UPDATE ON MEDICAL RECORDS PRIVACY

Over Democratic opposition, the House included a badly-drafted medical privacy provision in the financial modernization bill. We opposed it in the SAP we issued on the banking bill because of several significant shortcomings, including:

- **Preemption of the HHS regulations.** The provision undermines HHS' rulemaking authority under HIPAA, limiting that authority to entities other than insurers. It could also do harm by prohibiting disclosures that HHS would permit under regulation, and want to encourage, such as disclosures for public health purposes.

- **Preemption of stronger state laws.** Contrary to the Administration's position in medical privacy, the House bill would preempt stronger state medical privacy laws. These exist, for instance, for mental health records, HIV registries, and other sorts of especially sensitive information. A report next week will show 250 pages of state medical privacy laws, many of which would be preempted. It is important to note that Ganske is now circulating a letter saying that his amendment is not intended to preempt state law.

- **Research provision creates a huge loophole.** This provision allows transfers of information for "participating in research projects." In the medical privacy context, industry has testified that "research" includes "marketing research." In short, the bill would apparently allow an insurance company to ship information to other companies as part of "marketing research", allowing people's intimate medical data to be used by outside marketers.

- **No provisions prohibiting re-use of information.** The prohibitions on re-use of data in the rest of the House bill do not apply to the medical provisions. Companies that receive sensitive medical data from insurers are then free to use and sell the data without any Federal legal restrictions whatsoever.

- **Absence of minimum consent provisions.** There are no requirements for the minimum necessary content of a consent to use health information. This means that if a health care provider asked for documentation of your blood type, the insurer should not be permitted to release any other medical information they might have.

The Administration is currently actively advocating for this provision to be struck during conference. However, OMB and HHS think that the only way to successfully strike the provision would be to substitute it with an agreement to substantially delay issuance of the HHS regulations.

Jeffords won't do anything before September. But we should say we're moving forward with the reg.

Report by Labor Day

Deputies mid next week

payment card or account number, or by other payment means;

(B) the transfer of receivables, accounts, or interest therein;

(C) the audit of the debit, credit, or other payment information;

(D) compliance with Federal, State, or local law;

(E) compliance with a properly authorized civil, criminal, or regulatory investigation by Federal, State, or local authorities as governed by the requirements of this section; or

(F) fraud protection, risk control, resolving customer disputes or inquiries, communicating with the person to whom the information relates, or reporting to consumer reporting agencies.

(b) STATE ACTIONS FOR VIOLATIONS.—In addition to such other remedies as are provided under State law, if the chief law enforcement officer of a State, State insurance regulator, or an official or agency designated by a State, has reason to believe that any person has violated or is violating this title, the State may bring an action to enjoin such violation in any appropriate United States

district court or in any other court of competent jurisdiction.

(c) EFFECTIVE DATE; SUNSET.—

(1) EFFECTIVE DATE.—Except as provided in paragraph (2), subsection (a) shall take effect on February 1, 2000.

(2) SUNSET.—Subsection (a) shall not take effect if, or shall cease to be effective on and after the date on which, legislation is enacted that satisfies the requirements in section 264(c)(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033).

(d) CONSULTATION.—While subsection (a) is in effect, State insurance regulatory authorities, through the National Association of Insurance Commissioners, shall consult with the Secretary of Health and Human Services in connection with the administration of such subsection.

TITLE IV—UNITARY SAVINGS AND LOAN HOLDING COMPANIES

SEC. 401. PROHIBITION ON NEW UNITARY SAVINGS AND LOAN HOLDING COMPANIES.

(a) IN GENERAL.—Section 10(c) of the Home Owners' Loan Act (12 U.S.C. 1467a(c)) is amended by adding at the end the following new paragraph:

(3) the prospective application of any final State regulation, order, bulletin, or other statutorily authorized interpretation or action,

which, by its specific terms, expressly regulates or exempts from regulation any person who solicits the purchase of or sells insurance connected with, and incidental to, the short-term lease or rental of a motor vehicle.

(c) SCOPE OF APPLICATION.—This section shall apply with respect to—

(1) the lease or rental of a motor vehicle for a total period of 90 consecutive days or less; and

(2) insurance which is provided in connection with, and incidentally to, such lease or rental for a period of consecutive days not exceeding the lease or rental period.

(d) MOTOR VEHICLE DEFINED.—For purposes of this section, the term "motor vehicle" has the meaning given to such term in section 13102 of title 49, United States Code.

