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P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

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HIV

Mr. KENNEDY. Mr. President, just so we all know, after the amendment of the Senator is offered, I intend to offer an amendment in the second degree in behalf of myself and the majority leader. I would prefer to hear the full amendment, just until I have an opportunity to get it from staff that are in the back of the Chamber.

So I will object for that reason, and for no other, just so we could have the reading of the amendment.

The PRESIDING OFFICER. Objection is heard. The clerk will read the amendment.

The bill clerk read as follows:

At the appropriate place, add the following:

SECTION 1. ADMISSION TO THE UNITED STATES OF ALIENS INFECTED WITH THE AIDS VIRUS.

(a) Notwithstanding any other provision of law, regulations or directives concerning the exclusion of aliens on health related grounds, infection with HIV, the human immunodeficiency virus, shall constitute a communicable disease of public health significance for purposes of section 212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)(i)).

(b) REPORT REQUIRED.—The President shall submit a report by September 1, 1993 containing—

(1) an assessment of the anticipated costs of the admission to the United States of persons with HIV to public health care programs, including such costs as will be borne by States and municipalities, and private insurers and health care providers;

(2) an estimate of the number and origins of persons infected with HIV likely to seek entry into the United States before December 31, 2003;

(3) an assessment of the effectiveness of the Immigration and Nationality Act in preventing persons entering the United States likely to become a public charge, as well as the ability to enforce this Act with regard to persons infected with potentially costly health conditions including, but not limited to HIV;

(4) the cost implications of refugees entering or likely to enter the United States, who carry the HIV virus;

(5) A comparison of the anticipated public and private health care costs associated with aliens infected with HIV with the costs attributable to the entry of aliens suffering from other health conditions;

(c) HIV TESTING.—Except as otherwise provided in subsection (d) the Attorney General, in consultation with the Secretary of HHS, shall provide for the testing of aliens for infection with HIV in accordance with the policy in effect on January 1, 1993;

(d) WAIVER AUTHORITY.—Subsection (c) may be waived by the Attorney General, in consultation with the Secretary of HHS for non-immigrants who, except for the provisions of this act, would be admissible to the United States, and who seek admission for 30 days or less for the purpose of:

(1) attending educational or medical conferences;

(2) receiving medical treatment;

(3) visiting close family members;

(4) conducting temporary business activities; or

(5) visiting for pleasure (tourism);

and in addition such non-immigrants may be admitted without questions as to whether they are carriers of the HIV virus, at the discretion of the Attorney General.

(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of the Secretary of HHS to prescribe regulations, concerning communicable diseases of public health significance, other than infection with the human immunodeficiency virus in accordance with section 212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)(i)).

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

AMENDMENT NO. 38 TO AMENDMENT NO. 37

(Purpose: To provide that the current list of communicable diseases of public health significance remain in place for a 60-day period and to require that a careful review of potential costs to the United States health care system take place before any change in the list)

Mr. KENNEDY. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Massachusetts [Mr. KENNEDY] proposes an amendment numbered 38 to amendment No. 37.

Mr. NICKLES. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

In the amendment strike all after section and insert the following:

SEC. . CONDITIONS ON ANY REMOVAL OF HIV STATUS EXCLUSION.

(a) RETENTION OF EXCLUSION.—The current list of communicable diseases of public health significance as in effect on February 16, 1993, shall remain in effect for a period of at least 60 days after the date of enactment of this Act for purposes of section 212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)(i)).

(b) REPORT REQUIRED.—If the Secretary of Health and Human Services removes or alters the list described in subsection (a) after the expiration of the 60-day period described in that subsection, then the Secretary shall submit to Congress a report containing—

(1) an assessment of—

(A) the anticipated effect of such action on costs to United States public health care programs and entities, as well as to those operated by States and municipalities; and

(B) the anticipated costs to private insurers and health care providers of such action;

(2) any findings regarding current immigration law submitted by the Attorney General under subsection (c); and

(3) a comparison of the anticipated public and private health care costs associated with aliens infected with HIV with the costs attributable to the entry of aliens suffering from other health conditions.

(c) STUDY AND REPORT.—(1) The Attorney General shall conduct a study of the following:

(A) The effectiveness of current provisions of the Immigration and Nationality Act in guarding against entry into the United States of persons likely to become a public charge and in deporting, during a 5-year period after such entry, those immigrants who do become public charges.

(B) The ability of the Immigration and Naturalization Service to apply and enforce such Act with regard to immigrants infected with potentially costly health conditions including, but not limited to, HIV.

(2) The Attorney General shall submit to the President, the Secretary of Health and Human Services, and the Congress a report setting forth the findings of the study conducted under paragraph (1), and including such recommendations as the Attorney General determines may be necessary for revision of current immigration law to re that immigrants with costly health conditions who are likely to become public charges will be excluded.

Mr. NICKLES. Mr. President, the amendment that I offer today is on behalf of myself, Senator DOLE, Senator KASSEBAUM, Senator HELMS, Senator SHELBY, Senator GRAMM, Senator LOTT, Senator COATS, Senator MACK, Senator CRAIG, Senator BOND, and ator COVERDELL.

What this amendment would do would be to prohibit permanent immigration to the United States for persons infected with HIV. I think all of my colleagues are aware that President Clinton and his staff announced his intention to change the present policy which prohibits persons from entering this country permanently who are presently carrying the AIDS virus.

I think this change by President Clinton is a serious mistake. I think it is a serious mistake for several reasons. One is for the health implications. As I think all my colleag are aware, HIV is a deadly virus. I wish we had a cure for it. Under the bill we are considering right now, we are going to authorize and appropriate over $2 billion in research to try and find a cure for this very deadly disease, but we do not have a cure yet. As a matter of fact, it is not likely that we will for the next few years. I hope that we could have one tomorrow, but it is not there yet.

So if we change this policy and allow more people to come into the country that are HIV positive, if they do not change their social behavior, the disease will spread faster throughout the United States. It will infect a lot more people in this country. It will c lives and, Mr. President, the second part of this is that it will cost millions of dollars. This change in policy that is promoted by President Clinton is not only a decision that will cost lives, but it will cost hundreds of millions of dollars. It will overburden an already overburdened health care system, one that we are having a very difficult time affording today. We have heard different estimates of the cost of t ing someone that is HIV positive. I have quotes from some people who say it is $100,000. I have others who say it is $200,000. Some say those estimates are too low, and that the actual cost would even be higher.

I do know this: I know the cost in Medicaid is already exploding and that many of the people who have been coming into the country who are HIV tive would be Medicaid eligible and ultimately would be on Medicaid.

I have a chart that shows the recent charges for Medicaid and how rapidly it is growing. It is the fastest growing entitlement program, fastest growing program in Government today. aid last year grew at 29 percent, that is

$15.3 billion for 1992 alone. The year before it was 27.7 percent. The year before that 18.8 percent. So you can see that Medicaid costs are exploding, and this is without this new policy which, again, would just add to the growing medical crisis that we have.

I would like to compliment my colleague, Senator KASSEBAUM, who has worked with me on this amendment. Th e are several pieces of this amendment which are mine and there are several pieces which are Senator KASSEBAUM's. Also, I would like to thank Senator DOLE who helped make some constructive changes as well.

This amendment would do four things. One, it would codify the present provision in law, and I will just read it:

Notwithstanding any other provision in regulations or directives concerning the exc of aliens on health related grounds, infection with HIV, the human immunodeficiency virus, shall constitute a communicable disease of public health signif ce for purposes of section 212 of the Immigration and Nationality Act.

That is present practice. That has been the practice for several years.

tion B of the amendment was req ed by Senator KASSEBAUM, and I think makes eminent good sense, says the President shall submit a report by September 1, 1993, containing the assessments of cost and what the impact his proposal to lift the ban would be. I will allow Senator KASSEBAUM to make further statements on this as well.

Section C, HIV testing. We will continue to have testing for aliens coming into this country, as we do right now to test and find out whether or not they are HIV positive.

Section D would allow people to come into the country without testing if they are coming in temporarily. They can come in temporarily to attend an educational conference or medical conference, to receive medical treatment, to visit family members, to conduct temporary business or to even visit the country for tourism. But this would be a 30-day waiver and if they receive this waiver, they would not have to be tested for HIV.

But, Mr. President, what we would not do is allow people to come permanently into this country who are HIV positive, who may or may not continue their social behavior, which might spread the disease throughout the United States and also be a very significant financial drain and burden on an already burdened system.

This is a serious amendment. I have not had a chance really to analyze Senator KENNEDY's second-degree amendment. Earlier, we were negotiating on having a separate vote on both amendments. I hope that is exactly what we will have, an up-or-down vote on both amendments. I think that is important. If I understand Senator KENNEDY's amendment, it is basically a stay in change of policy, but then it would allow the Secretary and/or the President, I guess, to implement the change without any congressional action whatsoever. They would have a hearing, they would have some reports on costs, but it would still allow the Secretary, or the President through the Secretary to implement the change without congressional action. I think that would be a mistake. I think it would be costly both in the form of lives and costly in the form of dollars to an already overburdened system.

Mr. President, I yield the floor.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mrs. KASSEBAUM. Mr. President, 2 years ago when this issue was considered in the context of the upcoming World Conference on AIDS in Boston, the debate focused at that time largely on the issue of whether foreigners with AIDS would pose a public health risk to American citizens. Today, however, the chief issue has become cost, and I believe that it does need to be addressed.

AIDS is not spread by casual contact, through the air or from food, water or other objects. Thus, I believe it is important that we not simply support an AIDS ban out of fear, that entrance to the United States will pose an immediate contagious risk to Americans. I think this is very unfortunate if, indeed, in any way this is take in that context. An overwhelming majority of public health experts, including the Centers for Disease Control, the American Medical Association and the American Public Health Association stress that no such threat exists and that the current ban is not justifiable on public health grounds.

Mr. President, my concern lies in the area of potential financial costs to an already beleaguered American health care system. For example, people who I have talked to in Kansas tell me they cannot understand why we would allow immigration of highly expensive AIDS, and other health-related cases into this country, even as our own health care costs are exploding and one out of seven Americans has no health coverage at all.

Advocates of lifting the current AIDS exclusions claim that the likely financial cost of doing so will be acceptable and that current immigration laws already contain adequate protections against the entry of persons deemed "likely to become a public charge."

Mr. President, this may be true. Thus far, however, I do not believe the case has been adequately made. I am troubled, that there appears to be no documentation on whether or not existing immigration laws have in fact been working effectively to guard against entry of persons found likely to be "a public charge." Similarly, considering that a single AIDS case is currently estimated to cost about $102,000 over the lifetime of the patient, I think we deserve to know a lot more about how many AIDS-infected immigrants we are going to see in coming years if this ban is lifted. And again, I would wish to expand this inquiry to include immigrants who are entering the United States with other health-related concerns.

I believe the following key questions need to be examined more carefully before we move ahead with the lifting of the current immigration ban.

First, what are the estimates of the likely number and origin of persons infected with HIV who are likely to seek entry into the United States in the next few years?

Second, what exactly is the projected financial impact of such immigrants on cost to the U.S. public health care programs and to the health care system in general?

Third, how effective are our current immigration laws in screening out applicants likely to become "a public charge?" Are these laws working and are they adequately enforced?

Mr. President, I intend to support the amendment that has been offered by Senator NICKLES and others to require that the current AIDS exclusion remain in place pending legislative action to the contrary by Congress. I do so for two basic reasons.

First, as I have discussed, there are simply too many serious unanswered questions about potential cost to our health care system to permit lifting the AIDS immigration ban without further examination of the issue.

Second, I agree with the sponsors of this amendment that the issues involved with AIDS and immigration are too sensitive and too complex to prevent a lifting of the ban by regulation only as the opposition proposes.

This amendment offers what I believe to be a sensible alternative. We did try, and I appreciate the efforts of the chairman of the committee and others, to find a compromise. But this amendment I am cosponsoring would not in any way preclude the President from proposing at any time that the ban be lifted. All it would do is require that Congress consent to such an action through legislation.

The approach being advanced by the other side would provide for several months delay in which this issue would be studied, but after that time the Secretary would have full authority to lift the ban through regulation. Congress would not be consulted on the matter.

I would like to ask my colleagues this: If the troubling cost questions regarding AIDS and immigration are serious enough to warrant an act of Congress today to stop the President from moving forward, are they not also serious enough to justify requiring that Congress must act to approve the lifting of the ban several months from now?

The other side will argue that the list of health conditions on the immigration list should be a matter to be dealt with through regulation, not legislation. I appreciate this point, and I do agree that under normal circumstances matters such as disease exclusion lists for immigration are ones

that should be dealt with by the Secretary through regulation.

However, Mr. President, these are not normal circumstances and, tragically, AIDS is not just another disease. There is ample precedent for Congress to intervene in the executive regulatory process on issues of particular public importance, including the area of health policy. In fact, this very bill, as earlier NIH bills, includes a provision providing that any action by the Secretary of Health and Human Services to bar Federal funding for fetal tissue research must first be approved by a special ethics advisory board.

Also, let us not forget that the current AIDS exclusion exists in large part because of congressional action. In fact, the vote to add this exclusion passed the Senate in 1987 by a unanimous vote of 96 to zero. I hope and expect that if this amendment is passed, there will be renewed examination of the AIDS immigration question. If it can be shown that HIV-infected immigrants do not, in fact, pose a cost burden to the American health care system or if it can be demonstrated that there is a better way to handle our immigration policy in this area, I will be among the first to help seek an overturning of the current exclusion.

I am particularly pleased that the study includes an assessment of the effectiveness of the Immigration and Nationality Act in preventing persons who are likely to become a public charge. Additionally, a distinction is drawn between immigrants and refugees. The cost analysis of that study will be the cost implication of refugees entering, or likely to enter, the United States.

Mr. President, I believe as a result of this study we will gain a greater degree of information that will help us analyze this sensitive issue. Although a difficult question, I believe is one that must be answered to the satisfaction of the American public, and addressed by Congress in a responsible manner.

I yield the floor.

Mr. NICKLES. Mr. President.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. I wish to thank the Senator from Kansas for her statement and also for her leadership. As I mentioned before, the report required in a section of this amendment came from the Senator from Kansas and I think that is a very good addition to this amendment.

Also, Mr. President, I ask unanimous consent that Senator GRAMM, Senator THURMOND, and also Senator SMITH be added as cosponsors.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LOTT addressed the Chair.

The PRESIDING OFFICER. The Senator from Mississippi.

Mr. LOTT. I rise in support of the Nickles amendment, and I congratulate the Senator from Oklahoma for the work he has already done on this issue. He has a long list of cosponsors. He has been open to suggestions. I think that has been very helpful.

I also would like to express appreciation to the Senator from Kansas, Mrs. KASSEBAUM, for her work in coming up with this amendment.

I think this amendment, the Nickles amendment actually is too narrowly drawn. I would like it also to be applicable to other diseases that we have talked about in the past—gonorrhea, syphilis, other sexually communicable diseases.

But this one is narrowly aimed at the HIV and AIDS problem. So I am going to accept that. But I personally would like to see it broader.

I want to emphasize on a procedural point that I assume somewhere along the line there is going to be an agreement worked out where there can be a direct vote on the Nickles amendment, perhaps a direct vote on the Kennedy amendment. I do not think we should let this issue rest on a second-degree amendment which, in effect, wipes out the Nickles first-degree amendment. I had thought that agreement was being worked out and I hope that is going to happen. I think it is important that we have a direct, clear vote on the substance of the Nickles amendment.

Having said that, I would now like to address what is at stake.

This has been a very low-keyed debate so far. I think the people need to understand exactly what we are talking about this afternoon. President Clinton has indicated a policy or a change in policy that would allow immigrants to come into this country that are infected with the HIV virus. Let us make no mistake about it. Let us make it clear. We are talking about immigrants coming into the country with AIDS.

I think we need to think about that. When I was in my own State this past week, I had this subject raised more than any other subject, more than homosexuals in the military, more than the proposal to cut Social Security benefits, more than the proposal to tax Social Security benefits, more than the proposals to raise taxes on everyone down to people making only $30,000 a year. People would say, "Have you all lost your minds?"

First of all, most Americans think our immigration policy has gone askew. They wonder why we cannot control our borders, why do we have this flood of illegal aliens coming into the country. They also wonder why we have the flood of legal aliens that are coming into the country. They think that is out of control.

So they wonder about the laws on the books, and what the administrations—and I say that because it should include previous administrations—what are we thinking in not being able to control the flood of immigrants coming into this country? We have the Statue of Liberty. We also have the policy of letting people come into the country. But should we have some reasonable control? Absolutely. I think you will find that, if you ask people in this country, whether it is New York, Mississippi, California, or North Carolina.

Then you add to that. They ask me the question in Belzoni, or in Belmont, "Are you serious? You are talking about opening up the floodgates and allowing people to come in as immigrants with a problem, a disease that is sexually communicable?" They do not understand that. I do not understand it.

So I do not think we should study the problem, to address the costs—and they are significant—to address the question of health implications, and then let it go forward. I think we should put into law the policy that has been in place and then if the Congress wants to change that law, and answer their constituents, so be it. But to set up a system where we have a government study and then let it go forward, I do not believe the American people are going to accept that.

Mr. President, any time in this country when we have a threat to public health, big or even very small, this body and the appropriate Government institutions are responsible for taking steps to minimize or eliminate those threats—to take action. Recently, we had the tragedy involving food poisoning. It gripped the Nation. We saw little children sick and clinging to life—some dying. We took action. The appropriate Government agencies swung into action. They changed policy. They increased inspections. They moved in there to eliminate the threat. The Government responded immediately and appropriately to this tragedy.

Contrast that tragedy and that action to what we have proposed here by the President with regard to lifting immigration restrictions placed on people with AIDS. The proposed change in policy would increase the threat to the public, it would lead to the possible continued spread of a deadly communicable disease, and would burden the health care system in this country. There is no question that it has health care implications.

The President stated the other night directly that what we need more of in Washington is common sense. Certainly I agree with that. The current policy which excludes people who have a communicable disease, of public health significance, is the most commonsense policy I have ever heard. That is a policy we should keep in place. To reserve that sound policy would be a grave violation of not only common sense, but of our duty to protect the public.

