments when sick?

MS. SISKIN. That I would have to check on for you.

MS. SOLIS. And is it not true that while immigrants tend to have higher rates of uninsurance than citizens, there is no clear consensus on the impact of non-citizens on the overall U.S. uninsured population?

MS. SISKIN. That is true, the studies are all over the place on the impact.

MS. SOLIS. And now looking at the use of government benefits by immigrants, can you tell me whether there is any reliable evidence or studies that have shown rampant fraudulent use of Medicaid services by those who are not eligible for it, by reason of citizenship?

MS. SISKIN. I have not seen any studies like that. In the CMS study--I am sorry, the Inspector General study from the Department of Health

and Human Services that looked at this issue of self-declaration did not look at that issue.

MS. SOLIS. Thank you. My next question is for Ms. Sheil. I know that your agency is in the process of issuing a final rule on the Medicaid citizenship documentation requirements that passed Congress. And as you know, I along with 40 of my colleagues wrote a letter commenting on the rule and asking you to change some of the most egregious problems in the draft proposal. In addition, Ranking Member Dingell and Health Subcommittee Ranking Member Brown and Government Reform Committee Ranking Member Waxman also sent you similar comments.

And I would like to ask that both sets of my comments be placed into the record.

[The information follows:]

Congress of the United States
Washington, DC 20515

August 10, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Dr. McClellan:

We are writing to express our concern with the new citizenship documentation requirements for Medicaid services. The changes revealed in the July 7th release of the interim final rule do not eliminate the devastating impact that the provision will have on the health coverage of millions of Medicaid beneficiaries and applicants. As a result, between 1.2 and 2.3 million U.S.-born citizens, including between 600,000 and 1.6 million children and 500,000 to 600,000 adults are at risk of losing their coverage because they do not have a passport or birth certificate readily available.

As drafted, the interim final rule risks delaying needed care. In the interim final rule, the Secretary affords current beneficiaries, at their next redetermination of eligibility, a "reasonable opportunity" to provide documentation of citizenship before they may be terminated from coverage. However, this opportunity is not afforded to applicants who otherwise qualify for Medicaid and who self-attest that they are citizens. We believe the regulations should permit states to begin providing coverage to eligible citizens based on their sworn declaration of citizenship, and to then afford them a reasonable opportunity to provide the necessary documentation.

In addition, there are certain populations that need to be afforded special consideration. In the interim final rule, CMS exempts Medicare beneficiaries; and, in most states, SSI recipients from the Medicaid citizenship documentation requirements. However, it is a grave disservice not to similarly exempt children in foster care who are receiving assistance under title IV-E. Under current law, title IV-E agencies are required to verify the citizenship of children prior to their being found eligible, and once that eligibility has been established the children automatically qualify for Medicaid. The Secretary has the discretion to exempt individuals from the documentation requirements if he finds other satisfactory documentary evidence of citizenship. We believe that the Secretary should use this discretion and permit state Medicaid agencies to accept the IV-E agency's verification of citizenship, so as not to jeopardize care of these vulnerable populations.

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Additionally, the interim final regulations needlessly jeopardize the health care of newborns, all of whom require immediate well-baby care and many of whom (i.e., those born prematurely or at low birth weight) require more intensive care. Despite the fact that all children born in the United States are citizens, the interim final regulations do not permit states to consider a record of Medicaid (or other insurance) payment for the birth of a child as acceptable documentation of citizenship. We believe this will unnecessarily delay needed care for newborn children and may risk their long term health. We strongly encourage the Secretary to make the necessary changes to ensure the health and well-being of these children, including permitting states to accept a record of Medicaid payment (or other insurance payment) for the birth of a child born in the U.S. as proof of citizenship and a medical record of birth in a U.S. hospital or other setting as secondary evidence of citizenship for children under six.

Finally, there are many other U.S. citizens and nationals for whom the citizenship documentation requirements will pose an extreme hardship and which will result in a denial of critical coverage. These include victims of hurricanes and natural disasters whose records have been destroyed, homeless individuals, and naturalized citizens who have lost their certificate of naturalization. In addition, Native Americans, other than a few select tribes, are currently not allowed to use tribal enrollment cards as primary evidence of citizenship. We believe the Secretary should exercise discretion to give states flexibility to use alternative methods to verify citizenship or identify "special circumstances" when the state finds that compliance with the regulations would be a hardship and the state has reasonable grounds to conclude that the individual is a citizen.

Fundamentally, the interim final rule does nothing but shift the burden to families of modest means and risk denying coverage to millions of needy women and children. The rule, as written, will leave States with its citizens delaying necessary healthcare, families struggling to obtain documentation, and financially strained community-based organizations and health clinics torn between providing care and turning patients away. We strongly urge the Secretary to consider our suggestions and concerns, and only finalize this rule if it is determined that individuals otherwise eligible for Medicaid will not face increased barriers to quality healthcare that they deserve.

We thank you for your consideration and we look forward to working with you to help improve the health of our communities.

Sincerely,

HILDA L. SOLIS
Member of Congress

HENRY A. WAXMAN
Member of Congress

GRACE F. NAPOLITANO
Member of Congress

JOE BACA
Member of Congress

RAUL GRIJALVA
Member of Congress

LUCILLE ROYBAL-ALLARD
Member of Congress

XAVIER BECERRA
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ONE HUNDRED NINTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

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August 9, 2006

The Honorable Michael O. Leavitt
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Leavitt:

We are writing to comment on the July 12 interim final rule (71 *Fed. Reg.* 39214) published to implement section 6036 of the Deficit Reduction Act of 2005 (DRA). Section 6036 requires, effective July 1, any individual on Medicaid or applying for Medicaid to document both citizenship and identity. We have grave concerns that, as currently drafted, the rule would impose unnecessary hardship on beneficiaries and unnecessary burdens on States, localities, and healthcare providers. The end result will be millions of American citizens delaying or forgoing needed health care, worsening health outcomes in the United States.

There are numerous instances where the rule imposes requirements for documentation beyond those outlined in the statute. In addition, the rule fails to provide for commonsense, legitimate avenues for States and beneficiaries to obtain and present required documentation. As a result, access to needed care for many vulnerable individuals, such as newborns, individuals with disabilities or life-threatening ailments, and pregnant women in need of prenatal care, will be unnecessarily delayed or not received at all.

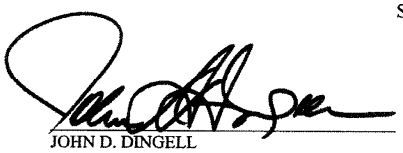
Medicaid is now the Nation's largest insurer, covering 60 million Americans, according to most recent estimates by the Congressional Budget Office. Over the past decade, the Federal and State governments have worked in partnership to facilitate enrollment in Medicaid coverage. They have streamlined and simplified the application process so that more families will enroll in this insurance program to help pay for needed care and treatment. Moreover, Congress and Federal agencies have tried in recent years to eliminate government bureaucracy, reduce paperwork, and become more responsive to its citizens. This rule, as proposed, is a step backwards. While it is unavoidable that the added bureaucracy caused by section 6036 of the Deficit Reduction Act will negatively affect public health and efforts to reduce the number of uninsured, we urge the Department to use its authorities to minimize the likelihood that U.S.

citizens applying for, or receiving, Medicaid coverage will face delay, denial, or loss of that coverage.

In that vein, there are a number of provisions in the interim final rule that require modification, particularly relating to newborns, foster children, and Native Americans. In addition, as currently drafted the interim final rule should also be revised with respect to: acceptable proof of citizenship for individuals without documentation; the opportunity to present documentation without delay in access to care or coverage; and methods for States to obtain documentation, including allowing the use of electronic verification as a first level tool. These matters are outlined in more detail in an attachment to this letter and we urge you to incorporate these comments into your final rule.

Our list, however, is not exhaustive, and we hope you will also give great weight to comments put forward by the States, Medicaid Directors, advocates for children and families, and public interest groups. Unfortunately, this provision will ultimately exact the majority of its punishment on U.S. citizens. We hope you will do your best to mitigate its negative effects on our Nation's people.

Sincerely,



JOHN D. DINGELL
RANKING MEMBER
COMMITTEE ON ENERGY AND COMMERCE

SHERROD BROWN
RANKING MEMBER
SUBCOMMITTEE ON HEALTH

HENRY A. WAXMAN
RANKING MEMBER
COMMITTEE ON GOVERNMENT REFORM

Attachment

ATTACHMENT

Comments of Representatives John D. Dingell, Sherrod Brown, and Henry A. Waxman on The Medicaid Citizenship Documentation Interim Final Rule 71 *Federal Register* 39214 (July 12, 2006)

Newborns

The interim final rule places an unnecessary burden on families with newborns, potentially jeopardizing infants' access to care and insurance coverage. An infant born in the United States is de facto a U.S. citizen. If the State agency paid for the birth under Medicaid, it would seem logical that the State could use this insurance claim as proof of citizenship for the purposes of the DRA requirements. Under the interim final rule, however, a health insurance record, including a record of Medicaid payment for the birth in a U.S. hospital, would not be satisfactory evidence for an infant. Only records created at least five years before the initial application for Medicaid are allowed, effectively nullifying the use of this evidence for newborns (42 CFR 435.407(c)(2)).

Moreover, under current law, infants born to U.S. citizens receiving Medicaid are deemed to be eligible for Medicaid upon birth and remain eligible for one year so long as the child remains in the family and the mother remains eligible for Medicaid (or would remain eligible if pregnant). The preamble to the interim final rule requires the family to produce citizenship and identity documentation for the child at the next redetermination of eligibility (71 *Fed. Reg.* 39216), which would be at age one. It is unnecessary and duplicative to require subsequent documentation, since the State Medicaid agency paid for the child's birth in a U.S. hospital and the child is by definition a citizen.

In the case of a child born in a U.S. hospital to a mother who is either a legal immigrant subject to the 5-year ban on Medicaid coverage or an undocumented immigrant, the preamble states that, in order for the newborn to be covered by Medicaid, an application for Medicaid coverage must be filed and the citizenship documentation requirements would apply (71 *Fed. Reg.* 39216). Again, this makes no sense, since the State Medicaid agency paid for the child's birth in a U.S. hospital and the child is by definition a citizen. The immigration status of the parent has no bearing on the child's citizenship status or eligibility for Medicaid.

Moreover, the preamble to the interim final rule takes the position that an applicant is not eligible for Medicaid until the documentation requirements have been satisfied. Under the interim final rule, newborns who fall under the requirement to apply for Medicaid would thus be denied coverage for needed care, whether it be wellness checkups or treatment for more serious problems, until additional documentation could be procured, even though the State is in possession of documentation of citizenship, in the form of the claim for payment of the birth. Hospitals and physicians treating newborns in these circumstances will be at risk for non-payment for the treatment of newborns who are low-birth weight, have postpartum

complications, or simply need well-baby care and who must, under the interim final rule, meet the documentation requirements. This is unnecessary, because the State Medicaid agency has already made the determination, by paying for the birth, that the child was born at a hospital in the U.S. and is a citizen.

We strongly urge that 42 CFR 435.407(a) be amended to specify that the State Medicaid agency's record of payment for the birth of a newborn in a U.S. hospital is satisfactory documentary evidence of both identity and citizenship and no further documentation should be required.