Subtitle D—Confidentiality

SEC. 351. CONFIDENTIALITY OF HEALTH AND MEDICAL INFORMATION.

(a) IN GENERAL.—A company which underwrites or sells annuities contracts or contracts insuring, guaranteeing, or indemnifying against loss, harm, damage, ill-

ness, disability, or death (other than credit-related insurance) and any subsidiary or affiliate thereof shall maintain a practice of protecting the confidentiality of individually identifiable customer health and medical and genetic information and may disclose such information only—

(1) with the consent, or at the direction, of the customer; specify conditions

(2) for insurance underwriting and reinsuring policies, account administration, reporting, investigating, or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), providing information to the customer's physician or other health care provider, participating in research projects, enabling the purchase, transfer, merger, or sale of any insurance-related business, or as otherwise required or specifically permitted by Federal or State law; or

(3) in connection with—

(A) the authorization, settlement, billing, processing, clearing, transferring, reconciling, or collection of amounts charged, debited, or otherwise paid using a debit, credit, or other

GREG GANSKE
4TH DISTRICT, IOWA

COMMERCE COMMITTEE
SUBCOMMITTEES:
HEALTH AND ENVIRONMENT
FINANCE AND HAZARDOUS MATERIALS
OVERSIGHT AND INVESTIGATIONS

CONGRESS OF THE UNITED STATES

HOUSE OF REPRESENTATIVES

July 12, 1999

Dear Colleague:

The medical privacy provision in H.R. 10 restricts disclosures of customer health and medical information by insurers.

Some concerns have been raised about the exceptions to the opt-in policy. I would like to take this opportunity to define some of the terms found in the exceptions and dispel the misinformation that is being circulated regarding these provisions.

Under current law, an insurance company obtains medical record information only with an individual's authorization. The medical privacy provision in H.R. 10 relates to how an insurance company shares the data after it has acquired it. The provision states that insurers can only disclose this information with an individual's consent except for limited, legitimate business purposes. These provisions would apply to all insurers who are currently engaged in the insurance business, and who have millions of contracts in force right now. Without these exceptions, these insurers would no longer be able to serve their customers.

The exceptions include ordinary functions that insurance companies are already doing in their day-to-day business. Such operations include:

Underwriting: Insurers use health information to underwrite. The price someone pays for insurance is based in part on an individual's state of health. Insurers gather medical information about applicants during the application and underwriting process. Underwriting is fundamental to the business of insurance. During the underwriting process, an insurer may use third parties, such as labs and health care providers to gather health information and/or to analyze health information. The insurer may also use third parties to perform all or part of the underwriting process and must disclose information to these third parties, such as doctors or third party administrators, so that they can enter into the contract in the first place.

Reinsuring Policies: Insurance companies sometimes assume a "risk" and then further spread the risk by "reinsuring" a policy. While often a "reinsurance" arrangement is made at the initiation of a contract, there are also times when reinsurance occurs after the policy is issued. The reinsurer needs access to the first insurer's underwriting practices

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as part of its due diligence. Without this language, the wheels of the reinsurance industry could literally grind to a halt.

Account Administration, Processing Premium Payments, and Processing Insurance Claims: In order to pay a claim for benefits, the insurer has to process the claim. This is a basic business function. These activities are the very reasons an individual signs up for a policy in the first place. Companies may use third party billing agencies and administrators to process this information. A company that doesn't today, may tomorrow; and we need to ensure that they can, so that consumers can be served.

Reporting, Investigating or Preventing Fraud or Material Misrepresentation: There are certainly times when individuals may not want to disclose all of their health information for valid reasons. However, there are those that may try to hide health information relevant to whether a policy would be issued or what would be charged for that policy. For example, nonsmokers usually pay less for insurance than smokers. On the other hand, if you have a chronic illness your premium may be higher. If an individual is engaged in fraud of material misrepresentation, it is highly unlikely that they would give their consent so that the insurer could disclose this information, for example, to its law firm to undertake an investigation of the matter or to the insurance commissioner or other appropriate authorities.

Risk Control: Credit card companies and other financial institutions involved in billing, conduct internal audits to ensure the integrity of the billing system. During this process, the company verifies that merchants, credit card holders and transactions are legitimate. These audits are done on random samples in which transactions dealing with medical services are not segregated or treated differently from other types of transactions. However, if this exception were not included, the company would be prevented from verifying the validity of transactions dealing with medical services. This would open the door for much fraud and abuse or the inability for consumers to write checks or use credit cards to pay for medical co-payments.