So I strongly support the Nickles amendment which would codify the existing immigration policy.

Should we have a study, and understand exactly what the impact might be on health care or the cost which might be involved? Fine. Sure. That is good. Go ahead, have a study, but do not set up a process where it automatically goes into effect without Congress being involved in the results of that

study and without additional congressional action.

A similar amendment to this one passed in 1987 by a vote of 96 to 0. I believe that was the vote. Not one Senator voted against it. Not one Senator stood to say this policy did not make sense. I would argue that the Senate's vote on that occasion represented common sense, not the absence of it.

What would happen if we changed the current policy to allow immigration of those which are HIV positive? Would public health benefit? Clearly the answer is no. Would it pose a significant risk to public health? Yes; it would. Would it help contain the spread of a tragic and incurable disease? No. Would the U.S. health care system bear the burden of additional AIDS case costs? Clearly, yes.

The reasons for maintaining the current policy are clear. It is sound. It protects public health. It helps contain the spread of a tragic disease, and prevents a further burdening of the U.S. health care system.

My colleagues, you have already heard documentation in terms of the impact on our Medicaid system. Even the American Medical Association, the body that should be most knowledgeable and experienced in AIDS policy, supports the current policy which is reflected in the Nickles amendment.

So my colleagues, I am for a very calm, cool and rational debate, but I feel passionately about this. If we do not put this law in place we are going to wind up with a decision being made by the Secretary of HHS just to change it summarily. I think that would be a tragic mistake. The Senate needs to vote on this issue. I believe when the Senate votes on this issue the current policy will be maintained. I certainly hope that will be the result.

I yield the floor at this time, Mr. President.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, on the procedure, I want to indicate to the Senator from Oklahoma, and to the membership, that at this time, or at some time, the leadership will address the various interests of Members in terms of this issue.

So I am glad to work with the Senator from Oklahoma and others to ensure that we have an opportunity to address this in an appropriate way at an appropriate time.

There are Members interested in this issue on both sides. I think a number of them are wondering when we are going to come to grips with this particular amendment. We were hopeful this might have been the last amendment. I think we are pretty close to completion of the bill. We have been appreciative of those who wanted to offer this amendment, for working with us over the past 24 hours.

Mr. President, first of all, I want to mention very briefly exactly what our amendment does.

AMENDMENT NO. 38, AS MODIFIED

Mr. KENNEDY. Mr. President, it is in order for me to send a modification of my amendment?

The PRESIDING OFFICER. The Senator has a right to modify the amendment.

Mr. KENNEDY. Mr. President, I send a modification to the desk, and indicate it simply changes 60 days to 90 days.

The PRESIDING OFFICER. The amendment is so modified.

Mr. HELMS. Just a moment. I want to know what the modification is.

Mr. KENNEDY. The modification maintains the status quo for 90 days rather than 60 days.

Mr. HELMS. That is all it does, just the dates?

Mr. KENNEDY. That is all it does.

The PRESIDING OFFICER. The amendment is so modified.

The amendment (No. 38) as modified, is as follows:

(Purpose: To provide that the current list of communicable diseases of public health significance remain in place for a 90-day period and to require that a careful review of potential costs to the United States health care system take place before any change in the list)

In the Nickles amendment No. 37, strike all after "Section" and input:

STUDY OF THE COST IMPLICATIONS OF ALTERING THE PUBLIC HEALTH EXCLUSION LIST.

(a) RETENTION OF EXCLUSION.—The current list of communicable diseases of public health significance as in effect on February 17, 1993, shall remain in effect for a period of at least 90 days after the date of enactment of this Act for purposes of section 212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)(i)).

(b) REPORT REQUIRED.—If the Secretary of Health and Human Services alters the list described in subsection (a) after the expiration of the 90-day period described in that subsection, then the Secretary shall submit to Congress a report containing—

(1) an assessment of—

(A) the anticipated effect of such action on costs to United States public health care programs and entities, as well as to those operated by States and municipalities; and

(B) the anticipated costs to private insurers and health care providers of such action;

(2) any findings regarding current immigration law submitted by the Attorney General under subsection (c);

(3) a comparison of the anticipated health care costs associated with immigrants infected with HIV with the costs attributable to the entry of immigrants suffering from other serious health conditions which significantly impair the individual's ability to earn a living; and

(4) an estimate of the costs associated with retention of the list described in subsection (a).

(c) STUDY AND REPORT.—(1) The Attorney General shall conduct a study of the following:

(A) The effectiveness of current provisions of the Immigration and Nationality Act in guarding against entry into the United States of persons likely to become a public charge and in deporting, during a 5-year period after such entry, those immigrants who do become public charges.

(B) The ability of the Immigration and Naturalization Service to apply and enforce such Act with regard to immigrants infected with potentially costly health conditions including, but not limited to, HIV.

(2) The Attorney General shall submit to the President, the Secretary of Health and Human Services, and the Congress a report setting forth the findings of the study conducted under paragraph (1) and including such recommendations as the Attorney General determines may be necessary for revision of current immigration law to ensure that immigrants with costly health conditions who are likely to become public charges will be excluded.

Mr. KENNEDY. Mr. President, what this amendment does is ensure that the list of communicable diseases of public health significance currently in effect, shall remain in effect for at least 90 days after the enactment of the legislation—the passage of the NIH bill.

Further, this amendment directs the Secretary of HHS, if she decides to alter the list described after the 90-day period, to submit a report to the Congress which responds to the cost concerns that have been raised. If she intends to modify the list she will submit to the Congress an assessment of the anticipated effect of such action on the cost to the U.S. public health care programs and entities, as well as those operated by the States and municipalities. This will provide us with complete study by the Department of HHS of what the cost implications are going to be to our health care system. Second, the study will explore the anticipated cost to the private insurers and health care providers of any such action.

We have also included a comparison of the anticipated health care costs associated with immigrants infected with HIV and the costs attributable to immigrants suffering from other serious health conditions which significantly impair the individual's ability to earn a living.

We hear a good deal about costs. This is not just an HIV issue. We heard concern about the burden on the local health care systems. And we heard a little earlier about the burden on the Medicaid system.

You can pass the amendment of the Senator from Oklahoma, and it is not going to do much for the Medicaid system for reasons I will illustrate. No matter how many times that is stated here that the Nickles amendment addresses Medicaid costs, this is not true. As a matter of fact, if they had such concerns about all of the costs taking place out in local communities, why were we not talking about the costs of renal failure or cancer? We do not hear people talking about that. People with those conditions can come in here.

The immigration program involves the reunification of families.—That is what we are talking about, basically—how this exclusion separates families and denies asylum to true refugees. Those are the conditions we are talking about. We are talking about members of families. If they can have cancer, they may become a ward of the State. But that is OK, according to those supporting this amendment. Immigrants can have all kinds of other

diseases. Well, we do not care if they will burden our local public health service. No, no. But the supporters of the Nickles amendment say they are out here to protect the taxpayer.

That is hogwash. All of us know what is happening out here. It is a similar kind of effort we saw last week in terms of gay bashing. We understand that.

We have, over the period of time of recent years, tried to bring this issue, this scourge, HIV, this epidemic that is taking place in our society, out of the political boardrooms and into the public health science boardrooms, and we have made some progress at different times.

Remember Mrs. Ryan White, who sat up there in the gallery, whose son died of a bad blood transfusion. You found everybody in this Chamber very quiet at that moment. We said we will accept scientific information on that situation—because Ryan White died of AIDS, died of AIDS, that horrible disease, but as a result of a blood transfusion. She was sitting up there, and everybody was marching in and saying we can understand that. Science meant something then. Let us bring science into public policy, we said. And we made some progress on that.

Do you know what we did in 1990 in the Immigration Act? We said, let us make science and science policy the controlling and guiding factor in terms of excluding those individuals who have diseases that are going to pose a public health threat to American citizens. So we do so on tuberculosis. We do not permit even temporary visits of people with tuberculosis. We do not permit them to go to a science fair or a conference. We do not permit them to do the five things this amendment permits HIV people to do. Why? Because it is a public health service determination. That is what we should be interested in. If you or a member of your family have the danger of tuberculosis, you cannot come into the United States of America. At the time we passed the Immigration Act of 1990, we had a Republican President of the United States and a Republican Secretary of HHS, and we had a Republican Attorney General, and we said we will permit them to make the judgment of how to handle excludable diseases. But now the Senator from Oklahoma won't have it. We were prepared in 1990 to give a Republican President the same kind of authority they want to take away from our President. Why? Why do they want to do that? They had their own Secretary of HHS that had made the request on a sound scientific basis that HIV be removed from the list. A Republican appointee that said that this should not be on the list.

Now we say it was OK for one President to handle this issue, but, by God, we are not going to allow this new President to do it. We are not going to give him the same kind of authority we gave President Bush. We want to take that away.

There have been legitimate questions raised in terms of the impact on costs to local communities. It is interesting that after we hear the supporters of the Nickles amendment speak and we imagine that thousands of people will be coming in with AIDS. But medical tests found only 450 2 years ago; of the 700,000 immigrants, there were 450 of them with HIV and they were excluded. You have to take a blood test to immigrate to the United States. There were 450 who failed 2 years ago, and 600 last year. One-tenth of 1 percent.

But what the supporters of the Nickles amendment are saying—and we all know what they are saying here today—is you have 268 black Haitians in Guantanamo Bay, 40 children and 2 have HIV, and 20 pregnant women. Many of them have been found to be in incredible fear of persecution or death if they go back to Haiti. The proponents of this amendment say, "Send them back. Send them back. We do not care."

It does not make much difference that somebody has HIV and come in here for 4 weeks and attends a conference and has not received any AIDS education. What kind of threat do they pose to the public health? They are not concerned about that. But send that black person back from Guantanamo Bay, even if she is pregnant. Let us get rid of this problem and not try to deal with something that is as important as this on the basis of science. Oh, no. Why, it is going to run up our Medicaid, Medicaid, Medicaid. All those poor people, many of them black, all those poor, sick people, let us get rid of them. Mr. President, we have heard it all on this floor. At least I have.

A point that is so interesting is that none of our friends on that side of the aisle point out when it comes to cost is that the Attorney General has the authority and power under the 1990 Immigration Act to make a determination that they are going to be a burden on the locality or the community or their State. And the Attorney General can send them back if they become public charges within the first 5 years. They never mentioned that. That point was never mentioned over there. The Attorney General has the authority and the responsibility and, under risk of not having conformed with the law, if he does not apply the public charge provisions. He has to do that. Has to do it. That is in the law at the present time. And he should conform and meet that responsibility if someone is going to be a public charge.

So, Mr. President, we have tried over a period of time to deal with this issue. We know that it is an issue which is of enormous concern to all Americans, as it should be. HIV is relatively new in our immigration history but we know a good deal about it. We are finding out more.

All you have to do is read the history of this country, and you find out that a number of years ago you could not work alongside a person that had cancer, because it was thought to be communicable. I doubt if there is a letter of the alphabet that is more terrifying than the letter C—cancer—for all Americans. Then we found out that it is not communicable in those ways. So what did we do? We adopted a scientific Public Health Service position on it.

The answer in this area, Mr. President, is what we have talked about before: education and other kinds of activity, to limit the spread of this disease. Education, communication, understanding, awareness is what we really need.

We had, not many years ago, epilepsy on the exclusion list. Regarding people that were epileptic, it was said, let us get them out. Basically, we did not understand them. They did not look good to us. We faced that same issue on the Americans With Disabilities Act, when people that owned restaurants said "keep the epileptics out. They have epilepsy and they scare our patrons, scare away our business." Well, we made progress on that issue. Why?

We have looked extensively at the public health aspects of it. We examined it, and thank God, we brought some rationality to it. On HIV issues we ought to deal in ways, Mr. President, that include Republicans and Democrats alike. This is how we have always preferred to proceed.

We have the former Dr. James Mason, who served under the Republican administration as the Assistant Secretary of Health, who has wholeheartedly supported our position. I have his statements, and I will include them at the appropriate place in the RECORD.

I see others want to speak.

We have Dr. James Todd of the AMA. It is interesting to hear Senator NICKLES speak about where the AMA stands on this issue. I have a letter from Dr. Todd, President of the American Medical Association, that is dated February 12, also in support of our position.

Mr. President, I ask unanimous consent to have this letter printed in the RECORD, along with other letters from a whole series of public health experts.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the U.S. Department of Health & Human Services, Washington, DC, Jan. 1991]

NEWS RELEASE

(By Don Berreth)

The Department of Health & Human Services today proposed that starting June infectious tuberculosis would be the only communicable disease which would exclude foreign visitors, workers, refugees and immigrants.

The Immigration Act of 1990 eliminated the category of "dangerous contagious" diseases that have been listed as bars to travel and immigration. The act instructed the HHS secretary to develop a new list of "communicable diseases of public health significance" based on medical and scientific considerations alone.

The medical experts consulted agreed that infectious tuberculosis should be on the

but that the other seven conditions—leprosy and six sexually transmitted diseases, including HIV infection—should not be considered as medical reasons for barring people under the new law. A formal proposal reflecting that view was published in the Jan. 23 Federal Register for public comment.

A medical examination with chest x-ray would continue to be required for adult immigrants. Other requirements will remain in effect to ensure that immigrants or foreign workers in the United States have the financial resources or responsible sponsors so they do not become medical or welfare dependents.

Under the law, drug abusers and addicts and people who are likely to cause harm because of a history of such behavior associated with mental health conditions would be excluded. Regulations governing such aliens will be announced later.

Under existing regulations, the list of dangerous contagious diseases includes five sexually transmitted diseases—infectious syphilis, gonorrhea, granuloma inguinale, lymphogranuloma venereum and chancroid. HIV was added at the end of 1987 by Con- Infectious leprosy and active tuberculosis round out the current list of eight.

The Centers for Disease Control, an agency of the Public Health Service within the Department of Health and Human Services, reviewed diseases in consultation with non-federal experts in infectious disease and public health and concluded that, from a public health standpoint, sexually transmitted diseases, including HIV infection, should not be on the list of excludable conditions.

HHS Assistant Secretary for Health James O. Mason, M.D., who heads the Public Health Service, endorsed the CDC's conclusions and forwarded them to HHS Secretary Louis W. Sullivan, M.D., who concurred. Dr. Sullivan said, "AIDS evokes an emotional response from many—and that's understandable—but we have been virtually the only major country to try to bar HIV-infected travelers. This policy will bring us in line with the best medical thinking, here and abroad."

In reaching their conclusions using the "communicable disease" definition of the new law, the medical experts agreed:

Sexually transmitted diseases, including HIV infection, are not spread by casual contact, through the air, or from food, water or other objects, nor will an infected person in a common public setting place another indivi l inadvertently or unwillingly at risk.

HIV infection is transmitted among adults in this country almost exclusively by two routes: sexual intercourse with an infected person, and sharing of contaminated injec- equipment by injection drug users. The risk of (or protection from) HIV infection c not from the nationality of the infected person, but from the specific behaviors that are practiced. The best defense against further spread of HIV infection, whether from a U.S. citizen or alien, is an educated population.

Leprosy (Hansen's disease) is spread only through prolonged contact with an infected person. Most imported cases occur in persons who do not manifest outward signs of the disease when they are medically screened abroad. Effective drugs are now available for treating this disease and suppressing its infectiousness. In recent years, management of patients with Hansen's disease has substantially changed from isolation from society to i latory treatment. There is a nationwide system in the United States to provide comprehensive care and treatment to per- i diagnosed with Hansen's disease.

Infectious tuberculosis is proposed for inclusion on the list because the disease can be transmitted through the air, and an infectious person places others at risk through casual contact. The tuberculosis bacillus is carried in airborne particles that can be generated when persons with pulmonary or laryngeal tuberculosis sneeze, cough, speak or sing. The disease can be spread by normal air currents in a room, building or airplane.

The CDC and the non-federal experts were also asked if there should be any other communicable diseases on a list of excludable conditions, and they agreed that no other diseases should be added. However, the Public Health Service, through the World Health Organization, maintains worldwide surveillance of communicable diseases and will add diseases to the list when necessary.

The comment period will close Feb. 22, 1991. Comments should be addressed to: Director, Division of Quarantine, Center for Prevention Services, Centers for Disease Control, Mail Stop E03, Atlanta, Ga. 30333.

DEPARTMENT OF HEALTH & HUMAN SERVICES, PUBLIC HEALTH SERVICE,

Washington, DC, March 14, 1990.

To: The Secretary.
From: Assistant Secretary for Health.
Subject: CDC Proposed Rule, 42 CFR Part 34, Medical Examination of Aliens—ACTION.

BACKGROUND

The Immigration and Nationality Act sets out medical grounds for exclusion of aliens; among these are the occurrence of a dangerous contagious disease. The Secretary of Health and Human Services normally specifies the particular diseases by regulation. Dangerous contagious diseases currently are defined as chancroid, gonorrhea, granuloma inguinale, human immunodeficieny virus (HIV) infection, lymphogranuloma venereum, infectious syphilis, infectious leprosy, and active tuberculosis. All except HIV infection were established by regulations promulgated by the Secretary. HIV infection was added to the regulations as required by section 518 of Public Law 100-71, the Supplemental Appropriations Act of 1987.

PROVISIONS OF PROPOSED REGULATIONS

This Notice of Proposed Rulemaking would modify 42 CFR Part 34.2(b), Medical Examination of Aliens, by deleting six of the eight currently listed diseases: chancroid; gonorrhea; granuloma inguinale; lymphogranuloma venereum; syphilis, infectious stage; and infectious leprosy. Aliens with these diseases can no longer be considered a public health threat to the United States. The proposal also changes "tuberculosis, active" to "infectious tuberculosis." Additionally, technical and conforming corrections are proposed in Section 34.4.

The sexually transmitted diseases proposed for deletion are not transmitted by casual contact, through the air, or from common vehicles (such as fomites, food, or water), nor will an infected person in a common or public setting place another individual inadvertently or unwillingly at risk. Rather, these diseases are primarily spread through voluntary exposure. Because HIV infection was added to the list of dangerous contagious diseases as mandated by Congress, we do not propose to delete it from the list in this NPRM. We are submitting a legislative proposal to repeal this provision so that we can delete HIV infection from the list as well.