Children in Foster Care

The interim final rule applies the DRA citizenship documentation requirements to all children who are U.S. citizens, except those eligible for Medicaid based on their receipt of SSI benefits. Among the children who would be subject to the documentation requirements are those in foster care, including those receiving Federal foster care assistance under Title IV-E.

We believe these onerous new documentation requirements should not apply to children in the foster care system for a number of reasons. First, under current Administration for Children and Families (ACF) policy, State child welfare agencies must verify the citizenship status of all foster care children in order to determine eligibility for Title IV-E payments. We believe current State practice in fulfilling the requirement to verify the citizenship or immigration status of all children receiving Federal foster care maintenance payments, adoption assistance payments, or independent living services (ACYF-CB-PIQ-99-01) have been and continue to be sufficient to meet the requirements for the purpose of Medicaid. The requirement for States to re-document a foster child's citizenship and identity imposed by the interim final rule imposes unnecessary duplication of the State agency effort and will delay health care for these children.

Second, foster children clearly fit into the DRA-allowed category for an exemption from these onerous requirements. The DRA stipulates that the citizenship documentation requirement shall not apply to individuals who are eligible for Medicaid "on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented," section 1903(x)(2)(C) of the Social Security Act. The receipt of Title IV-E payments is precisely such a basis of eligibility.

Third, given the adversarial process often used to remove children from their birth families, the majority of the citizenship determination is completed through electronic verification with vital statistics databases. Birth families often do not have the documents needed or are mentally incapacitated, or unwilling to provide this information. Requiring the foster care family or the State to procure original documentation or additional documentation beyond the proof obtained by the child welfare agency is an unrealistic exercise.

Fourth, the medical needs of foster children necessitate no delay in receiving Medicaid coverage. More than 80 percent of children in care have developmental, emotional, or behavioral problems. Many of the children in foster care have physical and/or psychological problems due to causes such as pre-natal exposure to alcohol or drugs, neglect and/or abuse, and multiple foster care placements. Thirty to 40 percent of children in the child welfare system have physical health problems. And, although children in foster care represent 3 percent of all Medicaid enrollees, they account for 25-41 percent of Medicaid mental health expenditures. This is hardly a group of individuals that should have their health care delayed or denied. Delaying healthcare coverage for these children so often in need of medical attention is unacceptable and contrary to public interest.

We would note that while section 6036 of the Deficit Reduction Act also requires proof of identity as a protection against fraud, the nature of foster care does not lend itself to this type of fraud. Establishing identity is generally a means to ensure that fraud is not committed by someone who is attempting to access services under a false name. Neither children nor their parents apply for foster care or Medicaid through the foster care system. Children are brought into the foster care system (often over the objection of their birth parents) to ensure their safety. Medical services are then provided through Medicaid to meet their often substantial healthcare needs. Caseworkers are rarely unsure about the identity of a child given that they work with the family and other members of community who corroborate the identity of the child, which negates the need for paper documentation. Additionally, most children in foster care do not have a driver's license, military card, identification card, or merchant mariner card and many, particularly those that are very young, do not have school records. Delaying or denying access to Medicaid coverage for foster children as a result of the requirements in the interim final rule will also deter foster families from taking in these children as many foster families could not afford the substantial medical needs of this population without Medicaid's assistance.

While the Centers for Medicare and Medicaid Services (CMS) has suggested verbally to States that foster children will be treated as current beneficiaries rather than applicants, and thus allowed to receive Medicaid-covered services for a period of time while the State seeks documentation, this is inadequate as it requires duplicative verification on the part of the States and ultimately may result in loss of healthcare services for particularly difficult cases. For the reasons listed above, we urge you to revise 42 CFR 435.1005 to add children eligible for Medicaid on the basis of receiving Title IV-E payments to the list of groups exempted from the documentation requirements of the Deficit Reduction Act.

Native Americans

Native Americans will be particularly disadvantaged and disenfranchised from Medicaid if the requirements in the current rule remain in effect for them. Given the chronic under-funding of the Indian Health Service, Medicaid is an important supplement for Native Americans' health care. Moreover, the health needs of this population are great. For example, the infant mortality rate is 150 percent greater for Native Americans than for Caucasian infants and Native

Americans are 2.6 times more likely to be diagnosed with diabetes as are Caucasians. Medicaid helps to offset the relatively low levels of private insurance coverage among American Indians; roughly 17 percent depend on Medicaid for their insurance. But unchanged, the rule will pose a great barrier to gaining access to health care for this population.

The interim final rule does not allow the use of tribal enrollment cards as evidence of citizenship, except in the case of the Texas Kickapoos. There are over 560 Native American tribes that are formally recognized by the Federal Government and are on a nation-to-nation basis with the U.S. Government. All of these tribes issue enrollment cards to individuals who are born in the U.S. (and have a U.S. birth certificate) or who are born to parents who are members of the tribe and who are U.S. citizens. In short, tribal enrollment cards are highly reliable evidence of U.S. citizenship.

The Secretary should exercise his discretion to specify that a tribal enrollment card issued by a Federally-recognized tribe should be treated like a passport and deemed primary evidence of citizenship and identity. However, in the case of a Federally-recognized tribe located in a State that borders Canada or Mexico that the Secretary finds issues tribal enrollment cards to non-citizens, tribal enrollment cards should then only qualify as evidence of identity, not citizenship.

U.S. Citizens Without Documentation

The interim final rule leaves many gaps in its treatment of individuals who are unable to produce necessary documentation. The rule directs States to assist individuals with "incapacity of mind or body" to obtain evidence of citizenship (42 CFR 435.407(g)) but it does not address a situation in which a State is unable to locate the necessary documents for such an individual. The interim final rule also fails to address the situation in which an individual does not have "incapacity of mind or body" but his or her documents have been lost or destroyed and, despite the best efforts of the individual or a representative, the documents cannot be obtained. As a result, if such individuals apply for Medicaid they can never qualify, and if such individuals are current beneficiaries, they will lose their coverage once their "reasonable opportunity" period expires. Unfortunately, victims of hurricanes and other natural disasters whose records have been destroyed, those who were born at home and never had a birth certificate issued, individuals whose information is housed in an area affected by such a disaster, or homeless individuals whose records have been lost will be unable to qualify for Medicaid under the CMS rule.

We urge the Secretary to use the discretion afforded under the DRA to allow State Medicaid agencies the authority to recognize when a U.S. citizen without documents is in fact a U.S. citizen for purposes of Medicaid eligibility. The regulations for the Supplemental Security Income (SSI) program allow people who cannot present any of the documents SSI allows as proof of citizenship to provide what information they do have and explain why they cannot provide other documents. This is a wise approach to adopt.

Specifically, 42 CFR 435.407 should be revised to enable a State Medicaid agency, at its option, to certify that it has obtained satisfactory documentary evidence of citizenship or national status for purposes of receiving Federal matching funds if an applicant or current beneficiary, or a representative of the State on the individual's behalf, has been unable to obtain primary, secondary, third, or fourth level evidence of citizenship during the reasonable opportunity period and it is reasonable to conclude that the individual is in fact a U.S. citizen or national. The State Medicaid agency would have to place the reasons for its conclusion in the individual's case file.

Reasonable Opportunity for Applicants to Obtain Required Documentation

Approximately 10 million low-income women and children will apply for Medicaid this year. Under the regulation, even if these women and children meet all of the State's criteria for Medicaid eligibility, they must wait for their Medicaid coverage to begin until they have assembled their documents and submitted them to the Medicaid agency. A pregnant mother who is waiting six weeks to have her original birth certificate mailed to her from out of State will have to forgo prenatal care in the interim. Needed care for children and mothers should not be delayed as parents await documents from State or Federal agencies. This delay in coverage also puts hospitals, physicians, clinics, and pharmacies at risk of not being paid for the services they provide.

First, we urge CMS to revise 42 CFR 435.407(j) to clarify that applicants who declare they are U.S. citizens or nationals and who meet the State's Medicaid eligibility criteria are eligible for Medicaid, and States must allow them a "reasonable opportunity" period of at least 45 days after this eligibility determination to obtain the necessary documentation. Individuals who are awaiting documents that require longer to process (for example, a Certificate of Citizenship can take more than six months to be processed, or a passport, which has a normal processing time of six weeks) should either be given additional time to produce documentation commensurate with the type of documentation sought or be able to request a waiver for additional time to produce the documentation.

Second, we urge CMS to revise 42 CFR 435.1008 to clarify that, consistent with current CMS regulations regarding eligibility, coverage is effective the third month before the month of application through the expiration of the "reasonable opportunity" period.

In the absence of this clarification, States and providers will have no assurance that Federal Medicaid matching funds are available for medically necessary covered services furnished by participating Medicaid providers to a U.S. citizen who has applied for Medicaid, been determined eligible, but is waiting for a birth record or an identity document. Failure to make these changes will result in numerous gravely ill individuals forgoing necessary treatment or preventive care. A sick child, for example, should not have his potentially life-saving care delayed while the family and State wait for a bureaucratic process to run its course. A hospital should not have to wait for payment because another government agency, wholly unrelated to health care, is backlogged with applications for citizenship documentation.

Original Copies and Electronic Information Interchange

Although there is no statutory basis for the requirement, the interim final rule requires that all documents proving citizenship, such as a birth certificate, and all documents proving identity, such as a driver's license with photo ID, "must be either originals or copies certified by the issuing agency." The rule estimates that "it would take an individual 10 minutes to acquire and provide to the State acceptable documentary evidence and to verify the declaration" and "it will take each State 5 minutes to obtain acceptable documentation, verify citizenship and maintain current records on each individual." This estimation is unrealistically low, considering the application process and processing times and the fact that many individuals are unlikely to have the necessary documents at hand. Furthermore, because CMS has failed to conduct statutorily required outreach, few people will be aware of the need to obtain these documents prior to application or redetermination.

Not only are individuals required to present original or certified copies of records, but States are also required to maintain copies of the evidence of citizenship and identity in case files or databases. These onerous requirements are not required by Federal law, and impose significant time and effort on both States and families seeking either originals or certified copies of their documents.

We urge CMS to modify the rule to comport with the statute, and eliminate the requirement that documents must either be originals or copies certified by the issuing agency. The final rule should also expand the ability of States to use computer matches to electronically document citizenship. For example, in addition to using automated vital records matches to document citizenship and certain other databases to document identity as allowed in the interim final rule, States should be able to use the Social Security Administration's NUMIDENT database, the SAVE database, or any other eletronic databases that contain identity or citizenship information, without requiring that the applicant or beneficiary first attempt, unsuccessfully, to provide documentation. These options would be highly accurate, less costly, and faster than requiring presentation of original or certified citizenship documents.

In addition, if one State has verified the citizenship or legal status of a Medicaid beneficiary, that verification should be acceptable in all States. When a beneficiary moves from one State to another State he or she would not have to go through the verification process again when applying for Medicaid service in the new State.

Finally, we urge CMS to begin the statutorily-required outreach campaign immediately so that families are aware of the information they must provide in order to receive coverage under Medicaid.

The problem I see with the new requirement is that it really will wind up hurting many U.S. citizens and I think that is what some of us are trying to get to at this hearing today.