Research: Insurers do research for many purposes. For example, life insurers will do research related to health status and mortality to help them more accurately underwrite and classify risk. This provision is needed so that insurers can continue to do research.

Information to the Customer's Physician: This exception is necessary to allow insurers to release information to an individual's physician. For example, during the underwriting process, an insurer may conduct blood test on an applicant. If the blood tests indicate that there may be something wrong, the insurer needs to be able to share the information with the individual's designated physician or health care provider so that they, together, can determine the best course of treatment.

Enabling the Purchase, Transfer, Merger or Sale of Any Insurance Related Business: No one has a crystal ball. A company does not know in advance when they will engage in these activities. It would be impractical if not impossible to obtain the tens of thousands of authorization forms signed and returned to the company so that a

company could purchase, transfer, merge or sell an insurance related business. Without this language, companies will not be able to serve their customers by forging new business frontiers. Since the privacy provision covers all insurance companies, the purchasing company will have to abide by the same restrictions as the original company.

Or as Otherwise Required or Specifically Permitted by Federal or State Law: There are some states that require or specifically permit the disclosure of medical information by insurance companies. For example, a company may have to disclose health information to a state insurance commissioner so that the commissioner can determine if the company is complying with state law banning unfair trade practices. A company may have information that would help the police in an investigation where they suspect an individual has murdered someone in order to collect life insurance benefits. This language is necessary for these and other important public interests.

I hope that this brief explanation of the exceptions to the strong "opt-in" provisions of the medical privacy provisions of H.R. 10 clears up some misperceptions. During floor debate, I said I would work to include explicit language stating that this provision does not prohibit the secretary of HHS from issuing regulations on medical privacy as specified by HIPAA.

Furthermore, I hope consensus can be achieved on a comprehensive medical privacy bill. However, I remain convinced that as new financial services entities that combine banking, securities and insurance are created by H.R. 10, it is important that personal health data can be shared inside, or outside, the company **only** with the patient's permission. That is what the Ganske Amendment did.

If you need additional information, please contact Heather Eilers at 5-4426.

Sincerely,

Greg Ganske

Greg Ganske
Member of Congress

Concerns

- The language restricts disclosure of health information, but not use of that information. Restrictions on the use of information within a health care entity are crucial components of medical information privacy. For example, an insurer should be able to use personal information to pay claims, but not for marketing.

  Nothing in this language would prevent either the insurer or its affiliates from giving information to their employees manager to use in employment related decisions.

- The research disclosure allowed here is particularly problematic because would allow the use of personally identifiable medical information to be used without requiring any corresponding safeguards.

- The language also has the potential to undermine the Department's rulemaking authority under HIPAA. While we don't believe it eliminates our authority completely, it can be argued that it eliminates it with respect to insurers (and any other entities covered by this bill).

  The sunset provision (section 351(c)) states that the insurer-confidentiality provision (section 351(a)) will sunset if legislation is enacted that satisfies section HIPAA, but not if a regulation is promulgated. Since the very purpose for the regulation under HIPAA would be to establish rules in the absence of such legislation, it could be argued that the legislative intent is that there not be any confidentiality regulation with respect to insurers. Essentially, the language in HR 10 does not repeal the rulemaking mandate of HIPAA, but it would limit that authority to persons other than insurers

- This language could also do harm by prohibiting disclosures that the Department would permit, and indeed, would want to encourage. For example, disclosures for public health purposes would be allowed by an HHS regulation, yet there is no clear exception in HR 10 for them. Therefore, this legislation might prohibit some such disclosures; the HIPAA regulation would not prohibit them; and as a result, they would be prohibited

- This language does not provide any mechanism for determining those research projects for which consent should be required before health or medical information is disclosed. Researchers seeking individually-identifiable health information should be subject to some sort of oversight mechanism whereby an assessment is made regarding the level of risk to the individual's privacy. If the research poses greater than a minimal risk,

informed consent should be required. Accordingly, individuals may be unwitting participants in research projects that pose a significant risk to their privacy and confidentiality.

- This language does not provide any requirements regarding safeguards to protect the confidentiality of the information or prohibitions on redisclosure. This would mean that a researcher could obtain very sensitive medical information for a research project and subsequently disclose this information to an individual's employer, colleagues, neighbors, etc.

Here are some examples of scenarios that could occur:

* A health insurance company releases mental health records to someone doing a research project on the connection between dieting and depression. The researcher concludes that people who diet frequently are more likely to commit suicide. Because the language of the bill does not include any prohibitions on further disclosure, the researcher subsequently discloses the information to a life insurance company which decides not to give the research participants life insurance. The individual denied life insurance coverage had no idea that she was even a participant in a research study.