Leprosy (Hansen's disease) is not highly contagious; the disease is spread through prolonged contact with an infected individual. The majority of imported cases occur in persons who do not manifest outward signs of the disease when they are medically screened abroad, but develop active disease after arriving in this country. Effective drugs are now available for treating this disease and for suppressing its infectiousness. In recent years, management of patients with Hansen's disease has substantially changed from isolation from society to ambulatory treatment. There is a nationwide system in the United States to provide comprehensive care and treatment for persons diagnosed with Hansen's disease.

We do propose to leave tuberculosis on the list. Unlike the other diseases on the list, tuberculosis can be transmitted through the air, and an infectious person can place others at risk through casual contact. Those found to have infectious tuberculosis should receive treatment until they are no longer infectious before they are allowed to travel to the United States. At that point, existing public health programs are capable of managing the relatively few who will require further treatment after arrival. We propose to change the term "tuberculosis, active" to "infectious tuberculosis" to correspond with modern medical terminology.

The proposal has been discussed with representatives of the American Medical Association (AMA), the American Public Health Association, a former Assistant Secretary for Health, the Association of State and Territorial Health Officials, CDC's Advisory Committee on the Elimination of Tuberculosis, CDC's Advisory Committee for the Prevention of HIV Infection, the Council of State and Territorial Epidemiologists, the Department of Defense, the National Association of County Health Officials, the National Commission on Acquired Immune Deficiency Syndrome, the National Medical Association, and the U.S. Conference of Local Health Officers.

All of those consulted have supported deleting from the list of dangerous contagious diseases chancroid, gonorrhea, granuloma inguinale, HIV infection, infectious leprosy, lymphogranuloma venereum, and infectious syphilis. All have supported the retention of infectious (or active) tuberculosis. The AMA favors HIV testing and counseling of immigrants as an important part of their medical record, but does not necessarily favor exclusion of those found positive.

REGULATORY FLEXIBILITY ANALYSIS

This proposed revision will not impact significantly on small entities; therefore, preparation of a regulatory flexibility analysis under the Regulatory Flexibility Act, Public Law 96-354, is not required.

REPORTING/RECORDKEEPING REQUIREMENTS

The proposed modifications under this part do not contain information collections which are subject to review by the Office of Management and Budget under section 3504(h) of the Paperwork Reduction Act of 1980.

CONSEQUENCES OF DISAPPROVAL

Disapproval may open the Department to criticism for failing to recognize that there is no public health value in continued screening for these medical conditions.

EXPECTATIONS

We anticipate objections to this NPRM by some who may consider that the importation of even one case of these diseases should not be allowed.

URGENCY

Due to the increasing concern of the public health community worldwide about our outdated policy for screening for these diseases, this NPRM should be published as soon as possible.

PRESS RELEASE

A press announcement will be developed.

RECOMMENDATION

I recommend that you sign the attached NPRM for publication in the Federal Register.

JAMES O. MASON, M.D., Dr.P.H.

ORGANIZATIONS SUPPORTING THE SECRETARY OF HHS'S AUTHORITY TO DETERMINE THE LIST OF COMMUNICABLE DISEASES OF PUBLIC HEALTH SIGNIFICANCE

AMERICAN MEDICAL ASSOCIATION
Chicago, IL, February 15, 1993.

Hon. EDWARD M. KENNEDY,
U.S. Senate, Washington, DC.

Re: HIV and Immigration.

DEAR SENATOR KENNEDY: The issue of HIV and immigration is once again before the Congress and the Administration. The purpose of this letter is to offer you the American Medical Association's current views.

The Association consistently has supported the authority of the Public Health Service (PHS) to determine which diseases should trigger exclusion of foreign nationals. Federal law requires the PHS to base this determination on current epidemiological concepts and medical diagnostic standards.

The 1990 immigration reform law provides the federal authority for excluding those individuals likely to become public charges. Any medical condition serious enough to interfere with employment or that could result in burdensome medical expenses could trigger this type of exclusion. With proper enforcement, this provision addresses our concerns about HIV-infected foreign nationals seeking to immigrate.

Sincerely,

JAMES S. TODD, MD.
Executive Vice President.

MIGRATION AND REFUGEE SERVICES,
NATIONAL OFFICE,
Washington, DC, February 16, 1993.

DEAR SENATOR: On behalf of several national organizations interested in immigration and refugee policy, I am sending the enclosed letter to express our strong support for removing HIV-infection from the list of diseases upon which individuals may be excluded from entering the United States.

We ask for your support in defeating any amendment that would overturn or interfere with the Department of Health and Human Service's authority to make this decision.

Thank you for your attention to this urgent issue.

Sincerely,

FR. RICHARD RYSCAVAGE, S.J.,
Executive Director.

Enclosure.

FEBRUARY 16, 1993.

Hon. EDWARD M. KENNEDY,
U.S. Senate, Washington, DC.

DEAR SENATOR KENNEDY: We, the undersigned organizations, express our support for removing HIV-infection from the list of diseases upon which persons may be excluded from traveling to, immigrating to, or seeking refuge in the U.S. We understand that an effort may be made on the Senate floor to legislate a travel ban for HIV positive visitors, immigrants or refugees. We strongly oppose this effort. We urge you to vote against any amendment that would overturn or otherwise interfere with the Department of Health and Human Service's authority to make this decision based on current epidemiological principles and medical standards.

Two reasons are generally advanced for placing HIV-infection on the list of diseases warranting automatic exclusion from the U.S. First, is the communicable nature of the disease. The 101st Congress, through enactment of the Immigration Act of 1990, appropriately placed all questions related to health-related exclusions in the hands of federal health professionals. We concur with Congress' decision that technical health policy issues should be left to public health officials, and we agree with the Public Health Service that otherwise eligible applicants should not be denied immigration status solely because they are HIV-positive.

A second reason generally advanced is the unwarranted perception that HIV-positive immigrants will become a public charge because of the expense associated with treating this condition. In actuality, these economic concerns are already addressed in existing law. Under current law, all foreign visitors and immigrants must meet financial eligibility criteria. Anyone who does not is precluded from visiting or immigrating to the U.S.

We believe that current U.S. law adequately addresses both the medical and economic concerns on HIV-positive immigrants, and we strongly oppose efforts to make major changes in immigration and refugee law based on prejudice or ignorance. We urge you to support the Department of Health and Human Services on this important issue.

Sincerely,

American Council for Nationalities Service, Church World Service, American Immigration Lawyers Association, Ethiopian Community Development Council, Indochinese Resource Action Center, The Tolstoy Foundation, U.S. Committee for Refugees, Lutheran Immigration Refugee Service, United States Catholic Conference Migration and Refugee Services.

[From the National Commission on Acquired Immune Deficiency Syndrome, Washington, DC]

STATEMENT ON IMMIGRATION POLICY

The National Commission on AIDS commends the Administration's preliminary decision to remove HIV infection from the list of conditions which constitute grounds for excluding an individual from traveling or immigrating to the United States.

The U.S. Congress reaffirmed under the Immigration Act of 1990 (P.L. 101-649) that public health judgments on these issues are appropriately placed in the hands of the Secretary of Health and Human Services, hence, there is no need of further congressional action in this matter. Under the Act, Congress directed the Secretary to look to "current epidemiological principles and medical standards" in assessing the need to exclude immigrant applicants on the basis of illness or medical condition. Accordingly, the Public Health Service reexamined the list of diseases to be used for the purposes of exclusion. Of the eight diseases on the list, the Public Health Service determined that only infectious tuberculosis should be retained as it alone was transmissible through the air and by casual contact, and therefore a threat to the public health. The Commission urges that any proposed or final rule realign U.S. immigration policy with sound public health principles.

Under the Immigration Act of 1990, the Congress also reaffirmed the appropriateness of placing determinations related to economic burden in the hands of the Attorney General. It has been argued by some that HIV-infected individuals should be barred from immigration into the United States on the basis of the financial cost they will pose to the nation. It is a fact that immigration applicants who are HIV positive, like every other applicant, will be obliged to satisfy all other immigration requirements, including financial requirements. Public charge provisions of the Immigration and Nationality Act require all applicants for immigrant and non-immigrant visas to demonstrate that they are not likely to become public charges. Anyone who does not do so is denied a visa and precluded from either visiting or immigrating to the United States. This is based on a "totality of circumstances" test which considers an applicant's health, financial resources, and their ability to earn a living in the future. As an added safeguard, the regulations provide that an alien who becomes a public charge within five years of entry be deported. Elimination of the exclusion based on HIV infection will in no way lessen these restrictions on individuals who wish to immigrate to the United States.

The Commission voices its deep distress over the encroachment, once again, of extraneous issues into a decision that should be science-based and focused solely on public health concerns. We must not allow arguments based on politics, misinformation, fear or discrimination to triumph. To do so is to betray the heart and integrity of the federal government's role in protecting and advancing the health of all its people. The desire of President Clinton and Secretary of Health and Human Services Shalala to base public health policy on sound science is unequivocally supported by the National Commission on AIDS.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS,
Washington, DC, February 12, 1993.

President WILLIAM J. CLINTON,
Pennsylvania Ave., NW.,
Washington, DC.

DEAR PRESIDENT CLINTON: I am writing on behalf of the Association of State and Territorial Health Officials (ASTHO), which represents the chief health officers of the 50 states, the District of Columbia and the U.S. territories, to express our strongest support for lifting the ban on HIV infected individuals seeking entry into the U.S.

Because HIV infection is not spread by casual contact and immigration of infected individuals does not pose a direct threat to the health or safety of the population, ASTHO continues to support removal of HIV infection from the list of communicable diseases of public health significance upon which U.S. travel and immigration can be denied. The public health and scientific community has overwhelmingly and repeatedly stressed the fact that restriction of immigration will neither protect the health of the American public, nor will it prevent or control the HIV epidemic. We urge you to use your action of lifting the immigration ban as an opportunity to truly educate the American public about the facts of HIV transmission.

In addition, ASTHO firmly believes that removing travel and immigration exclusions for HIV infected individuals is not principally an economic issue, as some are contending. Because the Immigration and Nationality Act continues to exclude persons who "are likely at any time to become public charges," concerns about HIV-infected persons immigrating and becoming wards of the state, are grossly exaggerated.

We applaud you for taking this strong stand based on science and we look forward to moving forward with the new Administration to address the real HIV prevention and treatment needs of individuals affected by this devastating epidemic.

Sincerely,

GEORGE K. DEGNON,
Executive Vice President.

AMERICAN PUBLIC HEALTH ASSOCIATION,
Washington, DC, February 11, 1993.

DEAR SENATOR KENNEDY: The American Public Health Association (APHA), the world's oldest and largest association of public health professionals, supports the Clinton Administration's decision to end the immigration policy which bars HIV-infected persons from entering the United States.

AFHA opposes the current immigration policy barring persons with communicable diseases (including syphilis, leprosy, gonorrhea, and HIV infection) from the United States in the absence of scientific evidence that such measures will protect the public's health. When such measures are likely to be protective, based on known mechanisms for disease transmission, we certainly support them. For example, we concur with Secretary Donna Shalala's decision to keep active tuberculosis on the list of excludable communicable diseases.

We cannot afford to send mixed messages about such a serious disease as HIV infection. The public is not at risk of HIV from c al contact with individuals with HIV infection or AIDS. As physicians and scientists concerned with the health of Americans, we must say so. Failure to change the immigration policy would do serious harm to the credibility and confidence we have all struggled to maintain during the HIV epidemic. It would especially erode confidence in the integrity of the U.S. Public Health Service. We can ill afford to cater to fear and discrimination.

We urge you to support this important public health policy.

Very truly yours,

WILLIAM H. MCBEATH, MD, MPH,
Executive Director.

AMERICAN BAR ASSOCIATION,
Washington, DC, February 12, 1993.

DEAR SENATOR: We understand that an amendment might be offered to S.1, the National Institutes of Health Revitalization Act of 1993, which would require the President to retain a travel ban on persons with the HIV virus. The American Bar Association opposes legislation that would require the President to exclude all HIV-infected travelers, refugees and immigrants from entering the United States.

In the Immigration Act of 1990, Congress directed the Secretary of Health and Human Services (HHS) to promulgate a new list of excludable "communicable diseases of public health significance." 8 U.S.C. §1182(a)(1)(A)(i), based solely on "current epidemiologic principles and medical standards." In so doing, Congress appropriately delegated responsibility for this health decision to the health experts, rather than the political branches. The national and international public health authorities, including former Secretary of Health and Human Services Dr. Louis Sullivan, concur that removing HIV from the list of diseases upon which persons may be barred from entering the U.S. will not endanger public health.

Moreover, the Immigration Act imposes numerous criteria that an individual must satisfy in order to be admitted to the United States. One of them requires that the applicant demonstrate that he or she is not "likely at any time to become a public charge." 8 U.S.C. §1182(a)(4).

Eliminating the HIV exclusion does not mean that any individual with HIV can enter the United States. It only means that a person who otherwise qualifies under the law will not be prevented entry solely on account of his or her HIV status.

The American Bar Association supports the Public Health Services's reconsideration of the current HIV bar and urges you to vote against any measure that would force the President to retain the current ban.

Sincerely,

ROBERT D. EVANS.

NATIONAL ORGANIZATIONS RESPONDING TO AIDS,
Washington, DC, February 16, 1993.

Senator EDWARD KENNEDY,
U.S. Senate, Washington, DC.

DEAR SENATOR KENNEDY: The undersigned members of the coalition National Organizations Responding to AIDS (NORA) write to support the action by the Department of Health and Human Services to lift the ban on HIV infected individuals seeking entry into the United States.

Virtually every public health organization in the U.S. and all public health officials including the former Secretary for Health and Human Services, Dr. Louis Sullivan, have stated that HIV infection should be removed from the list of communicable diseases of public health significance used to exclude aliens whose presence would threaten the public health.

As you may recall, as part of the Immigration Act of 1990 Congress charged the Public Health Service with determining the list of excludable diseases based on standard public health principles. Congress acted correctly in delegating responsibility for public health decisions to the chief public health authorities in our nation.

In the Immigration Act of 1990, Congress also affirmed that economic concerns are to be addressed through the Attorney General. All foreign visitors and immigrants must meet financial eligibility criteria to enter the United States. Under current law, immigrants and non-immigrants are subject to exclusion if they are "likely at any time to become a public charge." To determine public charge the INS looks at the aliens' physical and mental condition, as well as ability to earn a living and support themselves. An individual who becomes a "pubic charge" within five years of entry risks deportation.

Therefore, the economic impact of immigration policy is addressed by the public charge provision. Any decisions regarding public health are properly determined by the Public Health Service. We urge you to resist any attempt to direct specific actions that run counter to public health principles.

We support the President's desire to realign our immigration policy with sound public health and urge you to support the Public Health Service in lifting the ban on HIV infected individuals entering the United States for immigration purposes.

Sincerely,

AIDS Action Council.
AIDS National Interfaith Network.
American Civil Liberties Union.
American Foundation for AIDS Research.
American Friends Service Committee.
American Medical Student Association.
American Public Health Association.
Association of Schools of Public Health.
Association of State and Territorial Health Officials.
Broadway Cares/Equity Fights AIDS.
Center for Women Policy Studies.
Coalition for the Homeless.
Council of Jewish Federations.
Human Rights Campaign Fund.
Legal Action Center.
National Alliance of State and Territorial AIDS Directors.
National Association of Protection and Advocacy Systems.
National Association of Public Hospitals.
National Association of Social Workers.
National Catholic AIDS Network.
National Community AIDS Partnership.
National Education Association's Health Information Network.
National Healthcare for the Homeless Council.
National Hospice Organization.
National Native American AIDS Prevention Center.
National Puerto Rican Coalition.
National Women's Health Network.
Sex Information and Education Council of the U.S.
Therapeutic Communities of America.
UJA—Federation of Jewish Philanthropies of New York.

FEBRUARY 8, 1993.

President BILL CLINTON,
The White House, Washington, DC.

DEAR PRESIDENT CLINTON: The undersigned organizations represent a broad spectrum of public health organizations, HIV service providers, immigrant and refugee service providers, religious organizations, gay, lesbian and AIDS activist organizations, women's organizations and other national organizations. We commend your commitment to end the current exclusion and mandatory testing of immigrants and travelers with HIV and urge you to include this policy change as a priority for the first 100 days of your Administration by directing the Department of Health and Human Services to adopt as a final regulation the rule proposed in January 1991 that would establish the list of communicable diseases of public health significance. 56 Fed. Reg. 2484. It has been two years since this regulation was first proposed by then-Secretary of Health and Human Services Louis Sullivan, implementing the Congressional intent in enacting the Immigration Act of 1990 to revise the immigration exclusion list. There is no sound public health rationale to continue to delay the adoption of the January 1991 proposed regulation removing HIV and other diseases from the current exclusion list and ending the mandatory HIV testing of immigrants and refugees.

As direct service providers to persons subject to the HIV immigration exclusion, we can attest to the adverse consequences of this inhumane policy and the enormous hardship it imposes on our clients. For example, there are some applicants for legalization under the Immigration Reform and Control Act of 1986 that are still waiting for decisions on their waivers of exclusion, over five years after their applications were first submitted. All of these persons have resided in the United States for over ten years, have worked and paid taxes during that time, supporting themselves and their families and continuing to make economic and social contributions to their communities.

There are also many others who still remain ineligible to obtain lawful permanent residence solely because of their HIV status. Moreover, there is no monitoring of the accuracy or reliability of the mandatory HIV tests performed for immigrant purposes and no accountability for the lack of pre- and post-test counseling. Rather than providing any positive health education value, the exclusion policy has hindered our prevention education efforts in the immigrant and refugee communities by creating fear, mistrust and misunderstanding an prompting many seropositive immigrants to go underground.

The following experiences of individuals affected by the exclusion policy poignantly illustrate its detrimental and counterproductive results (names used are pseudonyms):

José Ramos tested seropositive, but because he also had a severe skin rash, his civil surgeon who had never before counseled a seropositive person misdiagnosed him as having AIDS. José was extremely distraught and was fired from his job when his employer found out about the diagnosis. With no money and no place to live, he turned himself in to the Immigration and Naturalization Service so that they could send him back to his country. After an unsuccessful suicide attempt, he eventually obtained as-

sistance of an advocate, who located appropriate referrals for his emotional, financial, health, legal and social service needs and who accompanied him to the hospital, where it was learned that he did not in fact have AIDS.