I understand that your boss, Dr. McClellan, already wrote in a letter to the Inspector General that States, and I quote, "States have little evidence that many non-eligible non-citizens are receiving Medicaid." What we have as a result of this new law is more government bureaucracy to address a largely fictitious problem. In fact, as a result of the new government burden, estimates are that one to two million

American citizens could lose their healthcare. When we already have 46 million uninsured, and when we know that the uninsured and uncompensated are a major burden for our Nation's health providers, we should not be taking action that would make more Americans lose their healthcare coverage.

First, the rule will delay, in my opinion, access to necessary healthcare. The rule says that a pregnant woman or a child, for example, who will meet all the requirements for eligibility but are waiting for their certified copy of their birth certificate to be mailed to them, cannot get their Medicaid coverage. Is that correct?

MS. SHEIL. Are you reading from a letter that Dr. McClellan wrote?

MS. SOLIS. No.

MS. SHEIL. This is your letter? Could you repeat the question, please?

MS. SOLIS. What I would like to know is if in fact, if a pregnant woman or a child, for example, who meets the requirements for eligibility but is waiting for the certified copy of a birth certificate to be mailed, would they be denied coverage?

MS. SHEIL. Applicants have 45 days from the date of application to present documentation.

MS. SOLIS. But if in fact they are found to be citizens after that time, they would still be denied?

MS. SHEIL. State agencies have 45 days from the date of application to make a determination of eligibility.

MS. SOLIS. So in a situation of an area like Georgia and victims of the Hurricane Katrina, how would that operate when most of the healthcare agencies there were flooded and many records are just not available? Mr. Ortiz.

MR. ORTIZ. When Hurricane Katrina hit Georgia, the only State that took in more evacuees than Georgia was Texas. What we did is we worked with CMS to establish presumptive eligibility. We also established links with the State of Louisiana and the State of Mississippi to verify with their drivers' license bureau and with their vital statistics, to verify that when individuals came in and said I was born in Louisiana, then we could verify that electronically and CMS provided us the flexibility and a time period to get that documentation in, but there was no disruption in coverage. They were immediately eligible, it was called presumptive eligibility and the Federal government worked with us to make sure that nothing happened where there was a delay in payment or healthcare.

MS. SOLIS. The other question I have just to wrap up, and I know my time is already running out, is with respect to foster care children and the fact that again, we are asking for proof of citizenship. And as you know,

the foster care system in many cases, a child jumps from one home to another, foster care is not always as stable as we would like and in many instances parents of foster care children do not want to provide proof of citizenship. What happens in a case for eligibility for that child if there is no documentation available?

MS. SHEIL. We believe that the State agencies have more information about foster children probably than any other children on the caseload. The requirement is not for Title IV-E, they get Title IV-E, it is for the Medicaid benefits. When they are found eligible for Title IV-E, they are made eligible automatically for Medicaid. The State agencies will consider them recipients and they will have, upon the first redetermination of eligibility, the responsibility to have collected information. So they will have a year to gather the information. The foster care workers will need to talk with the eligibility workers and they will use electronic means, they will be able to use matches with vital statistics, obtain birth certificates, just like any other type of case.

The policy that is outlined in the regulations provides very, very broad arrays of documents that may be used to document citizenship and identity.

MS. SOLIS. Just one last question with respect to Native Americans also. I understand that if they do not have adequate proof of citizenship for whatever reason, will they also be denied assistance? I mean that is a big issue right now that I think many people have questions about.

MS. SHEIL. The policy that we have outlined in the regulations, which is policy that basically has been a longstanding established policy used by the Social Security Administration with the types of documents that are listed. They have a broad array of ways of documenting satisfactorily your citizenship. Native Americans also can have birth certificates, we have utilized--

MS. SOLIS. Some will not though. So what would you use then?

MS. SHEIL. There will be ample room for States to use cross matches with vital statistics agencies, they will be able to use some Native American documents we did list as acceptable documents. We do use Native American documents, they are allowed to prove identity. But the policy is sufficient to provide much flexibility in terms of the documents that may be used.

MS. SOLIS. Thank you.

MR. DEAL. Dr. Norwood.

MR. NORWOOD. Thank you very much, Mr. Chairman.

It is the time in the hearing at which I want to remind us that this hearing is not about immigrants, it is about illegal aliens.

I want to ask you, Dr. Siskin, if I may, are you here as a private citizen or an employee of CRS?

MS. SISKIN. An employee of CRS.

MR. NORWOOD. Okay. Does CRS make assumptions about illegal aliens in their studies?

MS. SISKIN. What do you mean by assumptions about illegal--

MR. NORWOOD. You are the one that used assumptions all through your testimony. That is what I mean.

MS. SISKIN. We are very clear when we use census data or anything from the U.S. Census Bureau, that there is no way to determine who is an unauthorized alien.

MR. NORWOOD. So you do use assumptions?

MS. SISKIN. No, we would not say that those were unauthorized aliens, we would use the term non-citizen, meaning both legal and illegal aliens.

MR. NORWOOD. So other studies do use assumptions and you do not.

MS. SISKIN. Correct.

MR. NORWOOD. Ah-ha. I find that pretty interesting.

The Rand study, for example, that pointed out 65 percent of illegal aliens in this country do not have any kind of insurance, they account for about a third of the growth in non-insured people. Is that just an assumption?

MS. SISKIN. I would have to look at the study and see how they came up with that. I mean they may have extrapolated from an individual community but there is no census of the entire illegal population in this country.

MR. NORWOOD. Recently, Colorado State Emergency Medicaid Program estimated $30 million in hospital and physician delivery costs for about 6000 illegal alien mothers, an average of $5000 per baby. These 6000 births to illegal aliens represent 40 percent of the births paid for by Medicaid in Colorado. Is that an assumption?

MS. SISKIN. It would depend how they are determining who is an unauthorized alien. If they know for a fact that somebody is an unauthorized alien, but if they are using a proxy such as Social Security number or lack of Social Security number, it would be an assumption.

MR. NORWOOD. Do you not suppose that the State of Colorado would know? Mr. Ortiz, we would know in Georgia, would we not, sir?

MR. ORTIZ. We would look at our emergency Medicaid and know where they come in and the fact that they continue--one of the things when we talk about emergency room services, people are under the misconception that the billing stops at the emergency room. What tends to happen is it continues on when there is no emergency and you end up paying under emergency Medicaid for routine care and ongoing care.

And so I think it is more of a problem than just the emergency room you mentioned.

MR. NORWOOD. Yes, it is. But we do know information like that. We may turn and look the other way or not want to admit it, but we do know those things happen.

Dr. Siskin, I am going to tell you honestly, I am upset with your testimony and plan to make a complaint to CRS about it. We can go into this when we get back to Washington, but I want you to know I really did not appreciate the viewpoint you all took at CMS, not looking, in my opinion, at the whole picture.

Now Ms. Sheil--

MR. DEAL. You said CMS.

[Applause.]

MR. NORWOOD. I did not mean CMS, I beg your pardon--CRS.

Ms. Sheil, I want to tell you personally how much I appreciate the work you and Dennis Smith have been doing in an effort to try to get us to get this straightened out in this country so that only our own citizens receive the tax dollars that go into Medicare. I have worked with CMS for 12 years and it is always hard, it is always difficult, and I have great feelings about how well you all have handled this, how hard you have tried to work this out for the American citizen to make sure that we do not let anybody drop through the cracks because we are trying to zero in on not letting foreigners get into our social system.

Explain to me just a little bit briefly what has basically changed in the law that has caused us to come to this point to where Mr. Ortiz--who by the way is doing a great job for our Governor, thank you, sir--is changing how we do business in Georgia and obviously they are changing how they do business in Colorado. Just briefly explain to us what changes you see that we have made that have been most important.

MS. SHEIL. Well, the change is that we will now have to have documentation of citizenship and identity to protect the Medicaid program's integrity. There are no changes as far as citizens having to declare their citizenship, they have always had to do that, this is just a documentation requirement. And we are now holding States financially responsible for implementing the provisions of the law.

MR. NORWOOD. And now finally doing oversight--

MS. SHEIL. Correct.

MR. NORWOOD. --into making sure the States do. Mr. Ortiz, again, I know what all you have been doing for Governor Perdue and I want to tell you, we from Washington appreciate all of your help and all the good works that you are doing.

Very quickly, now that you are actually verifying citizenship, have you run into any particular problems, or has there been this great burden on the State of Georgia to try to narrow this down?

MR. ORTIZ. I think because the similar work has been done in the past for foster kids and you need to remember that Medicaid is a payer of last resort, so our eligibility workers already have to check SSI and Medicare before they make anybody eligible for Medicaid, so they are used to doing this type of work. So this is something that is just an enhancement to what they are already doing. And we see it as a necessary and responsible thing to do.

MR. NORWOOD. I see my time is up, Mr. Chairman. Thank you.

MR. DEAL. I want to thank the panel. We appreciate you being here today.

[Applause.]

MR. DEAL. I would like to ask the third panel if they would please come forward.

While our third panel is coming up, I want to express appreciation to the staff here at Northwest Georgia Trade and Convention Center for allowing us to hold this field hearing here in their facility today. You are very fortunate, we are all very fortunate here in the Dalton area, to have a facility of this type and the staff does a great job and I want to thank them all for their cooperation in facilitating this event today.

All right, we have the third and final panel and it will follow in the same distinguished fashion that the two that preceded it did. I will introduce them at this time. First of all, Mr. James E. Gardner, who is the President and Chief Executive Officer of Northeast Georgia Health Systems in Gainesville, Georgia; Mr. Charles Stewart, who is the Chief Executive Officer of Hutcheson Medical Center in Fort Oglethorpe, Georgia and Mr. Marty Michaels, who is Chair of the Georgia Chapter of the American Academy of Pediatricians and he is from Dalton, Georgia.

Gentlemen, thank you very much for being here and once again, I did not say it in the last panel, but your written testimony is a part of our record and we would ask you in your time of 5 minutes if you would summarize your testimony and Mr. Gardner, I will begin with you.

STATEMENTS OF JAMES E. GARDNER, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, NORTHEAST GEORGIA HEALTH SYSTEM, GAINESVILLE, GEORGIA; CHARLES STEWART, CHIEF EXECUTIVE OFFICER, HUTCHESON MEDICAL CENTER: AND DR. MARTY MICHAELS, CHAIR, GEORGIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

MR. GARDNER. Mr. Chairman, members of the Committee, thank you for inviting me to be with you today. My name is Jim Gardner and I am President and Chief Executive Officer of Northeast Georgia Medical Center and Health System in Gainesville, Georgia. Very much like Dalton, Gainesville is a community with a large Hispanic population. Gainesville's poultry and booming housing industry have attracted both legal and illegal immigrants to our community.

Before I get to the crux of my comments about how illegal immigration affects our medical facility, let me take a moment to defend the hard line that I am about to take.

At the Medical Center, I am surrounded by people who chose their professions because of a genuine and sincere desire to help people. We have a remarkable community of nurses and doctors who give of themselves completely and without prejudice to their patients. During hectic office hours, many of our community physicians volunteer to treat indigent patients through the Hall County Medical Society's Health Access Initiative without compensation. After they have worked their more than full-time jobs, many of our employees and physicians volunteer at the local Good News Clinics where free medical and dental services are provided for uninsured people who have no resources to pay for services. We had many employees who volunteered for Katrina relief efforts during their families' spring break, and countless employees and physicians used personal vacation time to travel the world on mission trips to use their medical skills in third world countries.