* An individual has received genetic testing that indicates that she has the BRCA 1 gene for breast cancer. Her health insurance company discloses this information without her knowledge to a researcher participating in a project to determine the percentage of individuals who both smoke and possess the gene who later develop breast cancer. The researcher discloses the results of his study back to the health insurance company which decides that it will no longer cover individuals who both smoke and possess the BRCA1 gene. The health insurer is affiliated with a life insurer that provides life insurance for employees of certain companies. The individual subsequently loses her job, or is denied employment.

* An individual applies for car insurance. The underwriter is a subsidiary of the individual's health insurer. The health insurer has disclosed the individual's health information to a researcher who is doing a study on the correlation between those individuals with a rare genetic disorder who fall asleep while driving. This information is released to the underwriter, and the individual is denied coverage.

* A researcher wants to do a study on whether an individual has a specific genetic mutation that might make him/her more likely to develop cancer if living directly under a power line. Despite the fact that the genetic information is highly sensitive, the health insurer releases it to the researcher without informed consent. The researcher subsequently releases the information to a mortgage company that denies mortgages to certain individuals based on this research. The individuals had no idea that they were participating in a research study.

Talking Points on Medical Privacy Language in HR 10

- The SAP needs to address highlight that the inclusion of this medical privacy language is problematic.

- By failing to mention our opposition to the language we are in essence acquiescing on whether we find it acceptable.

- The President, in the State of the Union, and in his May 4th speech on financial privacy, emphasized the Administration's strong desire to see comprehensive privacy legislation enacted this year. The Vice President has also made this point on several occasions.

    - This is necessary because Congress gave itself until August of this year to enact comprehensive medical privacy legislation. Failing that goal, HHS' regulations would be promulgated. However, those regs would provide more limited protections.

- We have been working very closely with key members in both the House and Senate to craft a meaningful, medical privacy bill. We are very close to working out the final issues in the Senate. This language completely undoes all of our efforts to reach the right balance. We don't want to see that work undone.

It was Congressman's Ganske's intent that this language limit the sharing of information from insurers to their affiliates. This language does not accomplish that goal. In fact, the language is very clear that both medical and genetic information may be provided without the consent of the patient (consumer) for many purposes. Other problems of this language include:

- Basic protections necessary to make health privacy provisions work are missing from the language. There are no requirements for the minimum necessary content of a consent to use of health information. This means if a health care provider asked for documentation of your blood type, the insurer should not be permitted to give them every bit of medical information they have in file about you.

- This language would permit life insurers or health insurers to share sensitive medical information with anyone purporting to be conducting a research project. This language is very broad, and would not be limited to behavioral or biomedical research. This would mean that a life insurer that conducts physical examinations could release medical information to someone conducting market research.

- There are no limits on re-disclosure of medical and genetic information. A credit agency could receive information from an insurer and then turn around and give it to anyone they desired.

- The bill allows reporting of medical and genetic information to a credit reporting agencies or banks again, without a patients consent or knowledge.

AMERICAN PSYCHIATRIC ASSOCIATION
DIVISION OF GOVERNMENT RELATIONS
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WASHINGTON, DC 20005
Phone: (202) 682-6060 Fax: (202) 682-6287

FAX COVER SHEET

TO: CHRIS JENNINGS

FAX #: 456-5557

FROM: William Bruno: Associate Director; Division of Government Relations

Please Contact me at (202) 682-6046 if there are any questions.

Number of pages transmitted 3 Date 6/29 Time _____
(Including cover sheet)

COMMENTS: Letter requesting deletion of medical records provisions in H.R. 10, signed by 34+ groups

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June 29, 1999

Member of Congress
House of Representatives
Washington, DC 20515

Medical Records Provisions of H.R. 10 Undermine Patient Privacy

Dear Representative:

The undersigned physician, provider, patient, and other national organizations strongly support medical records confidentiality not only from a personal privacy perspective, but also because of the critical importance of patient privacy for high quality medical care. We greatly appreciate the well-intentioned efforts of the many members that have resulted in the medical records privacy provisions of H.R. 10. Nevertheless, we have both serious procedural and substantive concerns about these provisions and urge that they be deleted from the bill.