Tomás Santos was astounded that the civil surgeon who was administering his medical exam for his legalization application had charged him excessively, so he sought advice from a community agency. The paralegal opened the sealed envelope containing the report of the exam to determine the anomaly and discovered that he had tested seropositive. She asked Tomás if he knew about AIDS. "I have heard about it," he responded, somewhat unsure of himself. She then asked whether the doctor had told him anything about his health, and he responded that the doctor had mentioned that he had a virus, adding, "I know I have a virus. I had a cold last week."

Marie Auguste is a Haitian national who came to the U.S. in 1973. She worked to buy a home where she continues to reside. She married a U.S. citizen, but the marriage ended when she discovered that her husband was unfaithful and had infected her with HIV. She applied for temporary residence but was denied. Her frustration with the government's continued apathy towards her tragic situation has led her to depression. She has repeatedly told the agency that is assisting her that she does not understand what she has done that is so bad that the government must punish her so, when she has been a contributing, upstanding, taxpaying member of American society for 18 years.

A U.S. citizen woman is petitioning for her HIV positive husband who is currently residing in Spain. The U.S. consulate in Spain has informed them of their right to apply for a waiver, but has warned them that there is a very high probability that they will deny it. Minimally, the couple faces months of separation waiting for the consulate to adjudicate the waiver, and they are threatened with indefinite separation. When she was informed that you have stated that as President, you will lift the exclusion of HIV positive immigrants, she cried and said, "I have been waiting for someone to tell me that for a long time. That's the best piece of news I have heard in awhile. At least now I have some hope."

The revision of the immigration exclusion list has been endorsed by every major public health and medical association in the United States. Over a thousand participants of the VIII International Conference on AIDS (moved from Boston to Amsterdam due to the U.S. policy) signed on to a document condemning discriminatory HIV immigration policies. All these people and organizations know from experience that mandatory testing and HIV immigration restrictions deter effective prevention education and early intervention efforts and in fact may be contributing to the spread of the disease.

Accordingly, we urge you to take immediate action to end this inhumane restriction that has so direly affected the lives of so many immigrants and refugees and their U.S. citizen and permanent resident family members. Simple regulatory action by your Administration could implement this long overdue policy change.

Finally, we urge that when your administration acts on this issue, you speak personally and publicly against any mandatory HIV testing of immigrants and refugees and against any immigration exclusion of persons with HIV, here in the United States or anywhere around the world. We ask that you hold a press conference and include immigrants and refugees with HIV to talk about the devastating impact these discriminatory laws have had. The unfortunate example set by current U.S. policy has already encouraged other countries to pass similar counterproductive policies. A clear and forceful statement directly from you as President of the United States will send an unequivocal message to the world community that AIDS truly knows no borders and that discrimination against persons with HIV must not be tolerated. Thank you.

Sincerely,

The undersigned 200 organizations:

16th Street Services.
ACT-UP San Francisco.
ACT-UP/OKC.
ActionAIDS.
African American Immigration Service, Inc.
AIDS Action Committee of Massachusetts.
AIDS Action Council.
AIDS Action—Baltimore.
AIDS Benefits Counselors.
AIDS Bulletin Board Services.
AIDS Center—Strong Memorial Hospital.
AIDS Council of Northeastern New York.
AIDS Education & Resource Center/SAHP-SUNY Stony Brook.
AIDS Health Care Foundation.
AIDS in Prison Project of the Correctional Association of New York.
AIDS Interfaith Network of New Jersey.
AIDS Mental Health Project/Greenwich House, Inc.
AIDS National Interfaith Network.
AIDS Project of Los Angeles.
AIDS Project of Contra Costa.
AIDS Rochester.
AIDS Service Center Lower Manhattan.
AIDS Services of Dallas.
AIDS Task Force—Philadelphia.
AIDS Treatment Data Network.
AIDS Treatment News.
AIDS Trust of Maryland (ATOM).
Alameda Health Consortium, Oakland, California.
ALTAMED Health Services Corporation.
American Association on Mental Retardation.
American Civil Liberties Union of Illinois.
American Council for Nationalities Service.
American Immigration Lawyers Association—New York Chapter.
American Jewish Congress, Northern Pacific Region.
American Medical Students Association.
American Psychiatric Association.
Asian AIDS Project.
Asian American Health Forum.
Asian American Recovery Services.
Asian and Pacific Islander Coalition on HIV/AIDS, New York
Asian Health Services.
Asian Law Alliance.
Asian Pacific Legal Center of Southern California.
Asian/Pacific AIDS Coalition.
Association of Asian/Pacific Community Health Organizations.
Association of Maternal and Child Health Programs.
Association of Performing Arts Presenters.
Bar Association of San Francisco.
Bay Area Haitian American Council.
Bay Area Physicians for Human rights.
Being Alive: People with HIV/AIDS Action Coalition.
Bienestar Latino AIDS Project.
Big Island AIDS Project.
Black and White Men Together, Los Angeles.
Black Coalition on AIDS.
Body Positive.
Broadway Cares/Equity Fights AIDS.
Brooklyn Haitian Ralph and Good Shepherd.
Building Service 32B-J Legal Services Fund.
California Association of AIDS Agencies.
California Council of Churches.
Caribbean Women's Health Association.
Catholic Charities Immigration and Refugee Services.
Catholic Emergency Legal Aid for Haitians-United States Catholic Conference.
Catholic Migration Office.
Center for Constitutional Rights.
Center for Population Options.
Central American Legal Assistance.
Central American Refugee Center, Hempstead.
Central American Refugee Center, Los Angeles.
Church Alive Ministries.
City AIDS Office of Los Angeles.
Coalition for Humane Immigration Rights of Los Angeles.
Coalition for Immigrant and Refugee Rights and Services.
Colorado AIDS Project.
Community Consortium.
Community Health Project.
Continuum HIV Day Services.
Contra Costa County AIDS Program.
Council of Jewish Federations.
D.C. Care Consortium.
Dance/USA.
Early Advocacy and Care for HIV (EACH)
El Rescate.
Family Link
Filipino Task Force on AIDS-Northern California.
Gay and Lesbian Latino AIDS Education Initiative.
Gay Asian Pacific Alliance Community HIV Project.
Gay Men's Health Crisis.
Gente Latina de Ambiente.
Haitian Americans United for Progress Cambria Heights.
Haitian Centers Council
Harvard AIDS Institute.
Harvey Milk Progressive Democratic Club
Hawaii Governor's Committee on AIDS.
Health Education Resource Organization (HERO).
Hellenic American Neighborhood Action Center (HANAC).
Help Project/Samaritan Inc.
Helping People with AIDS, Inc., Rochester New York.
Hyacinth AIDS Foundation.
Immigrant Legal Resource Center.
In God's Love We Deliver.
Indians HIV Advocacy Program.
Indochinese Community Center.
Institute for Radical Empowerment.
International Gay and Lesbian Human Rights Commission.
International Institute of Boston.
International Institute, Los Angeles.
International Institute, San Francisco.
International Ladies Garment Workers Union Immigration Project.
International Rescue Committee.
Jews for Racial and Economic Justice.
Kairos Support for Caregivers.
La Red.
Latino Lesbian/Gay Organization—LLEGO California.
Law Offices of Anthony, Howison & Landis.
Lawyers Committee for Civil Rights of the San Francisco Bay Area.
Legal Action Center.
Legal Aid Society of San Diego County.
LIFEbeat, the Music Industry Organization to Fight AIDS.
Lyon-Martin Women's Health Services.
Metropolitan Community Church of New York City.
Mexican American Legal Defense and Education Fund.
Mobilization Against AIDS.
Montefiore Medical Center Substance Abuse Treatment Program.
Mother's Voices.
Mujeres Project.

HIV

Office of the Attorney General
Washington, D. C. 20530

February 12, 1993

MEMORANDUM

TO : Honorable Anthony Lake
Assistant to the President for
National Security Affairs

FROM : Stuart M. Gerson
Acting Attorney General

SUBJECT : Resettlement of Medically Sensitive Population
At Guantanamo Naval Base

A. BACKGROUND:

Between October 1991 and May 1992, Immigration and Naturalization Service (INS) Asylum Officers interviewed approximately 37,000 Haitian asylum seekers at the naval base in Guantanamo Bay, Cuba. About 11,000 of these people were determined to have a credible fear of persecution if returned to Haiti, and were therefore processed for consideration under the Attorney General's authority to parole aliens into the United States. This processing included testing for medical conditions listed as statutory grounds for exclusion under United States immigration laws. Due to government concerns about spreading [illegible]

[illegible] and the United States was enjoined from [illegible] the ensuing litigat

of these asylum seekers without affording access further processing
Guantanamo naval base, 215 Haitians who have to counsel at the
the HIV virus (and 52 of their dependents) tested positive fo
o. remain in Guantanar

ulation of the Guantanamo camp has been there The entire po
onths, and most have been there over a year. for at least nine
e Haitians on Guantanamo are young adult males, Although most of th
ides 37 children and at least 19 pregnant women. the group also incl
lum seekers, 78 have serious dysfunction in the Of the 215 HIV+ asy
10 have symptomatic AIDS. The condition of immune system, and
eteriorated. Although medication and treatment several others has
at the base clinic, this is a small facility have been provided
for occasional outpatient treatment of a healthy designed primarily
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mbers on Guantanamo) have been paroled into the immediate family me
edical treatment that cannot be provided at the United States for

clinic. Finally, the protracted maintenance of a camp for HIV+ asylum seekers at the naval station has also imposed a substantial financial burden on the United States military.

One option for resolving this situation would be for the Attorney General to exercise the authority to parole the remaining Haitian asylum seekers into the United States notwithstanding the medical exclusion. The exercise of this option, however, raises a number of collateral issues of consequence, among them its precedential effect. These issues must be given full consideration at the most senior levels of government before any commitment can be made to the broad-scale regime described, infra. Other options include: 1) awaiting the outcome of the litigation; 2) maintaining the people at Guantanamo pending political developments in Haiti that might allow their safe return; and 3) attempting to satisfy the Court's requirement of access to counsel in Guantanamo so as to allow refugee processing there.

B. RESETTLEMENT OPERATIONS:

If the option of paroling the remaining Haitians into the United States is chosen, the Departments of Justice, Health and Human Services, Defense and State would implement the following resettlement plan.

- Community Relations Service (CRS) of DOJ would resettle this population in stages, in order to reduce public concern and allow for orderly resettlement.

- CRS would resettle as many migrants as possible outside the state of Florida, thus reducing the impact of this population on any one state. However, humanitarian resettlement policy has historically provided that migrants be resettled with family members whenever possible. (Historical evidence shows that approximately 70% of this population will be resettled with family members in South Florida and the remaining 30% with families or churches outside of Florida.) Although not guaranteed, CRS will attempt to disperse these individuals.

- The White House and the Attorney General's Office should consult with Congressional delegations and State and local officials from impacted states, principally, Florida, New York and Massachusetts. State and local officials should be advised of the resettlement plan, the need for their cooperation and assistance, and the financial assistance to be made available.

Resettlement Activities: Week One

- Sponsorship and Placement CRS would negotiate with its current grantees (i.e. National Voluntary Agencies (VOLAGS), U. S. Catholic Conference and Church World Service) to expand existing cooperative agreements to resettle this medically

sensitive population. It will cost CRS approximately $400,000 ($1,500 per person) to resettle this population.

- Resettlement Screening CRS would send staff to Guantanamo to coordinate all resettlement activities. CRS' fluent Creole speaking staff will gather information for placing migrants with family members or church sponsors in the United States, which will be sent to the VOLAGS in Miami for use in establishing willing and responsible sponsors.

- Medical Assessments Public Health Service (PHS) would send a representative to Guantanamo to perform a medical assessment and health screening of the population. PHS will then share the results with states as appropriate and work with state and local hospitals to place those who need immediate hospitalization.

- Entry Processing Immigration and Naturalization Service (INS) staff would go to Guantanamo for final processing for entry into the United States. This processing will include conducting criminal record checks, issuing a one-year parole document and Employment Authorization Card, and developing the alien file.

- Medical Benefits Health and Human Services staff would arrange for the severely ill migrants to complete applications for Supplemental Security Income (SSI), and Refugee Cash and Medical Assistance benefits to ensure their eligibility for medical benefits upon their arrival in the United States.

- Logistics The Departments of Justice, State and Defense would arrange to transport the migrants from Guantanamo to the United States. Family reunification or church sponsorship arrangements must be finalized before migrants will fly to Miami. Due to limited availability of hospital bed space, CRS estimates that the first flight of 50 would be ready within ten to fourteen days of CRS' arrival at Guantanamo. Transportation of 50 per week will continue thereafter.

- Community Relations CRS conciliation and mediation staff would address any community tensions that may arise as a result of the resettlement of this population.

Resettlement Activities: Week Two

- The first flight would comprise the most serious medical cases, unaccompanied minors, and relatively healthy family groups. This will demonstrate to the public and media that the President's policy is humane because of its attention to the most seriously ill and to the welfare of children and families.

- Reception in the United States Upon arrival, INS, U.S. Customs Service, CRS and VOLAG officials would meet the flights and process the individuals for resettlement into the United States. If a migrant is to be resettled with family members in South Florida, arrangements would be made for the family to meet the migrant at the VOLAG processing office. If the migrant is to be resettled with a family or church sponsorship outside of South Florida, the VOLAGS would arrange for the migrant to be flown from Miami to the destination city.

- Ongoing Resettlement After the initial resettlement, the VOLAGS would: 1) Provide temporary accommodation, as necessary, and assist in obtaining initial housing and essential furnishings; 2) Assist migrants in applying for appropriate state and federal health services and assist those with known health problems in securing immediate treatment; and 3) Provide employment counseling and referrals, provide advice on availability and procedures for applying for job training programs, assist migrants in applying for social security cards, and register children in schools.

Resettlement Activities: Weeks Three-Seven

- Weekly flights of 50 migrants would continue according to the procedures described above.

C. COST:

HHS has made the following estimates of the costs that would be borne by the Federal Government and the States if this population is resettled.[1]

FIRST-YEAR COSTS

STATE/LOCAL	FEDERAL	
REFUGEE CASH ASSISTANCE	$165,128	
REFUGEE MEDICAL (HIV-)	47,580	
REFUGEE MEDICAL (HIV+)	242,570	
REFUGEE UNACCOMPANIED MINOR	12,000	
SSI DISABILITY	265,608	
SSI DISABILITY STATE SUPPLEMENT		$16,601
MEDICAID (SYMPTOMATIC AIDS)	179,107	152,573
MEDICAID (T4 200-500)	98,971	84,309
MEDICAID (NORMAL PREGNANCIES)	4,320	3,680
MEDICAID (HIV+ PREGNANCIES)	56,700	48,300
GENERAL ASSISTANCE:		
FL		49,588
NY/MA		36,225
GENERAL MEDICAL ASSISTANCE		128,800
TOTAL	$1,071,984	$ 520,076

LIFETIME COSTS

STATE/LOCAL	FEDERAL	
REFUGEE CASH ASSISTANCE	$165,128	
REFUGEE MEDICAL (HIV NEG)	47,580	
REFUGEE MEDICAL (HIV POS)	242,570	
REFUGEE UNACCOMPANIED MINORS	96,000	
SSI DISABILITY	3,359,160	
SSI DISABILITY STATE SUPPLEMENT		$207,994
MEDICAID (SYMPTOMATIC AIDS)	7,701,610	6,560,615
MEDICAID (T4 200-500)	507,227	432,083
MEDICAID (NORMAL PREGNANCIES)	4,320	3,680
MEDICAID (HIV + PREGNANCIES)	56,770	48,300
GENERAL ASSISTANCE:		
FL		42,504
NY/MA		62,100
STATE/LOCAL MEDICAID		220,800
TOTAL	$12,197,587	$7,574,856

GRAND TOTAL: $19,772,443

[1] It should be noted that the states' cost estimates for this population could be as much as 30% to 40% higher than HHS' estimates for both the Federal and State shares.

D. USE OF IMMIGRATION EMERGENCY FUND:

Section 404 of the Immigration and Nationality Act provides for an Immigration Emergency Fund currently containing $30.6 million. Up to $20 million in the Fund is available to reimburse States and localities where "the lives, property, safety, or welfare of the residents of a State or locality are endangered" or "in any other circumstances as determined by the Attorney General." No money has yet been paid out of the Fund. Funds may be made available "by application" by States and localities. A written request would satisfy the "application" requirement. No formal action by the President would be necessary.

The Fund could be used to reimburse States and localities for some or all of the additional expenses they will incur because of the HIV status of Haitians who are paroled into the United States. Medicaid costs the States would incur for this group if they were not HIV+ need not be reimbursed. And because Section 404 is an exceptional remedial measure that has not previously been used despite substantial influxes of refugees, it would be appropriate to reimburse the States only to the extent that their expenses depart substantially from the norm. It should be emphasized that any reimbursement is made only because of the unique circumstances of the humanitarian emergency at Guantanamo resulting from the HIV status of the whole group and the injunction ordered by the Second Circuit. It is recommended that reimbursement be made in a lump sum payment to the affected States at the outset. In addition, it would be prudent to invoke its provision allowing reimbursement "in any other circumstances as determined by the Attorney General."

E. CONSULTATION:

Acceptance of the plan by state and local officials would be crucial for political and public relations reasons. Prior consultation with senior officials in areas that would be affected by entry of this group is essential to allay concerns regarding any cost and political implications of the decision. Prior to an announcement of the policy, the President, Office of the Attorney General, Secretary of HHS, and/or Deputy National Security Advisor should call Senators Graham and Mack and Governor Chiles of Florida, as well as Governor Cuomo of New York. In these conversations, the following points would be stressed: that this is a humanitarian issue involving children and families whose only alternative is indefinite detention at Guantanamo; that all have been deemed to have credible fears of persecution, and return to Haiti is not a humane alternative; that the Administration is very sensitive to the cost and political implications, and therefore has a detailed plan to effect entry in stages over 6 - 7 weeks, which will attempt to disperse the population, and -- most importantly -- provide compensation to affected States.