I am very proud of the dedication and compassion of the people I work with. I felt a need to say that, because in the current political climate, taking a position for any limitation on services to illegal immigrants is often painted with a broad brush as cruel and uncaring. That would be an unfair representation of the organization I serve and represent today. So I just wanted to get that clearly on the table before I begin to address how illegal immigration affects our healthcare facility.

In Hall County, the number of Hispanics has grown from 1 percent in 1980 to just over 24 percent today, according to the 2004 U.S. Census. Roughly one in four in Hall County is Hispanic. To identify how many illegal immigrants we have is difficult, as you have already heard. But at Northeast Georgia Medical Center and in physician offices all over the region, providers must cover the expense of bilingual staff to care for patients, and print out all forms and educational materials in two languages. In 2003, a local study "Healthy Hall" reported that 33 percent of all Latinos are uninsured, which represents 60 percent of the uninsured in Hall County. Uninsured patients face a huge burden on our health system and put our ability to care for the people in our region in jeopardy.

To the community, hospitals look like big business, with big money. In realty, our hospital must spend over a million dollars a day to provide the care our community needs. Even with our investment income, margins have declined in recent years, limiting our ability to care for the growing needs of the people of northeast Georgia. Recently, our organization made dramatic reductions, including the elimination of approximately 300 full time positions that have helped to stop that downward trend. However, with projections of continued illegal immigration and the inability of many area citizens to obtain health insurance, keeping our health system operating in the black remains a challenge.

The Deficit Reduction Act no longer allows for self-declaration of citizenship, but requires verification. This means that every Medicaid recipient must prove citizenship to be eligible for Medicaid benefits, but not to be eligible to receive emergency medical services. That is a very important distinction. The change in verifications only took place in July, but we are already seeing the impact on our operations and finances.

For the crux of my comments, I would like to share a true story of a young Latino woman, I will refer to as Maria, who came to our emergency room in the last month requesting dialysis. An illegal immigrant from Mexico, she had come directly to Gainesville at the request of her mother and sister, who both admitted they are living in the U.S. illegally. Mexico had requested upfront payment for the young woman's dialysis--funds which the patient did not have. She was told that the same would be required in the U.S., but she decided to make the journey anyway because her sister had been receiving outpatient dialysis in the Gainesville community for the last 2 years. Maria was encouraged by her sister to leave Mexico and come to Gainesville for care in spite of the fact that the dialysis center had informed her that her care would be denied and that Maria should remain in Mexico for treatments. The dialysis center referenced is a private outpatient facility and is not owned or operated by Northeast Georgia Medical Center. At the time Maria's request for service was made, this dialysis center had 56 patients, 11 of which were undocumented immigrants for whom they were receiving no reimbursement based on Georgia's January 2006 implementation of the Federal Medicaid rules which excludes Medicaid coverage for chronic conditions for non-U.S. citizens.

Maria's condition had become life-threatening by the time she arrived in Gainesville and presented in our emergency department for care. She had to be admitted by law, also by conscience, until her condition could be stabilized. Our staff worked for the next 8 days to locate an outpatient dialysis center that would accept her for follow-up

treatment upon her discharge from the hospital. They were in a tough place. They were caring, compassionate people whose moral compass was spinning. They talked with the distraught mother and sisters, contacted the Emory transplant center, the Georgia Medical Foundation, three local dialysis centers and the Mexican Consulate trying to find a way to secure dialysis treatment for this young woman who would need to be dialyzed on average 3 times a week indefinitely. The hospital does not provide outpatient dialysis services and all local outpatient providers refused to accept this woman as a patient because she had no sources for payment that would even cover the cost of her treatments.

Maria was dialyzed six times while at our hospital, five of those times out of necessity while we waited to find an outpatient provider to accept her. The direct cost of her care to Northeast Georgia Medical Center was over $9,500, which did not include the time expended by case managers and staff on this young woman's behalf. Medicare and Medicaid generally pays about $200 per procedure for basic dialysis services provided on an outpatient basis.

Based on a recommendation from the Mexican Consulate and with a discharge plan approved by her physician, the Health System worked with the patient and mother to arrange for the patient's transport back to Mexico. The hospital recommended that the patient's mother also accompany her to help coordinate the care needs.

Had Maria been discharged from the hospital without a resource for outpatient dialysis, she would have, most assuredly, returned to our emergency department or another emergency department within 2 to 3 days in a life-threatening condition that would have resulted in her emergency re-admission to the hospital.

The young woman's hospital care to stabilize her until she was safe to travel home cost our organization thousands of dollars which will not be reimbursed. The story, however, is heartbreaking. Similar stories could be told by staff of hospitals and care centers all over the country.

It will no doubt be a rough few years until word spreads that proof of citizenship will be required to receive benefits intended for U.S. citizens. Years of failing to require proof of citizenship has meant that illegal immigrants could come to the U.S. and receive free care, paid for with tax dollars, better care at no expense, becoming a magnet to draw the chronically sick to an already broken healthcare funding system.

To tell the truth, our moral compasses are still spinning. The nurses and doctors who cared for this woman will think of her often. Each of us has to make personal decisions about what we will do to help the people of Mexico and any other Nation that is not as fortunate as the United States, or for that matter the poor in our own country. Our Government must also make decisions about border control, foreign aid, trade

agreements and ways to strengthen our ability to help our neighbors. But the primary purpose of the Medicaid program has always been to provide care for U.S. citizens, and without these serious reforms, the system simply is doomed to fail.

I appreciate the work of this committee to keep the Medicaid program viable for United States citizens in need. I respect the difficulty of our work and ask for your continued help in providing affordable healthcare for the people of our community.

Thank you and I stand ready to answer questions.

MR. DEAL. Thank you, Mr. Gardner.

[Applause.]

MR. DEAL. Mr. Stewart.

[The prepared statement of James E. Gardner, Jr. follows:]

PREPARED STATEMENT OF JAMES E. GARDNER, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, NORTHEAST GEORGIA HEALTH SYSTEM

Mr. Chairman, members of the Committee, thank you for inviting me to be with you today. My name is Jim Gardner, and I am president and chief executive officer at Northeast Georgia Medical Center and Health System in Gainesville, Georgia. Very much like Dalton, Gainesville is a community with a large Hispanic population. Gainesville's poultry and booming housing industry have attracted both legal, and illegal immigrants to our community.

Before I get to the crux of my comments about how illegal immigration affects our medical facility, let me take a moment to defend the hard line that I am about to take.

At the Medical Center, I am surrounded by people who chose their professions because of a genuine, sincere desire to help people in need. We have a remarkable community of nurses and doctors who give of themselves completely and without prejudice to their patients. During their hectic office hours, many of our community physicians volunteer to treat indigent patients through the Hall County Medical Society's Health Access Initiative without compensation. After they have worked their more-than-fulltime jobs, many of our employees and physicians volunteer at the local Good News Clinics where free medical and dental services are provided for uninsured people who have no resources to pay for services. We had many employees who volunteered for Katrina relief efforts during their families' Spring Break, and countless employees and physicians use personal vacation time to travel the world on mission trips to use their medical skills in third world countries.

I am very proud of the dedication and compassion of the people I work with. I felt a need to say that, because in the current political climate, taking a position for any limitation on services to illegal immigrants is often painted with a broad brush as cruel and uncaring. That would be an unfair representation of the organization I serve and represent today. So I just wanted to get that clearly on the table before I began to address how illegal immigration affects our healthcare facility.

In Hall County, the number of Hispanics has grown from one percent in 1980 to just over 24 percent today, according to the 2004 U.S.Census. Roughly one in four people in Hall County is Hispanic. To identify exactly how many illegal immigrants we have is very difficult. But at Northeast Georgia Medical Center and in physician offices all over the region, providers must cover the expense of bilingual staff to care for patients, and print all forms and educational materials in two languages. In 2003, a local study "Healthy Hall" reported that 33 percent of all Latinos are uninsured, which represents 60

percent of the uninsured in Hall County. Uninsured patients place a huge financial burden on our health system and put our ability to care for the people of our region in jeopardy.

To the community, hospitals look like big business, with big money. In reality, our hospital must spend over a million dollars a day to provide the care our community needs. Even with our investment income, margins have declined in recent years, limiting our ability to care for the needs of the people of northeast Georgia. Recently, our organization made dramatic cost reductions that have helped stop the downward trend. However, with projections of continued illegal immigration and the inability of many area citizens to obtain health insurance, keeping our health system operating in the black remains a challenge.

The Deficit Reduction Act no longer allows for self-declaration of citizenship, but requires verification. This means that every Medicaid recipient must prove citizenship to be eligible for Medicaid benefits, but not to be eligible to receive emergency medical services. The change in verification requirements only recently took effect July 1 but already we are seeing its impact on our operations and finances.

Let me share the true story of a young Latino woman I will refer to as "Maria," who came to our emergency room requesting dialysis. An illegal immigrant from Mexico, she had come directly to Gainesville at the request of her mother and sister, who both admitted they are living in the U.S. illegally. Mexico had requested upfront payment for the young woman's dialysis – funds which the patient did not have. She was told that the same would be required in the U.S., but she decided to make the journey anyway because her sister has been receiving out-patient dialysis in the Gainesville community for the past two years. "Maria" was encouraged by her sister to leave Mexico and come to Gainesville for care in spite of the fact that the Dialysis Center had informed her that care here would be denied and that "Maria" should remain in Mexico for treatments. The Dialysis Center referenced is a private out-patient facility that is not owned or operated by Northeast Georgia Medical Center. At the time "Maria's" request for services was made, this dialysis center had 56 patients, 11 of which were undocumented immigrants for whom they were receiving no reimbursement based on Georgia's January 2006 implementation of Federal Medicaid rules which excludes Medicaid coverage of chronic conditions for non U.S. citizens. .

Maria's condition had become life-threatening by the time she arrived in Gainesville and presented in our emergency department for care. She had to be admitted by law, but also by conscience, until her condition could be stabilized. Our staff worked for the next eight days to locate an outpatient dialysis center that would accept her for follow-up treatment upon her discharge from the hospital. They were in a tough place: caring, compassionate people whose moral compasses were spinning. They talked with the distraught mother and sisters, contacted the Emory transplant center, The Georgia Medical Foundation, three local dialysis centers and the Mexican Consulate trying to find a way to secure dialysis treatment for this young woman who would need dialysis on average three times a week, indefinitely. The hospital does not provide outpatient dialysis services and all local outpatient providers refused to accept the young woman as a patient because she had no sources for payment that would even cover the cost of her treatments.

"Maria" was dialyzed 6 times while in our hospital—5 of those times out of necessity while we waited to find an outpatient provider to accept her. The direct cost of her care to Northeast Georgia Medical Center was over $9,500, which did not include the time expended by case managers and other staff on this young woman's behalf. Medicare and Medicaid generally pays about $200 per procedure for basic dialysis services provided on an outpatient basis.

Based on the recommendation from the Mexican Consulate and with a discharge plan approved by her physician, the Health System worked with the patient and mother to

arrange for the patient's transport back to Mexico. The hospital recommended that the patient's mother accompany her to help coordinate the care she needs.