We are particularly concerned because Section 351 of the bill would allow the use and disclosure of medical records information without the consent of the patient in extraordinarily broad circumstances. To give just two examples, law enforcement entities would enjoy virtually unfettered access to medical records and insurance companies could review individual medical records in performing marketing studies. The list of entities that could obtain medical records is also extensive. Why should life insurers, auto insurers, and even insurers providing travel cancellation insurance be able to routinely access patients' entire medical records without patient consent or even knowledge?

To complicate matters further, the legislation establishes no limitations on subsequent disclosures of medical records to non-affiliated entities. Once a disclosure has occurred, there is no limitation on the types of disclosures that the recipient of this information may make. Thus, if an insurer contracts out a certain authorized service to a bill collection agency or an administrative support company, nothing in the legislation would prevent these organizations from disclosing or selling the information for a host of inappropriate purposes far beyond any legitimate health use.

The legislation lacks basic protections included in all the major confidentiality bills before the Congress. The legislation lacks specific requirements for physical, technical, and administrative safeguards to prevent unintended disclosures of medical records. Nor does the legislation encourage the use of deidentified medical records or insure that patients will receive notice of the confidentiality, use, and disclosure practices of the insurance companies.

Confidentiality between the doctor or other health care professional and the patient is an essential component of high quality health, and particularly mental health, care. Unfortunately, the medical records confidentiality provisions in H.R. 10 will deter many patients from seeking needed health care and deter patients from making a full and frank disclosure of critical information needed for their treatment.

We also have numerous procedural concerns. Because the Senate HELP Committee has not yet been able to report out comprehensive medical records privacy provisions, H.R. 10's provisions, intended as a temporary measure until comprehensive legislation is enacted into law, could now

become long-lasting. This is extremely troublesome because H.R. 10 is designed to address only certain narrow aspects of medical records privacy and leaves key issues unresolved. We are deeply concerned that passage of H.R. 10's current medical records privacy language has the potential to undermine enactment of comprehensive medical records privacy legislation.

Thank you for considering these important issues. For further information, please contact William Bruno of the American Psychiatric Association at (202) 682-6194.

Sincerely,

American Psychiatric Association
American College of Occupational and Environmental Medicine
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Association of Occupational Health Nurses, Inc
American Association for Psychosocial Rehabilitation
American College of Physicians - American Society of Internal Medicine
American College of Surgeons
American Counseling Association
American Family Foundation
American Federation of State, County, and Municipal Employees
American Lung Association
American Medical Association
American Occupational Therapy Association
American Osteopathic Association
American Psychoanalytic Association
American Psychological Association
American Society for Gastrointestinal Endoscopy
American Society of Clinical Psychopharmacology
American Society of Cataract and Refractive Surgery
American Thoracic Society
Anxiety Disorders Association of America
Association for Ambulatory Behavioral Health
Association for the Advancement of Psychology
Bazelon Center for Mental Health Law
Corporation for the Advancement of Psychiatry
Federation of Behavioral, Psychological and Cognitive Sciences
International Association of Psychosocial Rehabilitation Services
National Association of Developmental Disabilities Councils
National Association of Psychiatric Treatment Centers for Children
National Association of Social Workers
National Council for Community Behavioral Healthcare
National Depressive and Manic Depressive Association
National Foundation for Depressive Illness
National Mental Health Association
Renal Physicians Association
Service Employees International Union

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FAX NUMBER: 456-5557

FROM: Tim

COMMENT: As Discussed

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The Consortium
Of Citizens with Disabilities
Contact: Jeff Crowley 898-0414

The Consumer Coalition
for Health Privacy
Contact: Janlori Goldman 687-0880

OPPOSE So-called Medical "Confidentiality" Sections of H.R. 10
H.R. 10 Protects Insurance Companies and HMOs, Not Patients

The Consortium of Citizens with Disabilities and the Consumer Coalition for Health Privacy both oppose the so-called medical "confidentiality" provisions now contained in Section 351 of H.R. 10. Both groups urge that **the provisions should be struck from the bill** and both organizations **oppose passage of H.R. 10 so long as it contains these provisions**.

While the language of the so-called confidentiality provisions is camouflaged to appear as though it provides protections for patients, in fact it is so **riddled with loopholes and possible preemption** of other Federal, State, and local law that it is **a step backward for patient protection** in many States. Those provisions would permit wide-ranging **disclosures of private medical information without the consent or knowledge of the patient**. For example:

- H.R. 10 would allow health, medical, and genetic information to be **sold or disclosed to credit agencies and banks**--without the patient's consent or knowledge.

- H.R. 10 would allow health, medical, and genetic information to be **sold or disclosed to any insurance company for any insurance underwriting purpose**--without the patient's consent or knowledge.