These consultations should be followed up immediately with similar conversations between Administration officials and 1) Members of Congress from areas that will be affected; 2) Miami and Dade County officials; 3) officials from New York, New Jersey, and Boston; and 4) non-governmental organizations. These consultations would address various public concerns and furnish a useful vehicle for

political support if the plan were otherwise acceptable to the Administration. This effort would be coordinated by the White House in consultation with HHS and DOJ.

Cleared:
HHS: P. Fleming
State/RP: P. Clapp

bcc:
Eric Schwartz

NATIONAL SECURITY COUNCIL
WASHINGTON, D.C. 20506

February 18, 1993

ACTION

MEMORANDUM FOR ANTHONY LAKE/SAMUEL BERGER

THROUGH: RICHARD CLARKE ES for RC

FROM: ERIC SCHWARTZ ES

SUBJECT: HIV Positive Applicants at Guantanamo Bay

I have enclosed a memorandum on the issue of HIV positive asylum applicants at Guantanamo Bay.

RECOMMENDATION

That you sign the memorandum at Tab I.

Attachments
Tab I Memorandum for the President
Tab A Justice Department Resettlement Plan

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Anthony Lake and Samuel Berger to the President, re: Haiti: HIV Cases at Guantanamo Bay, Cuba (5 pages)	ca. 02/1993	P1/b(1)

COLLECTION:
Clinton Presidential Records
National Security Council
Multilateral & Humanitarian Affairs (Schwartz, Eric)
OA/Box Number: 3424

FOLDER TITLE:
Haiti - HIV Positive, 1993 [5]

2007-1550-F
ke2049

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

TAB A

Office of the Attorney General
Washington, D. C. 20530

February 12, 1993

MEMORANDUM

TO : Honorable Anthony Lake
Assistant to the President for
National Security Affairs

FROM : Stuart M. Gerson
Acting Attorney General

SUBJECT : Resettlement of Medically Sensitive Population
At Guantanamo Naval Base

A. BACKGROUND:

Between October 1991 and May 1992, Immigration and Naturalization Service (INS) Asylum Officers interviewed approximately 37,000 Haitian asylum seekers at the naval base in Guantanamo Bay, Cuba. About 11,000 of these people were determined to have a credible fear of persecution if returned to Haiti, and were therefore processed for consideration under the Attorney General's authority to parole aliens into the United States. This processing included testing for medical conditions listed as statutory grounds for exclusion under United States immigration laws. Due to government concerns about paroling people into the United States who were statutorily excluded from admission, and to the ensuing litigation in which the United States was enjoined from further processing of these asylum seekers without affording access to counsel at the Guantanamo naval base, 215 Haitians who have tested positive for the HIV virus (and 52 of their dependents) remain in Guantanamo.

The entire population of the Guantanamo camp has been there for at least nine months, and most have been there over a year. Although most of the Haitians on Guantanamo are young adult males, the group also includes 37 children and at least 19 pregnant women. Of the 215 HIV+ asylum seekers, 78 have serious dysfunction in the immune system, and 10 have symptomatic AIDS. The condition of several others has deteriorated. Although medication and treatment have been provided at the base clinic, this is a small facility designed primarily for occasional outpatient treatment of a healthy population. To date, 38 people (either HIV+ Haitians or their immediate family members on Guantanamo) have been paroled into the United States for medical treatment that cannot be provided at the

clinic. Finally, the protracted maintenance of a camp for HIV+ asylum seekers at the naval station has also imposed a substantial financial burden on the United States military.

One option for resolving this situation would be for the Attorney General to exercise the authority to parole the remaining Haitian asylum seekers into the United States notwithstanding the medical exclusion. The exercise of this option, however, raises a number of collateral issues of consequence, among them its precedential effect. These issues must be given full consideration at the most senior levels of government before any commitment can be made to the broad-scale regime described, infra. Other options include: 1) awaiting the outcome of the litigation; 2) maintaining the people at Guantanamo pending political developments in Haiti that might allow their safe return; and 3) attempting to satisfy the Court's requirement of access to counsel in Guantanamo so as to allow refugee processing there.

B. RESETTLEMENT OPERATIONS:

If the option of paroling the remaining Haitians into the United States is chosen, the Departments of Justice, Health and Human Services, Defense and State would implement the following resettlement plan.

- Community Relations Service (CRS) of DOJ would resettle this population in stages, in order to reduce public concern and allow for orderly resettlement.

- CRS would resettle as many migrants as possible outside the state of Florida, thus reducing the impact of this population on any one state. However, humanitarian resettlement policy has historically provided that migrants be resettled with family members whenever possible. (Historical evidence shows that approximately 70% of this population will be resettled with family members in South Florida and the remaining 30% with families or churches outside of Florida.) Although not guaranteed, CRS will attempt to disperse these individuals.

- The White House and the Attorney General's Office should consult with Congressional delegations and State and local officials from impacted states, principally, Florida, New York and Massachusetts. State and local officials should be advised of the resettlement plan, the need for their cooperation and assistance, and the financial assistance to be made available.

Resettlement Activities: Week One

- Sponsorship and Placement CRS would negotiate with its current grantees (i.e. National Voluntary Agencies (VOLAGS), U. S. Catholic Conference and Church World Service) to expand existing cooperative agreements to resettle this medically

sensitive population. It will cost CRS approximately $400,000 ($1,500 per person) to resettle this population.

- Resettlement Screening CRS would send staff to Guantanamo to coordinate all resettlement activities. CRS' fluent Creole speaking staff will gather information for placing migrants with family members or church sponsors in the United States, which will be sent to the VOLAGS in Miami for use in establishing willing and responsible sponsors.

- Medical Assessments Public Health Service (PHS) would send a representative to Guantanamo to perform a medical assessment and health screening of the population. PHS will then share the results with states as appropriate and work with state and local hospitals to place those who need immediate hospitalization.

- Entry Processing Immigration and Naturalization Service (INS) staff would go to Guantanamo for final processing for entry into the United States. This processing will include conducting criminal record checks, issuing a one-year parole document and Employment Authorization Card, and developing the alien file.

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- Community Relations CRS conciliation and mediation staff would address any community tensions that may arise as a result of the resettlement of this population.

Resettlement Activities: Week Two

- The first flight would comprise the most serious medical cases, unaccompanied minors, and relatively healthy family groups. This will demonstrate to the public and media that the President's policy is humane because of its attention to the most seriously ill and to the welfare of children and families.

- Reception in the United States Upon arrival, INS, U.S. Customs Service, CRS and VOLAG officials would meet the flights and process the individuals for resettlement into the United States. If a migrant is to be resettled with family members in South Florida, arrangements would be made for the family to meet the migrant at the VOLAG processing office. If the migrant is to be resettled with a family or church sponsorship outside of South Florida, the VOLAGS would arrange for the migrant to be flown from Miami to the destination city.

- Ongoing Resettlement After the initial resettlement, the VOLAGS would: 1) Provide temporary accommodation, as necessary, and assist in obtaining initial housing and essential furnishings; 2) Assist migrants in applying for appropriate state and federal health services and assist those with known health problems in securing immediate treatment; and 3) Provide employment counseling and referrals, provide advice on availability and procedures for applying for job training programs, assist migrants in applying for social security cards, and register children in schools.

Resettlement Activities: Weeks Three-Seven

- Weekly flights of 50 migrants would continue according to the procedures described above.

C. COST:

HHS has made the following estimates of the costs that would be borne by the Federal Government and the States if this population is resettled.[1]

FIRST-YEAR COSTS

STATE/LOCAL	FEDERAL	
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MEDICAID (T4 200-500)	507,227	432,083
MEDICAID (NORMAL PREGNANCIES)	4,320	3,680
MEDICAID (HIV + PREGNANCIES)	56,770	48,300
GENERAL ASSISTANCE:		
FL		42,504
NY/MA		62,100
STATE/LOCAL MEDICAID		220,800
TOTAL	$12,197,587	$7,574,856

GRAND TOTAL: $19,772,443

[1] It should be noted that the states' cost estimates for this population could be as much as 30% to 40% higher than HHS' estimates for both the Federal and State shares.

D. USE OF IMMIGRATION EMERGENCY FUND:

Section 404 of the Immigration and Nationality Act provides for an Immigration Emergency Fund currently containing $30.6 million. Up to $20 million in the Fund is available to reimburse States and localities where "the lives, property, safety, or welfare of the residents of a State or locality are endangered" or "in any other circumstances as determined by the Attorney General." No money has yet been paid out of the Fund. Funds may be made available "by application" by States and localities. A written request would satisfy the "application" requirement. No formal action by the President would be necessary.

The Fund could be used to reimburse States and localities for some or all of the additional expenses they will incur because of the HIV status of Haitians who are paroled into the United States. Medicaid costs the States would incur for this group if they were not HIV+ need not be reimbursed. And because Section 404 is an exceptional remedial measure that has not previously been used despite substantial influxes of refugees, it would be appropriate to reimburse the States only to the extent that their expenses depart substantially from the norm. It should be emphasized that any reimbursement is made only because of the unique circumstances of the humanitarian emergency at Guantanamo resulting from the HIV status of the whole group and the injunction ordered by the Second Circuit. It is recommended that reimbursement be made in a lump sum payment to the affected States at the outset. In addition, it would be prudent to invoke its provision allowing reimbursement "in any other circumstances as determined by the Attorney General."

E. CONSULTATION:

Acceptance of the plan by state and local officials would be crucial for political and public relations reasons. Prior consultation with senior officials in areas that would be affected by entry of this group is essential to allay concerns regarding any cost and political implications of the decision. Prior to an announcement of the policy, the President, Office of the Attorney General, Secretary of HHS, and/or Deputy National Security Advisor should call Senators Graham and Mack and Governor Chiles of Florida, as well as Governor Cuomo of New York. In these conversations, the following points would be stressed: that this is a humanitarian issue involving children and families whose only alternative is indefinite detention at Guantanamo; that all have been deemed to have credible fears of persecution, and return to Haiti is not a humane alternative; that the Administration is very sensitive to the cost and political implications, and therefore has a detailed plan to effect entry in stages over 6 - 7 weeks, which will attempt to disperse the population, and -- most importantly -- provide compensation to affected States.

These consultations should be followed up immediately with similar conversations between Administration officials and 1) Members of Congress from areas that will be affected; 2) Miami and Dade County officials; 3) officials from New York, New Jersey, and Boston; and 4) non-governmental organizations. These consultations would address various public concerns and furnish a useful vehicle for

political support if the plan were otherwise acceptable to the Administration. This effort would be coordinated by the White House in consultation with HHS and DOJ.

Cleared:
HHS: P. Fleming
State/RP: P. Clapp

bcc:
Eric Schwartz

OFFICE OF [illegible]

FAX COVER SHEET

TO: Eric

FROM: Jacey

HIV

AMENDMENT NO. Calendar No. ____

Purpose: To provide that the current list of communicable diseases of public health significance remain in place for a 60-day period and to require that a careful review of potential costs to the United States health care system take place before any changes in the list.

IN THE SENATE OF THE UNITED STATES—103d Cong., 1st Sess.

S. 1

To amend the Public Health Service Act to revise and extend the programs of the National Institutes of Health, and for other purposes.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. KENNEDY (for himself and Mrs. KASSEBAUM)

Viz:

At the appropriate place in the bill, insert the following:

SEC. ___. CONDITIONS ON ANY REMOVAL OF HIV STATUS EXCLUSION.

(a) RETENTION OF EXCLUSION.—The current list of communicable diseases of public health significance as in effect on February 16, 1993, shall remain in effect for a period of at least 60 days after the date of enactment

of this Act for purposes of section 212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)(i)).

(b) REPORT REQUIRED.—If the Secretary of Health and Human Services removes an alien from the list described in subsection (a) after the expiration of the 60-day period described in that subsection, then the Secretary shall submit to Congress a report containing—

(1) an assessment of—

(A) the anticipated effect of such action on costs to United States public health care programs and entities, as well as to those operated by States and municipalities; and

(B) the anticipated costs to private insurers and health care providers of such action;

(2) any findings regarding current immigration law submitted by the Attorney General under subsection (c); and

(3) a comparison of the anticipated public and private health care costs associated with aliens infected with HIV with the costs attributable to the entry of aliens suffering from other health conditions.

(c) STUDY AND REPORT.—The Attorney General shall conduct a study of the following:

(A) The effectiveness of current provisions of the Immigration and Nationality Act in guarding against entry into the United States of persons likely to become a public charge and in deporting, during a 5-year period after such entry, those immigrants who do become public charges.

(B) The ability of the Immigration and Naturalization Service to apply or enforce such Act with regard to immigrants infected with potentially costly health conditions including, but not limited to, HIV.

(2) The Attorney General shall submit to the President, the Secretary of Health and Human Services, and the Congress a report setting forth the findings of the study conducted under paragraph (1) and including such recommendations as the Attorney General determines may be necessary for revision of current immigration law to ensure that immigrants with costly health conditions who are likely to become public charges will be excluded.

103rd CONGRESS
1st Session

AMDT ------

IN THE SENATE OF THE UNITED STATES

MR. DOLE, for himself, and
submitted the following amendment:

==========

Viz: At the appropriate place, add the following:

Section 1. ADMISSION TO THE UNITED STATES OF ALIENS INFECTED WITH THE AIDS VIRUS.

(a) Notwithstanding any other provision of law, regulations or directives concerning the exclusion of aliens on health related grounds, infection with HIV, the human immunodeficiency virus, shall constitute a communicable disease of public health significance for purposes of section 212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)(i)).

(b) REPORT REQUIRED--

The President shall submit a report by September 1, 1993 containing--

(1) an assessment of the anticipated costs of the admission to the United States of persons with HIV to public health care programs, including such costs as will be borne by States and municipalities, and private insurers and health care providers;

(2) an estimate of the number and origins of persons infected with HIV likely to seek entry into the United States before December 31, 2003;

(3) an assessment of the effectiveness of the Immigration and Nationality Act in preventing persons entering the United States likely to become a public charge, as well as the ability to enforce this Act with regard to persons infected with potentially costly health conditions including, but not limited to HIV;

(4) The cost implications of refugees entering or likely to enter the United States, who carry the HIV virus;

(5) A comparison of the anticipated public and private health care costs associated with aliens infected with HIV with the costs attributable to the entry of aliens suffering from other health conditions;

(c) HIV TESTING--

Except as otherwise provided in subsection (d) the Attorney General, in consultation with the Secretary of HHS, shall provide for the testing of aliens for infection with HIV in accordance with the policy in effect on January 1, 1993;

(d) WAIVER AUTHORITY--

Subsection (c) may be waived by the Attorney General, in consultation with the Secretary of HHS for non-immigrants who, except for the provisions of this act, would be admissible to the United States, and who seek admission for 30 days or less for the purpose of:

(1) attending educational or medical conferences;

(2) receiving medical treatment;

(3) visiting close family members;

(4) conducting temporary business activities; or

(5) visiting for pleasure (tourism);

and in addition such non-immigrants may be admitted without questions as to whether they are carriers of the HIV virus, at the discretion of the Attorney General.

(e) RULE OF CONSTRUCTION

Nothing in this section shall be construed to limit the authority of the Secretary of HHS to prescribe regulations concerning communicable diseases of public health significance, other than infection with the human immunodeficiency virus in accordance with section 212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)(i)).

OFFICE OF THE ...

WASHINGTON

FAX COVER SHEET

TO: Eric

FROM: Tracey

Pres 6 mths

Solemn ~~Strategy~~ Report

Dole language

file-

HIV.

REFUGEE RESETTLEMENT WORKING GROUP
FEBRUARY 11, 1993

NAME	ORGANIZATION	TEL NO. FAX NO.
Jeffrey Weiss	CRS/DOJ	301-492-5929 301-492-5984 (F) ✓ (H) 202-667-7411
Amy Dale	CRS/DOJ	301-492-5900 301-492-5984 (F) (H) 703-824-0472
Kenneth Leutbecker	CRS/DOJ	301-492-5818 301-492-5984 (F) (H) 703-534-4591
James A. Puleo	INS/OPS	202-514-8223 202-514-0197 (F) (H)
Ed Kneedler	Solicitor General's Office	202-514-3261 202-307-4613 (F) (H) 202-544-1292
John Cummings	INS/Int'l Affairs	202-633-1507 202-633-1068 (F)
Carmel Clay-Thompson	ORR/DHHS	202-401-4560 202-401-5487 (F) (H) 703-241-9667 (Pager) 202-901-9358
David B. Smith	ORR/DHHS	202-401-9256 202-401-5487 (F) (H) 202-547-6722
Toyo Biddle	ORR/DHHS	202-401-9250 202-401-5487 (F) (H) 301-270-4484
Patsy Fleming	IOS/HHS	202-690-5400 202-690-7755 (F) (H) 301-320-5420
Phyllis Coven	OAG/DOJ	202-514-2001 202-514-0468 (F) (H) 202-966-7717
Priscilla Clapp	State, RP	202-647-5767 202-647-8162 (F) (H) 202-797-8193

Katherine Perkins	State, RP/RPL		202-663-1073
			202-663-1061 (F)
		(H)	202-364-4055
Michael Cardozo	OAG/DOJ		202-514-2011
			202-514-0468 (F)
		(H)	301-320-4663
Eric Schwartz	NSC		202-395-1580
			202-395-1039 (F)
			202-686-9437 (H)
Grover Joseph Rees	INS/OGC		202-514-2895
		(H)	202-393-5985
		(Pager)	202-943-5997
			202-514-8044 (F)
*INS COMMAND CENTER			202-616-5000

HIV

MEMORANDUM

TO: Eric Schwartz
NSC

FROM: David Smith
Acting Director, ORR

SUBJECT: Corrections to the document "Resettlement of Medically Sensitive Population at Guantanamo Naval Base"

DATE: February 16, 1993

After reviewing the final draft of this document, we noticed the following changes or omissions had been made to our original text:

- The column heading for State/Local costs for both First-Year and Lifetime Costs has been eliminated;
- The State/Local column of figures for General Assistance is misaligned;
- The formulas used to calculate the costs (placed within parentheses in the original) have been eliminated;

We would like to suggest that, in the interest of textual clarity, these corrections be made if the document is reproduced or sent forward again.