Had "Maria" been discharged from the hospital without a resource for outpatient dialysis, she would have, most assuredly, returned to our emergency department or another nearby emergency department in 2-3 days in a life-threatening condition that would have resulted in her emergency re-admission to the hospital.

The young woman's hospital care to stabilize her until she was safe to travel home cost our organization thousands of dollars which will not be reimbursed. The story is heartbreaking. Similar stories could be told by staff of hospitals and care centers all over the country.

It will no doubt be a rough few years, until word spreads that proof of citizenship will be required to receive benefits intended for U.S. citizens. Years of failing to require proof of citizenship has meant that illegal immigrants could come to the U.S. and receive free care, paid for through tax dollars. Better care, at no expense… a magnet to draw chronically sick people to our already broken healthcare funding system.

To tell you the truth, our moral compasses are still spinning. The nurses and doctors who cared for this young woman will think of her often. Each of us must make personal decisions about what we will do to help the people of Mexico and any other nation that is not as fortunate as the United States and for that matter the poor in our own country. Our government must also make decisions about border control, foreign aid, trade agreements and ways to strengthen our ability to help our neighbors. But the primary purpose of the Medicaid program has always been to provide care for U.S. citizens, and without these serious reforms, the system simply is doomed to fail.

The verification component of the deficit reduction act will only work if healthcare providers enforce the law, even though enforcement will often require tough actions.

I appreciate the work of this committee to keep the Medicaid program viable for United States citizens in need. I respect the difficulty of your work and ask for your continued help in providing affordable healthcare for the people of our community. Thank you.

MR. STEWART. Good morning, Mr. Chairman and members of the committee. My colleague Mr. Gardner spoke of the impact of illegal aliens on the Gainesville community and I am very pleased to be here today to discuss the impact that illegal immigration is having on the Medicaid program and our health delivery system as a whole. I also wish to thank you, Chairman Deal, members of the committee, members of the Georgia legislature, and others for taking time to come to Dalton to address this important issue.

Since 1953, Hutcheson Medical Center has been northwest Georgia's community hospital. We are a 300-bed healthcare system with a commitment to provide access to quality, cost-effective healthcare to our growing population.

Being one of the largest community hospitals in Georgia, Hutcheson Medical Center has over 1,300 employees with more than 200 physicians and over 400 registered nurses and clinical staff. Our primary service area includes Catoosa, Dade, and Walker Counties with more than 137,000 residents.

Let me begin by saying that I share the committee's concern about the Nation's need to secure our borders. As you are aware,

undocumented aliens' use of medical services had been a longstanding issue for hospitals. As required by Federal law--the Emergency Medical Treatment and Labor Act or EMTALA--hospitals participating in Medicare must provide emergency medical services for all patients who seek care, regardless of their ability to pay. Under EMTALA, hospitals must provide an appropriate medical screening examination for individuals who seek emergency care in a hospital emergency department.

If an individual is found to have an emergency medical condition, the hospital must treat and stabilize the medical condition, or transfer the patient under certain circumstances. Additionally, if an individual's medical condition is not stable, the hospital may not transfer him or her unless the individual or someone acting on their behalf, requests the transfer, and the transfer is appropriate under EMTALA. Since hospitals are required to evaluate and treat all patients who seek care in hospital emergency departments, EMTALA, in effect, requires hospitals to provide free care for some patients, regardless of their condition or their citizenship status. This raises the concern that while we are treating the illegal immigrant population, how many Georgia citizens are not getting the quality treatment they require?

As Congressman Deal pointed out earlier, it costs approximately $340 to care for a non-emergency patient in the emergency department while it costs less than $75 to care for the same patient in a clinic. That means that over four people can be treated in a clinic for less money than one person can be seen in the emergency department. And, according to the Georgia Department of Community Health, 41.3 percent of ER visits were for non-emergencies on Mondays through Fridays from 8:00 a.m. until 5:00 p.m., which is when most physician offices and clinics are open. At Hutcheson Medical Center, we have seen our uncompensated care increase by a million and a half dollars just in this fiscal year alone.

Another issue the hospitals face in emergency departments is the growing number of births to illegal aliens. It is documented that in some States, more than half of emergency Medicaid expenditures were for labor and delivery services. Our current law provides that babies who are born on U.S. soil to illegal immigrants are to become immediately recognized as citizens; and thereby ultimately drive up the cost of healthcare, especially in those States with the highest estimated illegal populations, of which Georgia is a part. The question arises, how long are providers obligated to care for these newborns?

Additionally, there is concern that Title II, Sections 201 and 202 of H.R. 4437, if enacted, will place hospitals and caregivers at risk for violating provisions of the Immigration and Nationality Act. While I believe that it is not the intent of Congress to criminalize providers who

are just trying to provide quality care to their patients, some of the language is broadly worded, and at the very least, creates a Catch 22 for hospitals and providers that seek reimbursement under Section 1011 of the Medicare Modernization Act. In order to receive reimbursement, they must acknowledge that they have rendered treatment to an individual who is an undocumented alien.

Thank you again for giving me the opportunity to comment on this very important issue. I appreciate all of your service to our country and our State, and I am available for questions as well.

MR. DEAL. Thank you. Dr. Michaels.

[The prepared statement of Charles Stewart follows:]

PREPARED STATEMENT OF CHARLES STEWART, CHIEF EXECUTIVE OFFICER, HUTCHESON MEDICAL CENTER

Good Morning, Mr. Chairman and members of the committee, my name is Charles Stewart and I am the Chief Executive Officer of the Hutcheson Medical Center in Ft. Oglethorpe, Georgia. I am very pleased to be here today to discuss the impact that illegal immigration has on the Medicaid program and our health delivery system as a whole. I also wish to thank you, Chairman Deal, members of the Committee, members of the Georgia Legislature, and other witnesses for taking the time to come to Dalton to address this important issue.

Since 1953, Hutcheson Medical Center has been Northwest Georgia's community hospital. We are a 300-bed health care system with a commitment to provide access to quality, cost effective healthcare to our growing population.

Being one of the largest community hospitals in Georgia, Hutcheson Medical Center has over 1300 employees, with more than 270 physicians and over 400 registered nurses and clinical staff. Our primary service area includes Catoosa, Dade and Walker counties with more than 137,000 residents.

Let me begin by saying that I share the committee's concerns about the nation's need to secure its penetrable borders. As you are aware, undocumented aliens' use of medical services has been a longstanding issue for hospitals. As required by federal law - the Emergency Medical Treatment and Labor Act (EMTALA) - hospitals participating in Medicare must provide emergency medical services for all patients who seek care, regardless of their ability to pay. Under EMTALA, hospitals must provide an appropriate medical screening examination for individuals who seek emergency care in a hospital emergency department.

If an individual is found to have an emergency medical condition, the hospital must treat and stabilize the medical condition, or transfer the patient under certain circumstances. Additionally, if an individual's medical condition is not stable, the hospital may not transfer him or her unless the individual, or someone acting on their behalf, requests the transfer, and the transfer is appropriate under EMTALA. Since hospitals are required to evaluate and treat all patients who seek care in hospital emergency departments, EMTALA in effect requires hospitals to provide free care for some patients regardless of their condition or their citizenship status. This raises the concern that while we are treating the illegal immigrant population, how many Georgia citizens are not getting the quality treatment they require?

Meanwhile, it costs approximately $340 to care for a non-emergency patient in the emergency department while it costs less than $75 to care for the same patient in a clinic. That means over four people can be treated in a clinic for less money than one person can

be seen in the emergency department. And, according to the Georgia Department of Community Health, 41.3% of ER visits were for non-emergencies on Mondays through Fridays from 8:00 a.m. until 5:00 p.m., which is when most physician offices and clinics are open.

Another issue that hospitals face in emergency departments is the growing number of births to illegal aliens. It is documented that in some states, more than half of emergency Medicaid expenditures were for labor and delivery services. Our current law provides that babies who are born on U.S. soil to illegal immigrants are to become immediately recognized as citizens; and, thereby ultimately drive up the cost of healthcare, especially in those states with the highest estimated illegal populations of which Georgia is a part. The question arises how long are providers obligated to care for these newborns?

Additionally, there is a concern that Title II, Sections 201 and 202 of H.R. 4437, if enacted, will place hospitals and caregivers at risk for violating provisions of the Immigration and Nationality Act (INA). While I believe that it is not the intent of Congress to criminalize providers who are just trying to provide quality care to their patients, some of the language is broadly worded, and at the very least, creates a "Catch 22" for hospitals and providers that seek reimbursement under section 1011 of the Medicare Modernization Act: in order to receive reimbursement, they must acknowledge that they have rendered treatment to an individual who is an undocumented alien.

Thank you, again, for giving me the opportunity to comment on this very important topic. I appreciate your service to our great Country and State, and am happy to answer any questions you or members of the Committee may have.

MR. MICHAELS. Thank you, Mr. Chairman. Stop me if I am not supposed to do this, but I would like to thank the Congressmen and Congresswoman on the panel, Chairperson Deal, I would like to thank you personally for the time that you have taken in talking with me over the last year about children's healthcare issues and, Mr. Clark, I would like to thank you for the same. I have felt that I was listened to and I do feel that you are attuned to the important needs of children and I thank you for that and your leadership.

MR. DEAL. You can say that a long time. Thank you.

[Laughter.]

MR. MICHAELS. Congressman Norwood, I would like to thank you for your support on position issues with Steadfast, and I am glad to see that you are looking very well.

And Congresswoman Solis, I appreciate your advocacy for children, especially children of low-income families. So thank you for that.

I will be speaking today from my notes. This testimony is filed by the American Academy of Pediatrics. I will not be reading from this but this needs to be part of the official record because this states the official position of the American Academy of Pediatrics.

MR. DEAL. Without objection, that will be made part of the record.

MR. MICHAELS. Thank you, sir.

And my comments generally do reflect the opinion of the American Academy of Pediatrics, but there will be some personal comments that have not been discussed by the American Academy of Pediatrics, so this

should not be construed as the official position of the American Academy.

My name is Martin Michaels, I am a primary care pediatrician. I am President of the Georgia Chapter of the American Academy of Pediatrics and I am the founding partner of Peachcare P.C., which is medium-sized general pediatric practice in Dalton, Georgia. I am grateful for the opportunity to testify to the Health Subcommittee today in Dalton.

I will be focusing my comments on the impact of illegal immigration on the Medicaid Program and our healthcare delivery system, as it relates to the healthcare and the health status of children of illegal immigrants who live in the United States.

The definition for children for me is ages 0 to 18 years, for today's discussion.

A little bit about my practice and experience, I am a pediatrician who has practiced in northwest Georgia since 1984. When I began in practice, I had a lot more hair and the percent of children covered by Medicaid at that time in my practice was about 20 percent, and there was no SCHIP program at that time. There were very few immigrants in Dalton at that time. There was a large group of uninsured children and under-insured children and a minority of the children in my practice had a true medical home.

Early in my career, I saw first-hand the suboptimal outcomes and complications occurring because of the lack of medical home for a large number of children and the large majority of these children were Caucasian children, I had very few foreign born children in my practice at that time.