I also noticed a reference on the first page, under BACKGROUND, second paragraph, to "37 children" in this group. I believe the number should be 40 children in all. (37 of these have not been tested for HIV.)

Thanks for your attention to this.

HIV - (File)

EXECUTIVE

OMB - Office of Information + Reg
Shawn Koss
395 - 7316

OMB - Clears w/ Relevant Depts.

395 - 7316

Martha Folley. ↖ Christina Emmanuele,
Panetta's staff - ~~5100~~ 4790

Glen Haselson →

Issued (?)

Announcement.

Justice Bureau

Carol Rascoe - George Stephanopoulos.

HIV

United States Department of State

Washington, D.C. 20520

BUREAU FOR REFUGEE PROGRAMS
FAX MESSAGE COVER SHEET
Fax Telephone: (202) 647--8162

DATE: _____

PLEASE DELIVER THE FOLLOWING PAGES TO:

Name: ERIC SCHWARTZ

Office: _____

Fax Telephone: 395-1039

THIS MESSAGE IS FROM:

Name: PRISCILLA 1034

Office: _____

Telephone: _____

NUMBER OF PAGES INCLUDING COVER SHEET: 4

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NOTES:

Hunger strike - Friday. 70% of people. No one in health danger. Think that after hunger strike in Krome, people were released. No releases. Maybe one person released - called someone in G-TMO. Team of lawyers - arriving in GTMO. Some evidence of movement. Please tell their people - no releases in Krome. They want Justice.

3041

PAROLE FOR REMAINING HIV CASES AT GUANTANAMO

Should the President decide to parole into the United States the remaining 267 screened-in Haitians at Guantanamo (some 215 of whom are HIV positive) the following outlines the relevant considerations and suggested actions necessary to implement such a decision:

1. Relevant federal agencies, led by the Community Relations Service (CRS) of DOJ and the Public Health Service of HHS, would consult with state and local government officials of planned resettlement sites.

- Careful, ongoing consultations between the relevant federal agencies and the states (especially Florida) will be key to avoiding negative reaction to this initiative.
- Funding will be critical to the success of this effort. While under the Fascell-Stone amendment, the Haitians will be eligible for medical and cash assistance benefits equivalent to those available to refugees, for those ineligible for AFDC, i.e., single individuals or childless couples, there is a limited period of reimbursement to the states (currently 8 months) under this program. (Florida is currently seeking $7 million from the federal government for unreimbursed medical costs for the Haitians paroled in last year.)
- It has been estimated that total medical costs for an AIDS victim can be as much as $200,000. For this population, therefore, the total could be as much as $40 million.
- Possible funding sources would be: a) a supplemental appropriation; b) reprogramming of HHS funds; and c) the Immigration Emergency Fund (Section 404 of the INA) The latter includes $35 million for reimbursement to states and localities in providing assistance as requested by the Attorney General in meeting an immigration emergency as determined by the President, $20 million of which is available to cover state and local costs of providing assistance under other circumstances as determined by the Attorney General. These no-year funds have been appropriated but have never been used. In addition, regulations required by statute regarding the use of these funds have yet to be proposed by DOJ.

- Whatever funding source is identified, it should be made clear that this is a one-time initiative intended to resolve a long-standing humanitarian problem involving a specific group of people. These persons had met the same "credible fear" standard as the other 10,000+ Haitians from Guantanamo who have been allowed into this country to pursue asylum claims.

II. Relevant federal agencies (DOS, DOD, DOJ, HHS and PHS) led by CRS should initiate consultations with officials of the U.S. Catholic Conference (USCC) whose leadership has indicated its willingness to assume initial resettlement responsibility for this group.

- USCC would provide services to this group in much the same manner as they did last year for the 10,000+ screened-in Haitians from Guantanamo who were paroled in to pursue asylum claims.

- Services include provision of initial shelter, food, and clothing as well as assistance in registering for Social Security, public schools, vocational or language training, etc.

- CRS would reimburse USCC for initial resettlement services on a per capita or other agreed-upon basis which would be roughly equivalent to $1500 per person for a total cost of about $400,000.

III. DOD requests and the Attorney General authorizes parole in the public interest for all 271 Haitians at Guantanamo.

- DOD would file public interest parole requests for each individual remaining at Guantanamo.

- DOJ would determine the most efficient way of processing these requests. (The current practice of submitting each one to the INS Commissioner is cumbersome. The authority can be delegated.)

- Unlike other forms of parole, parole in the public interest does not require that an affadavit of support accompany the application. This simplifies the process and should be used for this group.

- INS would facilitate the entry of these persons by alerting INS officials at designated ports of entry.

IV. DOJ's Community Relations Service would work with USCC to place the Haitians at locations around the U.S.

- Arrivals would be spread out over three to four weeks to avoid overburdening receiving communities.

- DOD medical staff at Guantanamo would advise which of the Haitians are in need of immediate placement in medical care facilities. This information would guide initial placement planning.

- Every effort would be made to avoid creating a burden on any single jurisdiction. However, since most Haitians have ties to persons in Florida, the state is likely to receive the majority of this group as well since, even if initially placed elsewhere, many would secondarily migrate to Florida.

- It should be recognized that, if it is determined that in order to avoid concentrating too many of these Haitians in Florida family members will not necessarily be placed with relatives already here, the pace of placements may be slowed as sponsorships are developed. There may also be additional costs to the resettlement agency due to the non-availability of family support.

Fle - HIV

Draft discussion paper on this discussion.
We could resettle them in the same way we've settled others. CWS/USCC. HIV
U.S. Govt. want to do this.
Agree to resettle. Udays - go to families. 80 to 90% would have family member in the U.S.

When we met w/ Harold Koh ⇒ Thought to be said about 50%.

Weiss ⇒ seek to determine families. INS would have to go to guardianship.

Immediate hospitalization when they hit the shore. Pregnant woman - longer shelter.

What has happened in the past.
Placements case by case. Local hospitals. Benefits. But hospitals want

commitment to pay bills.

Hospital care - could be covered under medical assistance. ⇒

Medicaid eligible forever.

Quickly link up - w/ AIDS foundation.

Martin enlist - cash + medical assistance.
8 months. For about. Fully reimbursed by federal govt. SSI-eligible : Supple. Security income ⇒ hospital care. ⇒ 80 under 500 ⇒ cash assistance + medicaid.

Cash assistance ⇒ Federal / some state
Medicaid ⇒ Federal / some state
50 to 80% Federal govt.

Lifetime costs. ⇒ 125,000 per year. HHS.
87,000 for life-time costs.
40,000

Come off the boat - applicant process.

Refugee medical assistance.

Studies accept 45%.

75% of these will settle in south Florida. We know, in the past, State Health offices may be wary.

4 or 5 months → cash and medical assistance - totally picked up.

Medicaid. →

CRS → Resettlement

Jim Puleo - only facility that is capable - is Port Israel - Rosario.

Bring in people → it becomes difficult to get the rest.

Don't turn them over.

Jeff Weiss ⇒ No more than 400 - 500 per week.

↳ CRS ⇒ would do resettlement.

↳ Understanding - N.Y., NJ, MA., Florida.

Will want to have a clear understanding of the

Children pregnant / women / ← Children / ← ↑

Announcement ←

Anytime hunt we're going to let people out of HIV.

Going to removing HIV criminality - precedent → politically safer.

120,000 →

Consultation. →

This is such a large population.

Dribble them in. ←

You could implant via a statute.

↳ Up to $20 million of the money.
& USC 1101 Note A - States that other circumstances reimbursement when assistance can be made available.

HIV positive.

Buster Ellis

Nobody in life-threatening situation in Guantanamo.

Out of 267 down. Only 10 truly on hunger strikes. Hard core. ~~Their~~ They're fine. If look dehydrating → They get treated.

Living cinderblock houses. Constructed by Marine Corps. Sleeping on soccer field. Under stars. ~~The~~ Real constraint: Capability. Pneumonia - latter stages. 1 respirator. If someone in dire straights. AF Aircraft on standby. ~~[redacted]~~ $7-8 million → Assume this would be needed for large migrant camp hospital.

Equipment + doctors.

~~[redacted]~~

Folks encouraging hunger strike—

When people are going to die.

Critically ⇒ Lower.

Critical → None Point

D.O.D. → Will → Probably ←

Military facilities.

Medical facilities ⇐

Water facilities.

Pneumonia / heart problem / Baby.

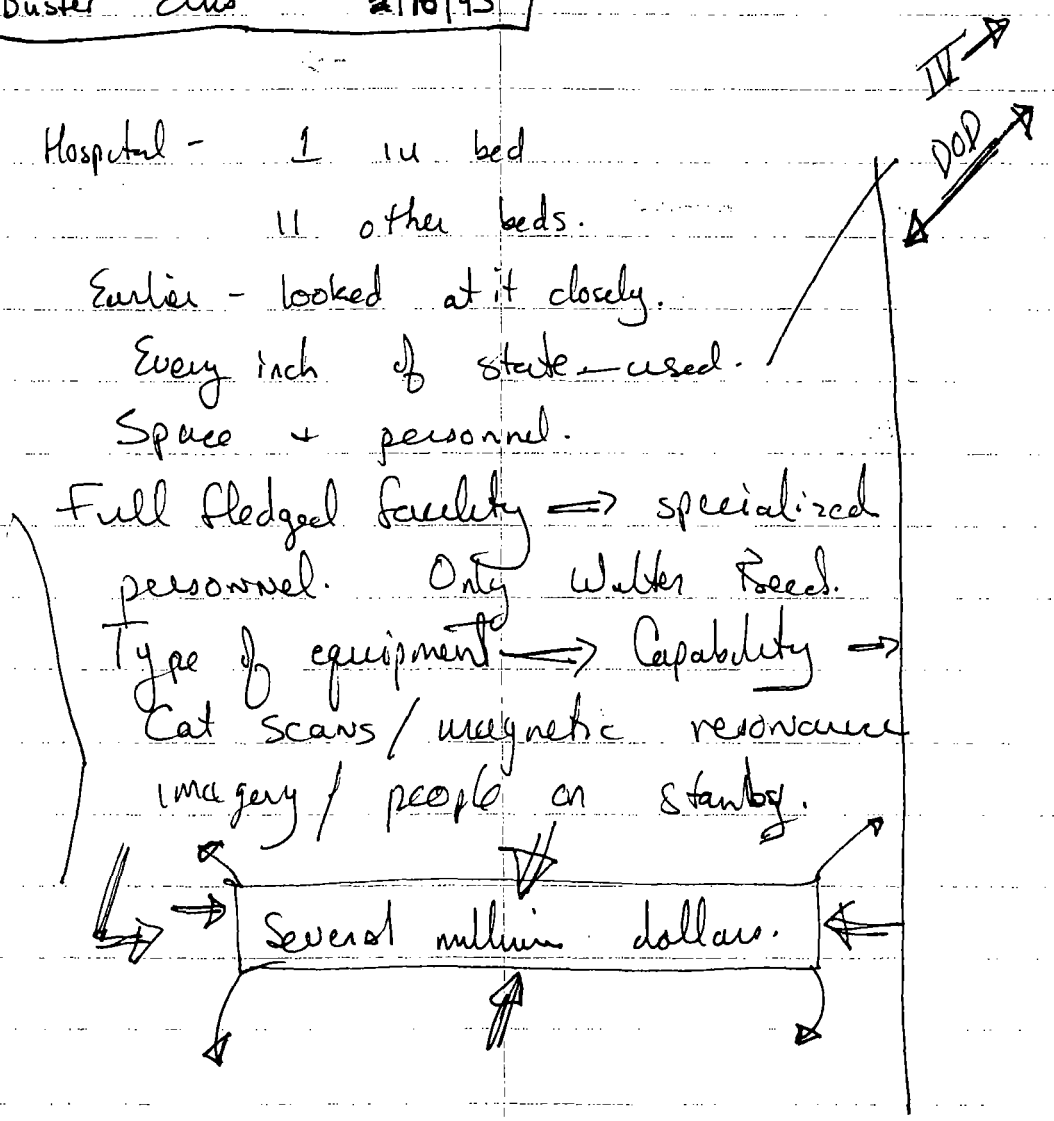
Hospital in Guantanamo ⇒ 11.

~~[redacted]~~ People in latent stages ⇒
They will go.

8:15

(703)6958166

Buster Ellis 2/10/93



Some opportunistic

Life - threaty. → babies - can deliver

Tumor on Tons.?.

HIV

F A X C O V E R S H E E T

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Ave., SW - Rm. 605-F
Washington, D.C. 20201

URGENT _____ NORMAL DELIVERY _____

DATE 2/18/93

TO Eric Schwartz - NSC

FAX # 395-1039 OFFICE # _____

FROM Patsy Fleming PHONE # 690-5400

Total Number of Pages, including this page: 3

Note: Please telephone (202) 690-5400 if all pages in this transmission are not received.

ADDITIONAL COMMENTS: _____

AIDS and Other Diseases.

- To estimate the economic burden of disease, a methodology called "cost-of-illness" is used. With the use of this methodology, the burden of disease is attributed to three components: direct medical costs, morbidity costs, and mortality costs.

  -- Direct medical costs reflects: the cost of preventive, diagnostic and treatment services related to the disease;

  -- Morbidity costs reflects: economic losses due to days lost from productive activity because of illness-related disability; and

  -- Mortality costs reflects: lost economic output, as measured by expected earnings (including imputed earnings for household work), due to the premature death of productive individuals.

- These last two costs are referred to, together, as indirect costs. Because of the lack of sufficient data sources and methodological difficulties, indirect costs are frequently not available.

- According to the latest estimates by the Public Health Service (PHS) Agency for Health Care Research and Policy (AHCPR), the national cost of treating all persons with the human immunodeficiency virus (HIV) rose considerably over the past year, and it will continue to rise over the next several years. It is forecast that the national cost of treating all persons with HIV will increase 48 percent from 1992 to 1995 ($10.3 to $15.2 billion).[1]

- It is estimated that the average yearly cost of treating a person with AIDS is $38,300 and that the average yearly cost of treating an infected person without AIDS is $10,000. The lifetime cost of treating a person with AIDS is calculated to be $102,000.[2]

- It is further estimated that the average yearly cost of treating an infected person without AIDS with a T-cell count below 200 is $13,525, and of treating an infected person without AIDS with a T-cell count equal to or greater than 200 is $6,444.[3]

What are the economic costs of HIV versus other chronic diseases?

- From various sources there are estimates of the cost of treating certain other illnesses. Caution must be advised with these estimates as there is no single comprehensive

study of this subject, and the "actual" numbers may vary significantly. Nevertheless, these estimates provide a rough basis for placing the cost of treating individuals with AIDS or HIV in perspective.

-- Liver and heart transplants are estimated to cost $100,000 - $200,000.[4]

-- The estimated lifetime cost of treating an individual with renal failure who requires dialysis is $158,000 (in 1984 dollars).[5] Preliminary data from the U.S. Renal Data System show that the cost for 153,000 patients is approximately $ 5.4 billion.[6]

-- The estimated lifetime cost of treating an individual paralyzed by an auto accident is $68,700 (in 1986 dollars).[7]

-- The most recent estimate of the five-year cost of treating an individual who has suffered an acute heart attack is $51,000.[8] An earlier estimate suggested that the lifetime cost of treating such an individual was $66,800.[9] The estimated five-year cost of treating an individual with unstable angina pectoris is $40,581.[10]

-- The estimated lifetime cost of treating an individual with cancer of the digestive system is $47,000 (in 1986 dollars).[11]

-- The estimated cost of treatment in the final year of life of individuals with cancer is $30,300 (in 1984 dollars).[12]

-- A recent article cited the cost of a low birth weight infant (< 1 Kg.) to typically range as high as $500,000.[13]

o Direct and indirect costs for cancer, all neoplasms in 1985 was estimated at $72 billion; in 1990, $103 billion.[14] The American Diabetes Association estimated diabetes cost $20.4 billion in 1987.[15] In 1988, heart disease costs were estimated at $26.8 billion.[16]

Source citations attached. [Prepared Tue Feb 16, 1993 - 1:47pm AL/NAPO]

1. Hellinger, Fred J. Forecasts of the Costs of Medical Care for Persons with HIV: 1992-1995. Draft article. February 11, 1992.

2. Hellinger, Fred J. Forecasts of the Costs of Medical Care for Persons with HIV: 1992-1995.

3. Hellinger, Fred J. Forecasts of the Costs of Medical Care for Persons with HIV: 1992-1995. Draft Article. February 11, 1992.

4. Henry. AIDS and Insurance Cutoffs. Washington Post, November 12, 1991. Cited in letter to Michael Astrue, Esq.

5. Fox and Thomas. AIDS Cost Analysis and Social Policy, 15 Law, Medicine and Health Care 186, 189 (1987/1988). Cited in letter to Michael Astrue, Esq.

6. U.S. Renal Data System. Annual Data Report, National Institutes of Health/NIDDK, Bethesda, MD. August 1990.

7. Fox and Thomas. AIDS Cost Analysis and Social Policy, 15 Law, Medicine and Health Care 186, 189 (1987/1988).

8. Wittels, Hay & Gotto. Medical Costs of Coronary Artery Disease in The United States, 65 American Journal of Cardiology 432, 435 (1990).

9. Fox & Thomas. AIDS Cost Analysis and Social Policy, 15 Law, Medicine and Health Care 186, 189 (1987, 1988).

10. Wittels, Hay & Gotto. Medical Costs of Coronary Artery Disease in the United States, 65, American Journal of Cardiology 432, 435 (1990). Cited in letter to Michael J. Astrue, Esq.

11. Fox and Thomas. AIDS Cost Analysis and Social Policy, 15 Law, Medicine and Health Care 186, 189 (1987/1988). Cited in letter to Michael Astrue, Esq.

12. Fox and Thomas. AIDS Cost Analysis and Social Policy, 15 Law, Medicine and Health Care 186, 189 (1987/1988). Cited in letter to Michael Astrue, Esq.

13. Henry, Sarah. AIDS and Insurance Cut-offs. Nation, November 11, 1991.

14. Brown, National Cancer Institute/NIH/HHS. Journal of the National Cancer Institute, December 1990.

15. American Diabetes Association. Direct and Indirect Costs of Diabetes in the U.S. in 1987.

16. Thom. NHLB/NIH/HHS from "Medical Cost of Coronary Disease in the U.S. American Journal of Cardiology, February, 1990.

H10 —

NATIONAL SECURITY COUNCIL
WASHINGTON, D.C. 20506

FAX TRANSMITTAL COVER SHEET

DATE: 2-9-93	
TO: Signal	FROM: Eric Schwartz
PHONE NO.: 2000	PHONE NO.: 1580
FAX NO.: 889-8430	FAX NO.: 1039

COMMENTS:

Names for conference call are:

MichaelCardozo (DOJ) 514-2011 ✓
Joseph Rees (INS) 514-1270 ✓
Phyllis Coven (DOJ) 514-2291 ✓
Priscella Clapp (State) 647-5767 ✓
Ed Needler (DOJ) 514-3261 ✓
Eric Schwartz (NSC) 395-1580
David Smith (HHS/ORR) 401-9255
Patsy Fleary (HHS) 690 5400 ✓

301 492 5929
Judy Weiss
CRS
Ken Lubeeka — Ass. Dir. Imm
Amy Dale CRS
514 4223
Jim Puleo — INS

NUMBER OF PAGES (including cover page): 1

HIV

United States Department of State

Washington, D.C. 20520

BUREAU FOR REFUGEE PROGRAMS
FAX MESSAGE COVER SHEET

Fax Telephone: (202) 663–1061

DATE: Feb. 1, 1993

PLEASE DELIVER THE FOLLOWING PAGES TO:

Name: Eric Schantz

Office: NSC

Fax Telephone: 395-1039

THIS MESSAGE IS FROM:

Name: Terry Rusch

Office: ~~663-1047~~ RP

Telephone: 663-1047

NUMBER OF PAGES INCLUDING COVER SHEET: 3

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NOTES:

Per your conversation with Priscilla.

$ Haiti

UNITED STATES CATHOLIC CONFERENCE

Migration and Refugee Services
Office of the Executive Director
3211 4th Street N.E. Washington, DC 20017-1194 (202) 541-3222 FAX (202) 541-3399 TELEX 7400424

January 28, 1993

Mr. Robert Gelbard
Principal Deputy Assistant Secretary
for Inter-American Affairs
Department of State
Washington, D.C. 20520-6258

Dear Mr. Gelbard: Bob

I wanted to reiterate our desire to participate in the resettlement of the HIV+ Haitians from Guantanamo Bay, as well as cite several factors that should be considered in any proposal affecting this group:

1. The Haitians should be accorded refugee status, and employment authorization must be unrestricted and available upon their arrival in the U.S.

2. The Haitians must have guaranteed Medicaid eligibility (derived from refugee status).

3. Biographical and profile information on the individuals should be made available as soon as possible to facilitate resettlement planning, on a case-by-case basis.

4. Volag processing staff should be sent to Guantanamo to expedite intake processing, identify and verify U.S. relatives, collect further biographical information, and provide initial orientation.

5. Other voluntary agencies should be encouraged to participate in this special resettlement effort.

6. Due to their exceptional needs, the resettlement program for these individuals should be for at least one year, for both family reunification and free case clients, and include services such as HIV/AIDS and family counseling, structured orientation, and case management/medical services coordination.

Factors specific to the movement of these individuals:

1. Processing and movement of the entire group at Guantanamo will take no more than 30 days after start-up.

2. After processing as many individuals as possible for direct departure to resettlement sites from Guantanamo, those without identifiable family members, or who cannot be moved for other reasons within one month, should be moved to temporary shelter/transit housing in the U.S. administered by voluntary agencies. Sponsorship development, screening, and orientation can be continued at these locations.

In closing, Bob, let me again say that we are very ready to get involved with actual processing in Haiti. We would be receptive to any proposal you may have for this effort, to include establishment and operation of multiple sites in the near future. Please keep us in the loop on this issue.

Sincerely,

Rick

Rev. Richard Ryscavage, S.J.
Executive Director

HIV

1

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

CC Carol Pascoe
Eric Schwartz

RE: HIV vote on Possible Tuesday

Facsimile Cover Memorandum

Nancy S

To: Nancy Stoesberg

Fax Number: 456-2560

From: Michael Iskowitz

Date & Time:

Number of Pages: Cover + 3

Return Fax Number : 202/224-3533
If there is trouble receiving this fax, please call 202/224-5880

Nancy, Thanks for your help on this. The ADA Commission is meeting with Eric this afternoon at 1:00.

I am very concerned that the attached amendment will be offered on the NIH bill next Tuesday, tying the President's hands. I am not sure that we can win it without considerable help.

Helms Amendment

tion 318 of the Public Health Service Act (42 U.S.C. 247c) to—

(1) routinely test each person receiving treatment for a sexually transmitted disease from the recipient to determine if such person is infected with the human immunodeficiency virus; and

(2) provide pre- and post-test counseling on acquired immunodeficiency syndrome to each such person.

(b) CONFIDENTIALITY.—In promulgating regulations under subsection (a), the Secretary shall ensure that confidentiality shall be provided to those tested under such regulations in accordance with section 552(a) of title 5 of the United States Code.

SEC. 20. IMMIGRATION REFORM.

Notwithstanding any other provision of law or any decision of the Secretary of Health and Human Services or any other Federal official, the President shall, pursuant to section 212(a)(6) of the Immigration and Nationality Act, add infection with the human immunodeficiency virus and syphillis to the list of dangerous contagious diseases contained in title 42 of the Code of Federal Regulations.

SEC. 21. HEALTH CARE WORKERS PROTECTION ACT.

(a) EXPOSURE PRONE INVASIVE PROCEDURES.—Notwithstanding any other provision of law, a State shall,

Bob Dole

NEWS U.S. SENATOR FOR KANSAS

FROM: SENATE REPUBLICAN LEADER

FOR IMMEDIATE RELEASE
FEBRUARY 10, 1993

CONTACT: WALT RIKER
(202) 224-5358

AIDS-INFECTED ALIENS

DOLE TO SHALALA: RESIST EXPLOSIVE POLICY CHANGE;
PROPOSED SHIFT RAISES SERIOUS QUESTIONS;
TAXPAYERS' FINANCIAL & PHYSICAL HEALTH MUST BE PROTECTED

WASHINGTON -- Senate Republican Leader Bob Dole (R-Kansas) today sent the following letter to Secretary of Health & Human Services Donna Shalala regarding the Clinton Administration's proposed change in the policy generally barring aliens infected with the AIDS virus from entering the United States:

Dear Secretary Shalala:

You have indicated that the Clinton Administration is preparing an executive order to reverse the policy generally barring aliens infected with the AIDS virus from entering the United States. The prospect of such a policy shift raises several troubling questions. These questions include but are not limited to:

Will people with the most advanced forms of AIDS be admitted? Who will care for these people should their physical condition worsen? Would these emigres be returned to their home country, or would taxpayers be forced to pay the astronomical cost of treatment for these patients, in effect establishing "health care asylum" in America? Will these AIDS patients add to the strain on our already overburdened health care system?

Is it wise to admit people to this country who may not be familiar with their responsibility to prevent the spread of AIDS? On top of the billions of dollars we have spent on AIDS research, our nation has invested untold millions of dollars to educate the public about the AIDS virus. Would the American taxpayer have to pay to educate these emigres, or are we willing to take our chances that these individuals will act responsibly? Would we be assured that none of these infected aliens had histories of sex crimes?

When America has faced a public health crisis, we have traditionally acted to limit cases of the infectious disease contributing to the threat. It is the responsibility of the U.S. Government to protect the well-being of our nation's people. While I realize some fears about AIDS are unfounded, I fail to see how bringing more people infected with AIDS into America will in any way contribute to the health and safety of the American public. It seems to me we have more than enough health care problems without adding to the crisis. The medical experts at the 300,000 member American Medical Association also oppose changing this policy.

In addition, it appears the current policy provision allowing infected aliens waivers for short-term visits for educational and humanitarian purposes is reasonable and adequate.

Unless you believe we have the AIDS crisis under control, I would advise you to resist this potentially explosive policy change. Furthermore, unless questions like those above can be adequately addressed, an executive order overturning current policy would likely precipitate Congressional action to safeguard the financial and physical health of the American taxpayer.

Sincerely,
BOB DOLE

cc: The Honorable Stuart Gerson, Acting Attorney General

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NATIONAL COMMISSION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME
1730 K Street, N.W., Suite 815
Washington, D.C. 20006
(202) 254-5125 FAX 254-3060 TDD 254-3816

February 10, 1993

STATEMENT ON IMMIGRATION POLICY

The National Commission on AIDS commends the Administration's preliminary decision to remove HIV infection from the list of conditions which constitute grounds for excluding an individual from traveling or immigrating to the United States.

The U.S. Congress reaffirmed under the Immigration Act of 1990 (P.L. 101-649) that public health judgments on these issues are appropriately placed in the hands of the Secretary of Health and Human Services, hence, there is no need of further congressional action in this matter. Under the Act, Congress directed the Secretary to look to "current epidemiological principles and medical standards" in assessing the need to exclude immigrant applicants on the basis of illness or medical condition. Accordingly, the Public Health Service reexamined the list of diseases to be used for the purposes of exclusion. Of the eight diseases on the list, the Public Health Service determined that only infectious tuberculosis should be retained as it alone was transmissible through the air and by casual contact, and therefore a threat to the public health. The Commission urges that any proposed or final rule realign U.S. immigration policy with sound public health principles.

Under the Immigration Act of 1990, the Congress also reaffirmed the appropriateness of placing determinations related to economic burden in the hands of the Attorney General. It has been argued by some that HIV-infected individuals should be barred from immigration into the United States on the basis of the financial cost they will pose to the nation. It is a fact that immigration applicants who are HIV positive, like every other applicant, will be obliged to satisfy all other immigration requirements, including financial requirements. Public charge provisions of the Immigration and Nationality Act require all applicants for immigrant and non-immigrant visas to demonstrate that they are not likely to become public charges. Anyone who does not do so is denied a visa and precluded from either visiting or immigrating to the United States. This is based on a "totality of circumstances" test which considers an applicant's health, financial resources, and their ability to earn a living in the future. As an added safeguard, the regulations provide that an alien who becomes a public charge within five years of entry be deported. Elimination of the exclusion based on HIV infection will in no way lessen these restrictions on individuals who wish to immigrate to the United States.

The Commission voices its deep distress over the encroachment, once again, of extraneous issues into a decision that should be science-based and focused solely on public health concerns. We must not allow arguments based on politics, misinformation, fear or discrimination to triumph. To do so is to betray the heart and integrity of the federal government's role in protecting and advancing the health of all its people. The desire of President Clinton and Secretary of Health and Human Services Shalala to base public health policy on sound science is unequivocally supported by the National Commission on AIDS.

Administration for Children and Families
Office of Refugee Resettlement
370 L'Enfant Promenade, SW
Washington, DC 20447-0001

Date: 2/12 **FAX: 401-5487**

To: Eric Schwartz	**From:** David Smith ORR
Phone:	**Phone:**

ORR Facsimile Instructions:

FAX machine number: (202) 395 — 1039

or SPEED-DIAL number: ____ **Please Confirm Transmission at:** ____

Message: Here is the revised version.

COST ASSUMPTIONS

The Haitian entrant population in Guantanamo Bay is comprised of 267 individuals, of whom 215 have been diagnosed as HIV-positive. Of those, 10 have symptomatic AIDS with T-4 counts (serum Thyroxine blood test) of less than 200; 78 have T-4 counts of 200--500, and the remainder are above 500.

Refugee cash assistance has been calculated for 179 individuals (267-88 eligible for SSI-disabled) for a period of 5 months at the average monthly rate of $205 per person.

Refugee medical assistance has been calculated for 52 individuals, known to be HIV negative or whose HIV status is unknown, at the rate of $183 per month (an RMA average cost) for 5 months; and for 127 individuals, HIV positive but without clinical symptoms, for a period of 5 months at the rate of $382 per month, based on an estimated annual medical care cost of $4,582.*

SSI Disability is calculated for 215 HIV positive individuals at the maximum Federal rate of $434 per month for an estimated 3 years.

SSI Disability State Supplement is based on estimates of 25% of the population qualifying at the rate of 25 percent of the Federal maximum payment.

Medicaid is calculated on the assumption that all 215 HIV positive cases will become active AIDS cases at some point and that thereafter costs will be $66,336 over 2 years. It also is assumed that cases with current T-4 counts from 200--500 will receive a year of Medicaid at $4,582 before becoming active AIDS cases.*

The cost of pregnancy-related care is calculated at $4,000 for two HIV-negative females and at $7,000 per capita for 15 HIV positive females. The Federal Medical Assistance Percentage (FMAP) is calculated at an average of 54%.

General Assistance (GA) is calculated for an estimated 46 recipients, 70 percent of whom will reside in Florida, at the Dade County GA rate of $220 per month. The cost for the remaining 30 percent are calculated using the average costs of New York and Massachusetts.

State and local general medical assistance costs are calculated for an estimated 46 recipients for one year at the rate of $400 per month.

*Costs for care of HIV positive individuals provided by the Agency for Health Care Policy and Research, HHS.

FIRST-YEAR COSTS

	FEDERAL	STATE/LOCAL
REFUGEE CASH ASSISTANCE	165,128	
REFUGEE MEDICAL (HIV-)	47,580	
REFUGEE MEDICAL (HIV+)	242,570	
REFUGEE UNACCOMPANIED MINOR	12,000	
SSI DISABILITY (51) ($434) (12mo)	265,608	
SSI DISABILITY STATE SUPPLEMENT ($265,608) (.25) (.25)		16,601
MEDICAID (ACTIVE AIDS) (10) ($33,168)	179,107	152,573
MEDICAID (T4 250-500) (40) ($4,528)	98,971	84,309
MEDICAID (NORMAL PREGNANCIES (2) ($4,000)	4,320	3,680
MEDICAID (HIV+ PREGNANCIES (15) (7,000)	56,700	48,300
GENERAL ASSISTANCE (46) (.70) ($220/mo) (7mo) (46) (.30) ($375/mo) (7mo)		49,588 36,225
GENERAL MEDICAL ASSISTANCE (46) ($400) (7)		128,800
TOTAL	1,071,984	520,076

LIFETIME COSTS

	FEDERAL	STATE/LOCAL
Refugee Cash Assistance (179)(.90)($205/mo)(5 mo)	165,128	
Refugee Medical (HIV Neg) (52)($183/mo)(5mo)	47,580	
Refugee Medical (HIV POS) (127)($382/mo)(5mo)	242,570	
Refugee Unaccompanied Minors	96,000	
SSI Disability (215)(434/mo)(36 mo)	3,359,160	
SSI Disability State Supplement ($3,327,912)(.25)(.25)		207,994
Medicaid (Active AIDS) (215)($66,336)	7,701,610	6,560,615
Medicaid (t4 200-500) (205)($4,582)(1 Yr)	507,227	432,083
Medicaid (Normal Pregnancies) (2)($4,000)	4,320	3,680
Medicaid (HIV + Pregnancies) (15)($7,000)	56,700	48,300
General Assistance		
(46)(.70)(220/mo)(6 mo) FL		42,504
(46)(.30)(375/mo)(12 mo) NY/MA		62,100
State/Local Medicaid (40)($400) (1 Yr)		220,800
Total	$12,197,587	$7,574,856

Grand Total $19,772,443

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

TO: The Secretary
Through COS
ES 2/4/93 FEB - 5 1993

FROM: Glen Harelson
Policy Coordinator/ Public Health

SUBJECT: **Final Rule--Medical Examination of Aliens--ACTION**

In response to your request for re-evaluation of pending regulations, the Public Health Service, Centers for Disease Control and Prevention has reviewed the attached draft final rule on the Medical Examination of aliens, and finds it appropriate for re-submission without modification.

PROVISIONS OF THE REGULATION

In this regulation, "communicable diseases of public health significance" are diseases for which aliens and immigrants can be excluded from entering the United States. This final rule defines such diseases for which aliens and immigrants can be excluded from entering the United States. This final rule defines such diseases as solely infectious tuberculosis. Thus HIV infection, syphilis, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum and Hansen's disease are deleted.

As the Conference Report for the Immigration Act of 1990 stated, "communicable diseases of public health significance" are "diseases for which admission of aliens with such disease would pose a public health risk to the United States," and the determination is to be made based on epidemiological principles and medical standards. On this basis, none of the seven deleted diseases constitutes a "communicable disease of public health significance."

EXPECTED IMPACT OF THE REGULATION

Of the almost 175,000 comments CDC received in response to the notice of proposed rulemaking and interim final rule, 65 percent supported deleting HIV infection from the list of communicable diseases, while only 35 percent supported keeping it on the list. Additionally, the public health community and others, both in the United States and around the world, continue to express concerns about the United States' current policy of excluding aliens with HIV infection. As you are aware, there are currently some 276 Haitian refugees detained at Guantanamo Naval Base, due to their HIV status, who will be eligible for admission to the United States upon the promulgation of this final rule. The effective date of this rule will be the date of publication in the Federal Register.

RECOMMENDATION

In addition to the Public Health Service, all OS staff offices concur with the content of draft final rule and recommend that you sign the attached rule for submission to OMB for clearance.

DECISION

Approve the regulation as drafted. If approved, please sign the regulation at the signature tab.

Date _____

Approve_____ Disapprove_____

Other_____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
42 CFR Part 34
RIN 0905-AD29
MEDICAL EXAMINATION OF ALIENS

AGENCY: Centers for Disease Control and Prevention (CDC), Public Health Service, HHS

ACTION: Final Rule.

SUMMARY: This final rule revises the interim final rule published in the Federal Register May 31, 1991 (56 FR 25001), implementing the health-related provisions of the Immigration Act of 1990 (Pub. L. 101-649). This rule revises the list of communicable diseases of public health significance, to include only infectious tuberculosis; clarifies the definitions of drug abuse and drug addiction; and includes technical changes to conform with the revised list of communicable diseases.