In our practice, we place a strong emphasis on providing a medical home for all our patients. A medical home is a place where the patient and family are known by the providers, where the families have a trusting relationship with the providers and comprehensive preventive and acute care is available in a timely and continuous way. A permanent, complete, ongoing medical record exists in the medical home. Parents preferentially seek care in their medical home rather than the ER for many reasons.

My practice accepts all children without regard for ability to pay. We have never used a collection agency and we never will. If a family calls and says they have good insurance or bad insurance, Medicaid, Peachcare or no insurance and no money, we will still see the child.

When looking at the issue of healthcare for children of immigrants, illegal and legal, it is important to remember that we are talking about individual families and individual children. This is not a faceless mass from any one country. I have seen immigrants in Dalton from every continent of the world except for Antarctica. Within the primarily

Spanish speaking population in Dalton, there is huge diversity. There are families from South America, Central America, Mexico, and Cuba. Each of these families is unique and different, just as each white and African-American family is unique and different.

I want to talk a little bit about focusing on children. I am sure that no one on any of these panels, the three panels that have spoken, the panel of Congressmen and women, the folks in the audience--I do not think that anybody here wants to intentionally or unintentionally hurt children. I think either we have children, we have grandchildren, we have friends that have children, nieces, nephews--none of us wants to intentionally or unintentionally hurt a child.

Remember that children do not have a choice in what we are talking about today. They are innocent of wrongdoing and they find their healthcare availability subject to decisions made by adults, adult legislators, adult employers, and adult parents. Adult legislators make decisions about immigration policies, border entry, regulation, level of enforcement of policies in the interior of the Nation, in the workplace and in the community. Adult immigrants make decisions about whether to bend or break the rules. Adult employers make decisions about whether to bend or break the rules.

As a pediatrician, I have witnessed first-hand complications that occur when primary healthcare is not accessible to children, and it is my position that all children who reside in the United States should have equal access to quality healthcare directed by a medical home. This includes children of documented immigrants, some of whom were born in other countries and some who were born in the United States, and children of undocumented immigrants, some who were born in other countries and some who were born in the United States. Foster children, newborns, children affected by disasters such as Hurricane Katrina, Native American Indian children, all must have immediate presumptive eligibility upon application to avoid disastrous and expensive health outcomes due to lack of access to appropriate primary care.

I will say as a sidebar, one of the panelists mentioned that State agencies have more information than anyone else about foster children. But just to give you an example from the front lines, when a foster child comes to my office for the first time, I do not have immunization records, I do not know if that child is allergic to anything, I do not know if that child has seen a specialist, I have pretty much zilch. And it is a big problem. We are working on it in Georgia, the officials in Georgia are aware of this, it is not that it has not been talked about, but it has not gotten better. We have been talking about that for years. So if we think that they are going to be able to figure out documentation for eligibility

in a time efficient way, I would predict not. And I do not mean that in an ugly way, I just mean that in a practical way.

Also, any policies about documentation of citizenship must take into account the healthcare literacy level of the population served and must be geared at a low enough educational level that the clients can reasonably carry out the requirements of the policy. I have not heard anybody say anything about healthcare literacy today, but that is a term in the literature and you need to look at examples of different levels of healthcare literacy, what it takes to figure out a Social Security card, what it takes to get a birth certificate. These are levels of functioning that may be above the levels of many of the parents that I see.

When children do not have access to medical homes, the resulting costs are human health costs and suffering for the immigrant child, adverse health consequences for the community, not just for the child, but contractible diseases that the community is exposed to because of lack of primary care for the immigrant child, increased unreimbursed costs for hospitals and for physicians and other providers, increased taxes and increased healthcare premiums for the community because care outside of the medical home is very expensive.

I want to make a comment about virtual barriers to care. Virtual barriers to care must be avoided. These are roadblocks whose intent is to make it more difficult to get care to which an individual is otherwise legally entitled. Setting up virtual barriers to care for children is becoming rampant in my experience in our healthcare system and it is unethical. Requiring the parents of a newborn or foster child to bring in a birth certificate before they can get Medicaid benefits is a virtual barrier to care and one that will result in expensive medical complications and ER visits.

I want to talk a little bit about spending our limited healthcare dollars, and Mr. Deal and Mr. Clark, you and I have talked about this. I think you know that I understand it is not a bottomless pit of dollars that we have to spend, I understand that very clearly and I have made individual efforts to learn about that and how to cut those costs in a good way. There are economic, moral, and ethical aspects to how we spend our healthcare dollars. Our healthcare dollars are limited, they are precious, they must be used wisely and not wasted.

Children are not breaking the bank of Medicaid nationally or in Georgia. Seventy percent of the recipients of Medicaid are children, but they only account nationally for 30 percent of the cost. And in Georgia, that break is even bigger, as I understand it.

The other specific I want to share from Georgia is that between 2000 and 2005, the cost of Medicaid and SCHIP for Georgia, combined State and Federal expenditures, increased from $3.5 billion in 2000 to $6.5

billion in 2005. That is an alarming looking number. But it is very important to remember that the number of enrollees went from 970,000 in 2000 to 1.5 million in 2005, there was an increase of 150 percent in the number of enrollees.

And Mr. Norwood, just to go back to the comment about Georgia being a deficit State for Peachcare, I think it would be important to look and see if the deficit is really there in terms of members served per--amount paid per member per year. Because I suspect that what happened there is we had such a huge increase in enrollment, and that was due to the leadership of the Department of Community Health in doing a great job of enrolling kids. Georgia back in 2000-2001 was the poster state for the SCHIP program, we were doing great. And I think Deanna Key at that time, who was the membership person at DCH, did an outstanding job and got kids signed up quickly that were eligible, and therefore, Georgia spent more money. But I think it is real important to look at the per member per year cost to make sure we are really a deficit state. I think other States received more money than they were supposed to and did not sign up as many kids, and I think they owe us some back, is the way I understand it. I may be wrong on that, but I think that is correct.

And in summary of that, I want to say that the increased per member per year in Georgia for kids between 2000 and 2005, per member per year, was 2.5 percent. The inflation rate I believe between 2000 and 2005 averaged over 2.5 percent and I know of no other healthcare system that did not increase faster than the rate of inflation. If there is, I would like for somebody to tell me where that was.

So Georgia had a very successful, in my opinion, healthcare expenditure during those 5 years. Why? Because all those children in the Georgia program were assigned to a medical home. That is my opinion about why that increase was so low, and it was called Georgia Better Healthcare, it was a primary care case management system and kids could not be in the system without a primary care provider.

Creating barriers to access to care for children is neither moral or ethical. It will not save significant healthcare dollars. It will adversely affect the health of children who do not have access to care. It will adversely affect the health of our Dalton, Whitfield, Murray communities. It will adversely affect our State's vital statistics. I am really sorry to say, Mr. Norwood and Mr. Deal, that our infant mortality rates and our neonatal mortality rates in Georgia are among the lowest in the country. We are number 44 and number 45 out of 50 States in neonatal mortality and infant mortality. And I am not saying that in an accusatory way, I am saying that we need to do something about that. The doctors have talked about that for many years, it is something that needs to improve. A lot of it has to do with socio-economic factors, but

the fact is not providing access to care for legal or illegal immigrants will put us down from 45, we may end up below Alabama and Mississippi, States that are at the bottom of the list.

To make things a little bit more upbeat, our immunization rate in Georgia is actually number four in the country, we are fourth in the country in fully immunized 3-year olds. Why? Because our Vaccine for Children program in Georgia covers uninsured and under-insured children. If we do not continue access to care for immigrants, illegal, legal, if we make those barriers to care there, our immunization rate is going to plummet and I think when industries look to see what State they want to locate in, they look at healthcare indicators and for children, in my experience, immunization rates, neonatal mortality, infant mortality are three top indicators that people look at.

MR. DEAL. Dr. Michaels, would you summarize for us, please, sir?

MR. MICHAELS. Yes, sir. How to save healthcare dollars. Wasting healthcare dollars is immoral. The right way to save money in the healthcare system is to study utilization and outcomes and how these two are linked. We must have excellent outcomes for all children, we must find the most cost-effective way to reach those outcomes, identify best practices, and then require mandatory non-onerous, non-punitive review of profiling in practice patterns by practicing providers and require mandatory non-punitive education about cost-effective ways to achieve the best outcomes. This type of model could be called PFE, Pay for Education, and it can be implemented in a more fair way than Pay for Performance.

Medical homes save healthcare dollars. All children residing in the United States should receive care in a medical home. Practical examples, to minimize ER visits. Our practice, which is a medical home, pays $24,000 a year for a 24-hour telephone triage system, so our patients do not go to the ER before they call that number. They go through a very safe protocol which is handled over the phone by a registered nurse. And if they are told to go to the ER, they go. If they are told to give Tylenol and see us in the morning, they do that. Our low-income families abide by those suggestions. And that is a suggestion I have about EMTALA. I would suggest the Federal government figure out a way to require telephone triage of children through a safe pediatric telephone triage system such as that of Dr. Barton Schmidt in Colorado.

In summary, the recommendations of the American Academy of Pediatrics--and this will just take 45 seconds I think to sum up. Our mission statement is to attain optimal physical, mental, and social health and well being for all infants, children, adolescents, and young adults. Thereby, the official recommendations of the American Academy of

Pediatrics are that CMS should confirm with the States that newborns are considered eligible for Medicaid coverage.

Paperwork should not delay payment for services provided to newborns. Eligibility for newborns should be presumptive.

The deemed sponsor rule should be changed so that immigrant children are not denied access to insurance and, by extension, quality healthcare.

Community resources should be pooled to address unpaid care provided by pediatricians to immigrant children.

Outreach efforts to enroll children who do qualify for Medicaid and SCHIP but who are not currently enrolled should be expanded.

Payment policies should encourage the establishment of a medical home for all children residing in the United States. The medical home, since it saves dollars in decreased referrals, ER use, and hospitalization, should be recognized as a scorable element in the healthcare budget process. And a case management fee is one mechanism to have a payment policy that will encourage the establishment of a medical home.

Finally in 15 seconds, the Marty Michaels recommendations which are not the official position of the American Academy of Pediatrics are:

That all children residing in the United States should have a medical home.

Cost savings should be achieved by finding ways to spend healthcare dollars effectively through improved utilization and outcomes derived from a Pay for Education model.

And lastly, policies regarding documentation of citizenship should not create virtual barriers to healthcare for children.

Thank you to the Committee and the community for listening; thank you all in advance for working proactively to develop policies that ensure that all children residing in the United States have a medical home and access to needed preventive and acute healthcare. Together we can provide appropriate care for all children residing in the United States while preserving precious United States healthcare dollars.

[Applause.]

[The prepared statement of Marty Michaels follows:]

PREPARED STATEMENT OF DR. MARTY MICHAELS, CHAIR, GEORGIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics (AAP) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, who are deeply committed to protecting the health of children, adolescents and young adults in the United States. Our testimony in today's Hearing, "Examining the Impact of Illegal Immigration on the Medicaid Program and Our Healthcare Delivery System," will focus on children, the innocent victims of illegal immigration.

Children, whether they are undocumented or not, need care in our communities. Most immigrant children's care should be preventive, but too often, that care is foregone. Comprehensive, coordinated, and continuous health services provided within a medical home should be integral to all efforts on behalf of immigrant children. Children need and deserve access to care, and communities benefit when they receive it.

Unfortunately, immigrant children often do not receive the care they need because of federal, state and local laws limiting payment for their care, or a generalized belief that if children seek care, their families or loved ones may become the target of law enforcement.

AAP believes that barriers to access, such as the recent promulgation of rules by the Centers for Medicare and Medicaid Services requiring Medicaid recipients to document citizenship and identification, will harm the health of the children in our country and the communities they live in.

Immigrant Children

One in every five American children is a member of an immigrant family. About one-third of the nation's low-income, uninsured children live in immigrant families. Children of immigrants, often racial or ethnic minorities, experience significant health disparities. These disparities arise because of complex and often poorly understood factors, many of which are worsened by the circumstances of their lives. Although these children have similar challenges with regard to poverty, housing, and food, significant physical, mental, and social health issues may exist that are unique to each individual child.

Children of immigrants are more likely to be uninsured and less likely to gain access to health care services than children in native families. Socioeconomic, financial, geographic, linguistic, legal, cultural, and medical barriers often limit these families from accessing even basic health care services. Once care is available, communication barriers often result in immigrant children receiving lower-quality services. Many immigrant families also have varied immigration statuses that confer different legal rights and affect the extent to which these families are eligible for public programs such as SCHIP, the State Children's Health Insurance Program, and Medicaid. Thus, the immigration status of children in the same family may differ. As a result, a foreign-born child may be ineligible for insurance coverage, while his or her younger, U.S.-born sibling is eligible as a native citizen.

Each immigrant's experience is unique and complex but certain overarching health issues are common in caring for immigrant families. Immigration imposes unique stresses on children and families, including:

- depression, grief, or anxiety associated with migration and acculturation;
- separation from support systems;
- inadequate language skills in a society that is not tolerant of linguistic differences;
- disparities in social, professional, and economic status between the country of origin and the United States; and
- traumatic events, such as war or persecution, that may have occurred in their native country.

The health of immigrant children not only impacts the child, it impacts the entire community. Preventive care commonly provided to children born in the United States will often not be available to children of immigrants. Left untreated, the health issues caused by this lack of prevention cause immigrant families to seek care for their children in emergency settings. Children commonly present with worse health status in the emergency room than if they had received preventive care.

Beyond the health status of the child, communities should also care about the health of the children who live in them because immigrant children may have diseases that are rarely diagnosed in the United States. Left untreated, these diseases may be passed on to the communities in which immigrant children reside. In addition, many foreign-born children have not been immunized adequately or lack documents verifying their immunization status. Dental problems are also common among immigrant children.

The measles vaccine is an example of the importance of prevention for communities. Measles is a highly infectious viral disease that can cause a rash, fever, diarrhea and, in severe cases, pneumonia, encephalitis and even death. Worldwide, it infects some 30 million people and causes more than 450,000 deaths a year. In the United States, measles was once a common childhood disease, but it had been largely eliminated by 2000. Nevertheless, an outbreak of measles occurred in Indiana last year. A 17-year-old unvaccinated girl who visited an orphanage in Romania on a church mission picked up the virus there.

When the girl returned, she attended a gathering of some 500 church members that included many other unvaccinated children. By the time the outbreak had run its course, 34 people had become ill. Three were hospitalized, including one with life-threatening complications. Clearly, communities should care about the health of those who reside in them.

Federal and State Health Programs for Immigrants

One of the most important risk factors for lack of health coverage is a child's family immigration status. Some children in the United States are ineligible for Medicaid and SCHIP because of immigrant eligibility restrictions. Many others are eligible but not enrolled because their families encounter language barriers to enrollment, are confused about program rules and eligibility status, or are worried about repercussions if they use public benefits.

The vast majority of immigrant children meet the income requirements for eligibility for Medicaid or the State Children's Health Insurance Program (SCHIP), but for various reasons are not enrolled. Medicaid and SCHIP are not available to most immigrant children because of eligibility restrictions imposed by various federal laws. Two examples include the sponsor deeming rule and the recently promulgated citizenship and identification documentation requirements.

While qualified immigrants can become eligible to receive federal benefits after five years of U.S. residency, secondary rules often interfere with their access to benefits, such as the "sponsor deeming" rule. Current law requires that people who immigrate through family "sponsors" may have their sponsors' income counted in determining eligibility. This rule applies even if the sponsor lives in a separate household and does not actually contribute to the immigrant's financial support. Sponsor deeming has made a majority of low-income immigrants ineligible for benefits, even after five years have passed. Moreover, if an immigrant uses certain benefits, including Medicaid and SCHIP, his or her sponsor can be required to repay the government for the value of the benefits used until the immigrant becomes a citizen or has had approximately 10 years of employment in the United States. Together, these requirements impose significant barriers to securing health coverage, even when immigrant children are otherwise eligible.

Immigrant children who used to qualify based on certifications as to their immigrant status now may not qualify because of changes contained in the Deficit Reduction Act. These changes require that Medicaid applicants, who would otherwise qualify, must now also provide documentation such as a passport or original birth certificate to verify their citizenship status and identity. While designed to weed out fraud and abuse from the system, AAP has already received information that the rule has limited access to care for poor children who would otherwise qualify for Medicaid. An extreme example of this

can be found in new rules denying coverage for children born in the United States to undocumented mothers.

According to these new rules, newborns may not be eligible for Medicaid until strenuous documentation requirements have been satisfied. Hospital records may not be used in most cases to prove that children are citizens, even though the child was born in the hospital providing care and are, by definition, citizens. Thus, care for some citizen newborns may not be paid for by Medicaid because paperwork documenting their status is not yet available. Pediatricians treating these citizen newborns whether they are low-birthweight, have post-partum complications, or simply need well-baby care, may not be paid. This result is completely unnecessary because the child will eventually qualify for Medicaid benefits as a result of where he or she was born.

Recommendations

Lawmakers should be aware of and sensitive to the onerous financial, educational, geographic, linguistic, and cultural barriers that interfere with achieving optimal health status for immigrant children. This awareness should translate into:

- CMS confirming with states that newborns are presumed eligible for Medicaid coverage. Paperwork should not delay payment for services provided to resident newborns.
- The deemed sponsor rule should be changed so that immigrant children are not denied access to insurance, and by extension, quality health care.
- The pooling of community resources to address unpaid-for care provided by pediatricians to immigrant children. Undocumented children receive care from pediatricians. Communities benefit from the provision of this care. Communities should not expect pediatricians alone to provide the resources needed to furnish this care.
- Encouraging payment policies to support the establishment of a medical home for all children residing in the United States. Comprehensive, coordinated, and continuous health services provided within a medical home should be integral to all efforts on behalf of immigrant children. In addition, the establishment of a medical home should be a "scorable element" for children, as the medical home will have the effect of providing care for children away from the emergency room in many instances.
- Outreach efforts for children who are potentially eligible for Medicaid and SCHIP but not enrolled, simplified enrollment for both programs, and state funding for those who are not eligible for Medicaid or SCHIP. The Medicaid reciprocity model, which allows Medicaid recipients in one state to qualify for services in another state without reestablishing eligibility, is an example of a model that enables underserved families to access health benefits more easily.

In closing, the American Academy of Pediatrics seeks to ensure that Congress keeps in mind the children we care for as it considers restructuring immigration law. Pediatricians and a host of other health professionals provide care to children throughout the United States. We must not compromise children's health in the name of reform.

MR. DEAL. Thank you, thank you all.

My observation is that all three of you have established the primary reason why we should secure our borders. And that is, you are having to deal with the effects of our not doing so. And Dr. Michaels, certainly the empathy that you display for your patients and for children in general is exemplary.

But we should not be putting you in that position and we should not be putting the hospitals in the position of having to determine whether somebody is legal, illegal, et cetera. The security of our border will go a long way toward relieving that burden that is being placed on you.

And since we have come so close to other legislative issues that are not really the thrust of this hearing, let me mention a few. You mentioned about immunization records. Hopefully, the Health IT bill that we have all worked on, and hopefully we will see finalized, will go a long way toward providing that seamless flow of information. And the other general category that is not directly involved here and that is a bill that I am the sponsor of of terminating birthright citizenship because that--

[Applause.]

MR. DEAL. --is part of the reason that many of these expenditures that you are talking about actually come about. The case of Maria is an example of just the lack of security at the border and you are put in a very delicate and difficult position, are you not, Mr. Gardner?

MR. GARDNER. Absolutely. And I think the challenge for healthcare folks--and you touched on it, Congressman Deal, is that this is not the business that we got into. It is about taking care of patients. And to have that very difficult choice of literally sometimes losing tens or hundreds of thousands of dollars, depending on what the case is trying to do the right thing versus the practicality of--for every $50,000 that the hospital loses, it translates into one full time job that has to be eliminated. And that is the balance that goes on every day.

MR. DEAL. Well, you alluded to some other things too, and that is the cost factor of those who present themselves in your emergency rooms and I think Mr. Stewart also alluded to the EMTALA law. I know Dr. Norwood and I have both been very conscious of the fact that we need to revisit that to try to give you some relief. We tried to build in some provisions in the Deficit Reduction Act that would give you some liability protections for making decisions to defer from your ERs to alternative sites. Unfortunately some of that language did not survive, but it is a constant concern.

The other thing is when you have someone who presents themselves in your hospital, whether it be through ER or in other methods of presentation, and they do not have any insurance and they do not have, or say they do not have the ability to pay out of their pocket for the cost of their care; am I not correct that what that does is it drives up the cost of care for other people, either those who have insurance, because you have to reflect that in the charges that you make, and insurance companies have to reflect that in their premiums, or it is reflected to the general population in some form or fashion for those who are fortunate enough to

get subsidized assistance for indigent care, and I know that not all of you have that ability to get that money. But does it not just shift this cost?

MR. GARDNER. You know, without question, there is actually an explicit tax, I would argue, on top of all insurance premiums, whatever the true cost of insurance would be, and I cannot estimate that exact premium to you. But you know, for instance if you just take a look at Northeast Georgia Medical Center, our bad debt this year is going to be approximately $30 million on a budget of about $400 million. So that has to come from somewhere, that $30 million is transferred somewhere else in the system in terms of increased rates. And in fairness to the insurance companies they have to be able to remain solvent also.

So ultimately it is passed back to those of us that have health insurance.

MR. DEAL. And it is a Catch 22 because as they pass those costs back, it raises the cost of insurance and, therefore, you have more people who cannot afford to buy that insurance and more who fall into the uninsured category.

MR. GARDNER. There is the dilemma.

MR. DEAL. One quick last question, and you may not have the information, but I would like to ask it. Do either of you hospital administrators have any information as to the number of children born in your facilities that were born to parents who are illegally in our country?

MR. STEWART. I do not know that we have that information available.

MR. GARDNER. We do not have that information available either. But I can tell you we did 4,200 deliveries last year and it is reflective of our community in terms of the numbers of individuals to various demographic factors of our community.

MR. DEAL. Thank you. Ms. Solis.

MS. SOLIS. Yes, I just wanted to make a brief comment. Mr. Gardner, you said that your individual that you pointed out, Maria, had six dialysis treatments totaling $9,500. That is about $1583 per treatment. But you also are saying that Medicare and Medicaid only pays to reimburse for $200 for treatment. So is Medicare underpaying the dialysis by $1300?

MR. GARDNER. I do not know that I can address that.