EFFECTIVE DATE: [Insert date of publication in the Federal Register.]

FOR FURTHER INFORMATION CONTACT: Mr. Charles R. McCance, Director, Division of Quarantine, National Center for Prevention Services, Centers for Disease Control and Prevention (CDC), Mail Stop E04, Atlanta, GA 30333; telephone (404) 639-1455.

SUPPLEMENTARY INFORMATION: On January 23, 1991, a Notice of Proposed Rulemaking (NPRM) was published in the Federal Register (56 FR 2486) proposing that infectious tuberculosis be the only communicable disease of public health significance for exclusion purposes. During the 30-day comment period, approximately 48,300 comments were received. In view of the extent of the public comment and the concerns expressed by the commenters, the Department decided that more time was needed to review the issue. Therefore, in order for the Department to implement the health exclusion provisions of the Immigration Act of 1990 in a timely fashion, the eight diseases previously listed at 42 CFR 34.2(b) were listed as "communicable diseases of public health significance" in an interim rule (IR) published in the Federal Register on May 31, 1991 (56 FR 25000). These eight diseases are chancroid, gonorrhea, granuloma inguinale, human immunodeficiency virus (HIV) infection, infectious leprosy, lymphogranuloma venereum, infectious stage syphilis, and active tuberculosis. This IR also included provisions for implementing the other health-related exclusion provisions (i.e., mental and physical disorders with associated harmful behavior, drug abuse and addiction, and other health conditions resulting in substantial departures from normal health and well being). During the 60-day comment period following publication of the IR, approximately 126,500 additional comments were received.

Combined Comments on the NPRM and IR

A total of 174,800 comments were received on the NPRM and IR. Overall, 35 percent supported listing HIV infection as a communicable disease of public health significance while 65 percent supported not listing HIV infection.

Economic Concerns. In the NPRM comments, the largest single set of reasons given for objecting to the absence of HIV from the list of communicable diseases of public health significance related to economic concerns. Many commenters apparently interpreted the words "public health significance" to include economic and resource issues as well as disease transmissibility.

The NPRM was developed based on those public health "threats" to the United States that could be demonstrated using epidemiological principles and other relevant medical considerations. The Conference Report for the Immigration Act of 1990 stated in part:

> By substituting the words "public health significance" for "dangerous," Congress intends to insure that this exclusion will apply only to those diseases for which admission of aliens with such disease would pose a public health risk to the United States.... A disease of public health significance means one in which admission of aliens with such disease would

constitute a public health threat to the United States. Such determination shall be based on current epidemiological principles and medical standards. (136 Congressional Record H13238, October 26, 1990.)

It is unlikely that Congress intended to address economic concerns through the public health significance exclusion since that exclusion is limited to communicable diseases and does not address other categories of noncommunicable diseases that would be of equal or greater potential economic threat such as end-stage renal disease, cardiovascular conditions, or cancer.

Under the old law, there was a health-related exclusion for aliens (designated 212(a)(7)) having a physical defect, disease, or disability that would prevent them from earning a living. This exclusion was repealed by P.L. 101-649 and has no explicit counterpart among the health-related exclusions that became effective on June 1, 1991.

However, in the Immigration Act of 1990, the Congress preserved the "public charge" exclusion that provides for the denial of a visa to any applicant who is likely to become a public charge. In discussing the public charge language and the deletion of the "ability to earn a living" provision in the 1988 predecessor to the Act, the House Judiciary Committee specifically pointed out that:

"Section 212(a)(7) of current law, providing for the exclusion of aliens who have a physical defect which may affect their ability to earn a living, would be subsumed under the public charge exclusion.... The Committee report states, 'In relaxing the health grounds for exclusion, the public charge exclusion may become a factor in even more cases than it has in the past.'" STAFF OF HOUSE COMM. ON THE JUDICIARY, 100TH CONG., 2D SESS., GROUNDS FOR EXCLUSION OF ALIENS UNDER THE IMMIGRATION AND NATIONALITY ACT, HISTORICAL BACKGROUND AND ANALYSIS 93 (Comm. Print 1988)

In discussing the public charge exclusion, the 1988 Judiciary Committee Report referred to in the Print provided that:

"Proposed section 212(a)(4)(A) . . . preserves the Executive's ability to exclude any alien likely to become a public charge. This ground for exclusion has the highest number of denials of any exclusion category, which attests to its viability and effectiveness. Its obvious purpose is to ensure that immigration does not create a drain on the public fisc."

"In relaxing the health grounds for exclusion, the public charge exclusion may become a factor in even more cases than it has in the past. Although it is not the Committee's intent that the public charge exclusion be more strictly applied in cases involving mental and physical disorders, the Attorney

General and HHS are charged with certain responsibilities to ensure that aliens are subjected to public health safeguards. In order to do this, coordination with treatment facilities in the United States and local health care officials will sometimes be required. Officials must be convinced that sufficient assurances are in place to overcome public charge problems that could result if conditions of admission are not met. Other tools, of course, are available to the Attorney General after admission, including deportation when aliens do not follow through with treatments or other conditions imposed as a precondition to their admission." (H. Rep. 100-882, pp. 37-38.)

From the foregoing, it is apparent that Congress was concerned about economic burdens that might be incurred by admitting aliens to the United States with any health conditions, communicable and noncommunicable. It is clear that Congress chose to address these concerns through the public charge exclusion now contained in section 212(a)(4).

Health Risk Concerns. In early 1990, the Public Health Service reviewed the list of dangerous contagious diseases to determine whether the diseases on the old list presented a public health risk to the United States. Following that review it was determined that only infectious (or active) tuberculosis should be on such a list. As indicated in the NPRM, the issue was

discussed with representatives of the American Medical Association (AMA), the American Public Health Association, the Association of State and Territorial Health Officials, CDC's Advisory Committee on the Elimination of Tuberculosis, CDC's Advisory Committee on the Prevention of HIV Infection, the Council of State and Territorial Epidemiologists, the Department of Defense, the National Association of County Health Officials, the National Commission on Acquired Immune Deficiency Syndrome, the National Medical Association, the U.S. Conference of Local Health Officers, and with a former Assistant Secretary for Health. All of those consulted supported deleting all of the diseases on the list of dangerous contagious diseases except infectious (or active) tuberculosis. The non-Federal experts were also asked if there should be any other communicable diseases on a list of excludable conditions, and they agreed that no other diseases in aliens would pose a significant health risk to the U.S. population.

Also in early 1991, the Centers for Disease Control asked the non-Federal consultants, who had previously reviewed the list of dangerous contagious diseases in 1990, for their comments on the NPRM published on January 23, 1991. Representatives of the American Public Health Association, the Association of State and Territorial Health Officials, CDC's Advisory Committee on the Elimination of Tuberculosis, the Council of State and Territorial Epidemiologists, the National Association of County Health

Officials, the National Commission on Acquired Immune Deficiency Syndrome, and the National Medical Association still believed that infectious tuberculosis should be the only disease on the list. The AMA, while expressing concern about the implications for the health care delivery system of an influx of HIV-infected immigrants, also agreed that only infectious tuberculosis should be left on the list, since inclusion of HIV infection would result in nonimmigrant travelers being excluded from the United States. The AMA suggested that legislation be enacted to modify the immigration law so that exclusion of HIV-infected persons would be limited to immigrants. In addition, the AMA indicated that decisions on testing and exclusion of immigrants to the United States should be made only by the Public Health Service, based on the best available medical, scientific and public health information.

HIV infection is transmitted among adults in this country almost exclusively by two routes: sexual intercourse with an infected person, and the sharing of contaminated injection equipment by injecting drug users. The risk of (or protection from) HIV infection comes not from the nationality of the infected person, but from the specific behaviors that are practiced. A careful consideration of epidemiological principles and current medical knowledge leads us to conclude that allowing HIV-infected aliens into this country will not pose a significant additional risk of HIV infection to the U.S. population, where HIV infection is

already widespread. Our best defense against further spread of HIV infection, whether from a U.S. citizen or alien, is an educated population.

Other Diseases. The other sexually transmitted diseases are not transmitted by casual contact, through the air, or from common vehicles (such as food or water), nor will an infected person in a common or public setting place another individual inadvertently or unwillingly at risk. Again, a careful consideration of epidemiological principles and current medical knowledge leads us to conclude that allowing persons with these conditions to enter the United States will not pose a significant risk to the general population, where there is already a widespread prevalence of these sexually transmitted diseases.

Hansen's disease (leprosy) is not highly contagious. It is spread thrcugh prolonged contact with an infected individual. The majority of imported cases occur in persons who do not manifest outward signs of the disease when they are medically screened abroad, but develop active disease after arriving in this country. Effective drugs are now available for treating this disease and suppressing its infectiousness. In recent years, management of patients with Hansen's disease has substantially changed from isolation from society to ambulatory treatment. There is a nationwide system in the United States to

provide comprehensive care and treatment to persons diagnosed with Hansen's disease.

Thus, we have reviewed and carefully considered all the comments received on whether to include or not include HIV infection and the seven other diseases on the list of communicable diseases of public health significance. In view of: (1) current epidemiological principles and medical standards; (2) the statutory context of this particular health-related exclusion; and (3) the clear legislative intent that economic considerations are to be handled under the separate "public charge" exclusion of 212(a)(4), we have concluded that only infectious tuberculosis should be listed as a communicable disease of public health significance. We are changing the term currently in the regulation, "tuberculosis, active," to "tuberculosis, infectious" to correspond with current medical terminology. Additionally, technical changes are included to conform with the revised list of communicable diseases.

No substantive comments were received on the physical/mental disorders associated with harmful behavior or the drug abuse/addiction aspects of the IR. However, since implementing the medical provisions of the Immigration Act of 1990, some panel physicians have stated they are having difficulty in establishing a diagnosis in cases of single or occasional use of psychoactive substances under the definitions of drug abuse and drug addiction

established in the IR. Consequently, we have clarified the definitions of drug abuse and drug addiction. Examining physicians will now be required to use the Diagnostic and Statistical Manual of Mental Disorders (DSM) (of the American Psychiatric Association) definitions for "psychoactive substance abuse" and "psychoactive substance dependence."

The definition of "CDC" has been changed to Centers for Disease Control and Prevention as authorized in Public Law 102-321.

ECONOMIC IMPACT

Economic Analysis. The Secretary has determined that this rule will not have a significant impact on a substantial number of small entities and therefore does not require a regulatory flexibility analysis under the Regulatory Flexibility Act, Pub. L. 96-354. The Secretary has also determined that this rule would not be a "major rule" under Executive Order 12291. Thus, a regulatory impact analysis is not required because this rule will not:

1. Have an annual effect of $100 million or more on the economy;
2. Impose a major increase in costs or prices for consumers; individual industries; Federal, State, or local government agencies; or geographic regions; or

3. Result in significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

LIST OF SUBJECTS IN 42 CFR PART 34:

Aliens, Health care, Passports and Visas, Public Health

Therefore, Part 34 of Title 42 of the Code of Federal Regulations is amended as set forth below.

Dated: FEB 5 1993

Audrey F. Manley

Audrey F. Manley M.D., M.P.H.
Acting Assistant Secretary for Health

Approved:

Donna E. Shalala
Secretary

PART 34 - MEDICAL EXAMINATION OF ALIENS

1. Section 34.2(a), 34.2(b), 34.2(g), and 34.2(h) of Part 34 are revised to read as follows:

§ 34.2 Definitions.

(a) CDC. Centers for Disease Control and Prevention (CDC), Public Health Service, U.S. Department of Health and Human Services

(b) Communicable Disease of Public Health Significance. Tuberculosis, infectious.

(g) Drug abuse. The non-medical use of a substance listed in section 202 of the Controlled Substances Act, as amended (21 U.S.C. 812), which has not necessarily resulted in physical or psychological dependence. ("Drug abuse" is synonymous with psychoactive substance abuse as defined in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.)

(h) Drug addiction. The non-medical use of a substance listed in section 202 of the Controlled Substances Act, as amended (21 U.S.C. 812), which has resulted in physical or psychological dependence. ("Drug addiction" is synonymous with psychoactive

substance dependence as defined in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.)

* * * * *

2. In §34.3, paragraphs (b), (b)(1), (b)(1)(v), and paragraph (b)(4), and paragraph (b)(5) are revised to read as follows:

§34.3 Scope of examinations.

(a) * * *

(b) Persons subject to requirement for chest X-ray examination.

(1) Except as provided in paragraph (b)(1)(v) of this section, a chest X-ray examination of persons 15 years of age and older shall be required as part of the examination of:

* * * *

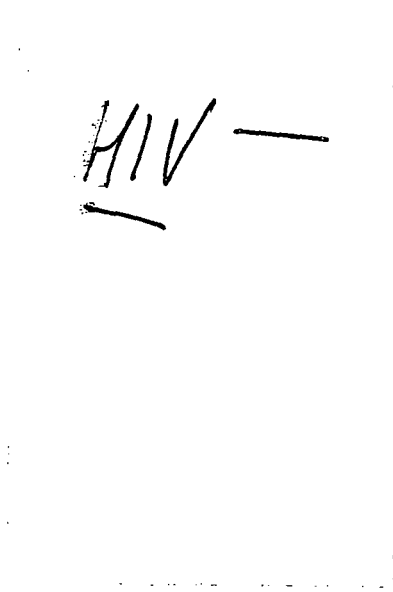
(v) Exceptions. A chest X-ray examination shall not be required if the alien is under the age of 15. Provided, a tuberculin skin test shall be required if there is evidence of contact with a person known to have tuberculosis or other reason to suspect tuberculosis, and a chest X-ray examination shall be required in the event of a positive tuberculin reaction. Additional exceptions to the requirement for a chest X-ray examination may be authorized for good cause upon application approved by the Director.

* * * *

(4) How performed. All chest X-ray films used in medical examinations performed under the regulations in this part shall be large enough to encompass the entire chest (approximately 14 by 17 inches; 35.6 X 43.2 cm.).

(5) Chest X-ray, laboratory, and treatment reports. The chest X-ray reading shall be included in the medical notification. When the medical examiner's conclusions are based on a study of more than one chest X-ray film, the medical notification shall include at least a summary statement of findings of the earlier films, followed by a complete reading of the last film, and dates and details of any laboratory tests and treatment for tuberculosis.

* * * *


HIV —

WORKING PAPER

Wl **policy with respect to such persons? Do**
yc **en: o the US to obtain necessary care?**
Do **me sent to the US to obtain medical care?**

It is the responsibilty of INS to provide medical care to migrants held in retention. The military's policy has always been to seek parole for any migrant whose medical care needs exceed the capability at GTMO. In the past, DOD sought parole and INS granted the parole, but INS refused to take the migrants into INS facilities or INS contract facilities, therefore DOD assumed the responsibility by default and brought them to DOD medical facilities in CONUS. There have been six (6) migrants paroled in for medical care beyond GTMO's capability: one (1) [illegible] problem (treated and released to INS), one (1) [illegible] lobe pneumonia (died after 3 days at Walter Reed and four (4) with eye problems (treated and released to INS).

- There have also been 14 HIV-positive pregnant migrants and a 7-year old girl with AIDS paroled in to the AIDS Resource Foundation for Children in Newark, NJ. Although childbearing has taken place at GTMO, the pregnant migrants were paroled in as a precaution against any complication during birth. The 7-year old was paroled in solely for humanitarian reasons.

Under what other circumstances do you seek to have Haitians sent to the US. For example, do you do this when loss of life is imminent?

- Haitians are requested to be sent to the US when they require specialty consults that are not available [illegible] i.e. eye examinations. When patients are in the terminal stages of AIDS, parole and evacuation into the US is requested.

What general (and recurring) health problems do you see on GTMO that you are not able to handle there?

- None, however, for advanced HIV/AIDS see above re question #2.

How much money would it cost to obtain the capacity to deal with such problems?

- Initial estimates are start up costs of $218 million and $9 million in annual costs.

WORKING PAPER

ANSWERS TO QUESTIONS RELATING TO GUANTANAMO (GTMO) AND HEALTH CARE.

Are there Haitians on GTMO who have health needs that the GTMO facility is not able to meet?

- There are currently seven (7) HIV-positive migrants who have health care needs beyond GTMO's capability.

What exactly are those needs?

- Five (5) have such a low CD4 (T-cell count) that they will soon require medical specialists, diagnostic equipment, and facilities for diagnosis and treatment of life-threatening illnesses that are not available at GTMO.

- The low CD4 counts are 18, 23, 32, 54, and 74.

- The migrant with the CD4 count of 32 was recently hospitalized for two weeks with reactivation of pulminary tuberculosis and pleural effusion. He was in intensive care for several days. He is stable, but weak and remains vulnerable to other opportunistic infections.

- Two (2) migrants have specific medical needs:

  - One was given an AIDS defining diagnosis of pulminary tuberculosis in May 1992. He has progressive chronic renal failure of uncertain which complicates the medical therapy for his HIV infection. He has developed evidence of unexplained intracranial bleeding and meningitis. An MRI is required to properly assess this patients problem--but it is not available at GTMO.

  - The other has a possible malignant tumor of his right tonsil. Otolaryngologist and diagnostic equipment, such as CT Scanning to assess the extent of the mass are needed to properly evaluate and treat this patient--but it is not available at GTMO.

- In general, GTMO does not have the level of care to meet the standard of care set for advanced HIV-positive patients. The hospital facility does not have the capability to care for terminal AIDS patients.

Is it true that there are only 10 hunger strikers, and that they are accepting IVs, so that they are not in any imminent risk of death?

- The hunger strike is in its twelfth day and it is true that only about 10 of the migrants at GTMO are hard core hunger strikers. These 10 have agreed to regularly consume a liquid electrolyte solution which will help them fight off dehydration--the only problem that has resulted from the hunger strike to date. Food distribution in the camp continues to be widespread and tolerated by the strike leaders as long as it is hidden from open view. The strike does not appear to be a unified migrant effort. Any migrants that require medical attention (only dehydration so far) have received it and they have been cooperative. There are no migrants who are in any imminent risk of death as a result of the strike.