MS. SOLIS. Or are you overcharging the uninsured women then?

MR. GARDNER. No, this lady had a very--

MS. SOLIS. Thank you.

MR. GARDNER. --she had a very complicated stay within the ICU for about 8 days. Slightly more expensive than a dialysis treatment.

MS. SOLIS. Thank you. Mr. Michaels, I really appreciate the fact that you came and were very objective and honest about what your

services are. And with respect to the SCHIP program, I know in the State of California and many cases in other States, we turn back money, we have not really fully utilized and really done a good job as the State of Georgia has. So I commend the State of Georgia and obviously your work for doing that. Perhaps there is a way we could negotiate through the Congress so that States like yours that are actually on the increase because you have a higher number of uninsured that are now--

MR. MICHAELS. We would go for that.

MS. SOLIS. --we can work on that. That is something that I would agree with. I mean children need to be covered.

And I wanted to ask you what the costs are for a child that does not receive say prenatal healthcare and what additional costs would be assumed by the State if prenatal care were denied for children who were born here but parents were undocumented?

MR. MICHAELS. Yeah. Well, the cost of neonatal ICU is one of the most exorbitant in pediatrics and if you look at the private sector, HMOs, when they do not make money, one of the big reasons they do not is they had higher than anticipated neonatal ICU charges for that quarter. So the big risk with lack of prenatal care is complications that lead to prolonged ICU stays for newborns--extreme prematurity, you can have a baby born 25-26 weeks, that bill can probably be a million dollars, I do not know. You can tell me on that. Hundreds of thousands anyway for sure, because they can have lots of complications and need a ventilator for several months and they can have all kinds of surgical complications. So high risks of prematurity and other complications, you will have a higher mortality rate for newborns, higher stillbirth rate, and a lot higher expense due to intensive care costs.

MS. SOLIS. One other question I had was you talked about foster care and not being able to receive adequate information for immunization, basic things that should be made available. We heard earlier from the other panel that that was not the case, that they are able to get that information and they can collaborate. Could you please allude to me, am I getting something wrong here?

MR. MICHAELS. Well, I guess it is one of those things where there is probably some theoretical--I do not know all the details of what the caseworkers are doing when they do the intake, but all I can tell you from a practical standpoint, most of the time, every day--well, we see foster kids every day in our office and when we see a new foster child, I generally do not have any medical records at all at that visit. I generally do not have the immunization records, I generally do not have allergies, any of those things.

MS. SOLIS. Generally what would the time frame be for you to receive that information? Does it vary, is it more than a year?

MR. MICHAELS. It can really vary, because these kids--they are put in foster care here but they may have lived in south Georgia prior to that. We do have an immunization registry in Georgia, so that problem that we alluded to hopefully will be improving over time, but it is not fully in use by all parties yet.

MS. SOLIS. One of the other questions I had was regarding the EMTALA law and what would happen if there were restrictions on that. If, for example, women who were undocumented were removed from assistance, what would happen to the State of Georgia?

MR. MICHAELS. You are talking about pregnant women?

MS. SOLIS. Uh-huh.

MR. MICHAELS. If pregnant women came in and EMTALA had been relaxed and the hospital was not obliged to treat those women, you would have a lot of complications. You could have mortality, a woman could die of a ruptured placenta and just bleed and the baby and the mother could die, there could be infection and sepsis which are life-threatening for the baby and for the mother as well.

MS. SOLIS. Do you honestly believe that by taking away that service, that people are going to have less pregnancies?

MR. MICHAELS. No.

MS. SOLIS. One last question. With respect to your particular caseload of individuals, what would you say--when you get into a situation of providing service, do you have a rough estimate of what the legal and illegal are?

MR. MICHAELS. I really do not know because I do not ask, first of all. I do not think providers should be in the position of asking because that disrupts the trust of the medical home.

MS. SOLIS. How would you feel if you were, according to the Sensenbrenner Bill, held liable, there would be penalties against you for servicing undocumented? How would you--what kind of atmosphere would that place in your home setting or your hospital setting?

MR. MICHAELS. It would place us in terrible conflict, but I am confident that Congress will not do that to the providers.

MS. SOLIS. Okay, thank you. That concludes my questions.

[Applause.]

MR. DEAL. Dr. Norwood.

MR. NORWOOD. Thank you, Mr. Chairman.

Mr. Gardner, according to the United States Senate immigration bill, the Reid-Kennedy-McCain-Hagel Bill, we would increase the number of citizens in this country somewhere in the neighborhood of 66 million new people in the next 20 years. I think I know Georgia pretty well, we have got 159 counties, we have got rural hospitals in every county, sometimes maybe even two. What is that going to do to hospitals like

yours, either one of you, Mr. Stewart or Mr. Gardner, if we have that kind of influx of new people into the country over the next 20 years?

MR. GARDNER. Congressman, I think it is a bit of a complicated answer, but you know, undoubtedly the cost of healthcare is going to continue to go up. Right now, Northeast Georgia, we have the third busiest emergency room in the State of Georgia with about 105,000 visits per year. So if you just extrapolate, look at the population and how many folks are coming, it is just going to make an already unmanageable situation that much more difficult.

MR. NORWOOD. Well, the Rand study says most of these people will not have any type of healthcare insurance. So if you are in a position now that you are having to cost shift over because you are spending so many dollars, and you said what, a million a day?

MR. GARDNER. A million a day.

MR. NORWOOD. Something to that effect. What is going to happen when it goes to three million a day? At what point do you close?

MR. GARDNER. What I am concerned about right now is our uncompensated care and bad debt has gone from $20 million to $30 million in the last 4 years. That rate of growth is what is not sustainable. We have literally since 1984 given away in excess of a quarter billion dollars of free care at Northeast Georgia Healthcare System. We cannot do it.

MR. NORWOOD. Why do you not just cost shift that over to the Americans who have healthcare insurance, make us pay for it?

MR. GARDNER. Well, you know what the answer to that is, it is a Catch 22 because then fewer individuals continue to buy health insurance, the business community cannot pay for health insurance and we end up just exacerbating an already difficult problem.

MR. NORWOOD. Well, then, cost shift it over to Medicare, make them pay more.

MR. GARDNER. Well, Congressman, I think the answer to that is the DRA and there is no place to cost shift any more.

MR. NORWOOD. That is exactly my point I am trying to get to. We are at the end of the road shifting these costs over to other people.

[Applause.]

MR. NORWOOD. What is going to happen with this 66 million, maybe 100 million new patients that we are going to see in this country in regards to tuberculosis or meningitis or measles? The communicable diseases that we do a pretty good job of in this country, but not necessarily around the world, what is going to happen to you with those? Is that going to go up?

MR. GARDNER. I think it is fair to say--

MR. NORWOOD. Speculate, I know you cannot--

MR. GARDNER. I am a hospital administrator, I am not a physician, but the numbers and history would tell you that as the population increases, the incidence of disease goes up.

MR. NORWOOD. That is the point.

Well, one last thing. You do not know actually for sure how much uncompensated care you have to extend, do you, on illegal aliens? You do not know that number, do you?

MR. GARDNER. No, we sure do not.

MR. NORWOOD. Is that because you do not ask citizenship status? Just to put together the information.

MR. GARDNER. Frankly, we do not ask, it is a very uncomfortable situation for providers, just being honest with you.

MR. NORWOOD. You do not ask people to pay you, do you? Are you uncomfortable asking other people to pay you?

[Laughter.]

MR. NORWOOD. Now wait a minute, Doc, I know you do not, but I know the hospital does. Are you uncomfortable asking me to pay you if I come to your hospital?

MR. GARDNER. You would be surprised, but in our organization up until probably a couple of years ago, it was relatively lax in terms of requesting payment. As the situation has worsened, we have become more appropriately inquisitive about payment.

MR. NORWOOD. As they have all over the State, but that is not new. I have been in healthcare awhile too. Hospitals want their money, but you refuse to ask somebody if they are a citizen of this country or not? Because you know as well as I do sitting here, now you can laugh it off all you want to, but that is going to determine whether you get paid. It is going to determine whether that person pays you or whether Congressman Deal pays you. That is what that question is going to determine. Why do you guys not ask and why does the American Hospital Association find that so difficult when they are right on the money when they want me to pay them?

MR. GARDNER. You know, again, it is not why we went into healthcare in the first place. And having to act as an immigration traffic cop does not come comfortably to us. But the situation is such that that is unfortunately the world that we are probably going to live in, we are going to do what is required.

MR. NORWOOD. You are going to do that or close. And I have got 25 counties and I have got small rural hospitals all over the place that are going to shut down because of all this; because they cannot stand a million dollars a day. You happen to be big enough maybe you can offset it, but most of Georgia's rural hospitals simply cannot continue with this.

Let us talk just real quickly about birthright citizenship. To my knowledge, there is not one Nation, at least western nation, that allows birthright citizenship besides the United States. Now I noticed when that subject came up a minute ago, three or four people in this room were just adamantly against us doing away with that, just shaking their head all over the place. We have got to have birthright citizenship.

But the rest of the world is not doing that. I wonder why they are not doing that kind of thing? Mexico does not do that. Why do we not follow their lead? Why do we not do like they do? They do not allow you to be born in Mexico and immediately become a citizen. Why is it people from Mexico who come here want us to do the absolute opposite?

Last quick question. Doctor, how many Medicaid patients in your practice?

MR. MICHAELS. We have about 5,500.

MR. NORWOOD. What percent might that be?

MR. MICHAELS. About 75 percent of the folks we see are on Medicaid or SCHIP.

MR. NORWOOD. Do you have any idea in your practice how many of those Medicaid patients might be illegal aliens?

MR. MICHAELS. I do not know. You know, most of our Medicaid patients are young age, so most of them were born here in the United States, so by definition of the current situation, I think they are citizens.

MR. NORWOOD. So let me maybe phrase it another way. Do you know the percentage of those that might be parents of illegal aliens?

MR. MICHAELS. I have no idea.

MR. NORWOOD. Yeah, you are not interested in knowing?

MR. MICHAELS. Well, because the Hippocratic Oath that I took in medical school when I graduated said "Do no harm." And the medical home--

[Applause.]

MR. MICHAELS. --is a critical concept for me in my provision of care to patients and is based on a trusting relationship between the parents and provider.

MR. NORWOOD. I understand.

MR. MICHAELS. and if I ask them that question, the trust is totally eroded. They will not come back.

MR. NORWOOD. I understand. But the Hippocratic Oath says "Do no harm," and we are doing a tremendous harm to this country, to the medical system and the citizens of this Nation--

[Applause.]

MR. NORWOOD. --by not dealing with this upfront and being honest with ourselves and being honest with people who are crossing our borders illegally. We have to face this problem and deal with it.

Sorry, Mr. Chairman, I went over. Thank you very much.

MR. DEAL. Well, I want to thank this panel as well and this concludes this hearing. I think whether there is agreement or disagreement on the issues that have been discussed here, I think it does illustrate the difficulty that the issue of illegal immigration has created in our country and by the consequence of that, the difficulty of Congress arriving at a reasonable and fair solution to it.

We appreciate the testimony of all the witnesses. We thank the audience for your participation, and with that this field hearing is adjourned.

[Whereupon, at 12:55 p.m., the Committee was adjourned.]

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