- H.R. 10 would allow health, medical, and genetic information to be **sold or disclosed to anyone for the purpose of "risk control," a term which is not defined in the bill**--without the patient's consent or knowledge.

- H.R. 10 would allow health, medical, and genetic information to be sold or disclosed for **any "research project," a term which is not defined in the bill**--without the patient's consent or knowledge. Note that this "research" is not just biomedical research but **any project that may be self-styled "research," whether it is research of credit ratings of patients' families or research of mental health services to Members of Congress.**

- H.R. 10 contains **no limits on re-disclosure**. If a credit agency or an insurance broker receives information from an insurer, there are no limits on how they may use the information, or further disclose it. Once released by an insurance agency, **the recipient may send the information to newspapers, mortgage bankers, political campaigns, divorce lawyers, etc.**

- H.R. 10 provides **no clear procedure for disclosure** of health, medical, or genetic information **to Federal, State, or local government officials, including law enforcement authorities**. The bill may authorize access without a patient's knowledge or consent **without a court order or warrant or even notice**.

(over)

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In addition to these disclosures and loopholes, H.R. 10 has additional fatal flaws:

- Even in those areas in which H.R. 10 prohibits disclosure, it provides **no effective remedy for illegal disclosures**. It contains no fines, no criminal penalties, and no right for consumers to recover their damages. Moreover, it does not even permit consumers to act to stop illegal disclosures. Only State officials may enforce the law and they may only act to enjoin future violations, not to punish past ones.

- H.R. 10 makes **no attempt to distinguish between disclosures of debts or payment records and disclosures of diagnoses or treatments**. Even when a debt is owed to a financial organization, there is no need to **disclose sensitive records (from mental health services to family planning information) to a financial institution**, but H.R. 10 would permit such sensitive information to be sold or disclosed without limit.

- H.R. 10 **may preempt Federal, State, or local laws providing more privacy protections**. While the bill does not interfere with other laws allowing additional disclosures, it could preempt other laws prohibiting the disclosures allowed in H.R. 10.

The Consortium of Citizens with Disabilities and the Consumer Coalition for Health Privacy urge that the so-called medical-confidentiality provisions be struck from H.R. 10 and, if that effort fails, that H.R. 10 be defeated. Medical privacy should be dealt with comprehensively--not with one set of rules for insurers and another for doctors and another for hospitals. We urge Congress to enact clear and complete legislation with genuine protections for privacy.

H.R. 10 Protects Insurance Companies and HMOs, Not Patients
OPPOSE So-called Medical "Confidentiality" Sections of H.R. 10

DATE: 7-1-98

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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REMARKS:

LOS ANGELES TIMES EDITORIALS

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JANET CLAYTON, *Editor of the Editorial Pages*

No Rx for Privacy

Congress had an opportunity this year to set a national standard that would protect the privacy of medical records from snooping commercial eyes. Perversely, it is doing just the opposite. Like a midnight prowler, Rep. Greg Ganske (R-Iowa) tacked onto unrelated banking reform legislation an amendment that would allow health insurers to sell medical records to other insurers without the consent or even knowledge of the patients. Using this data, a car insurer, for example, could deny coverage or jack up premiums for any individual with high blood pressure.

That amendment, which shamefully remained intact through the House Rules Committee, chaired by Rep. David Dreier (R-San Dimas), should be soundly defeated when it reaches the House floor today.

The House must defeat legislation that would allow health insurers to sell medical records to other insurers without the consent or even knowledge of the patients.

The need to set a federal policy for safeguarding medical data was recognized by Congress in 1996 when it passed the Health Insurance Portability and Accountability Act. The law required Secretary of Health and Human Resources Donna E. Shalala to draw up privacy regulations if the Congress itself didn't enact privacy laws by August. Shalala drafted well-thought guidelines for regulations that would allow the sharing of patients' medical files by treating physicians and for medical research. It would guard against abuses by requiring that patients' names be concealed.

Under the the Ganske bill, not a shred of those protections are left. Individuals would be allowed to ask for nondisclosure of their medical files to others—employers, banks or direct marketers—but medical insurers could deny coverage to anyone objecting to disclosure. Moreover, the law may well preempt stronger state medical privacy measures, such as those in California that protect the confidentiality of HIV test results.

It is bad enough that the medical privacy policy would be set by a rider to another, unrelated legislation without hearings or public debate of any kind. But the impact of such legislation is even worse. Health insurers could peddle patients' privacy with little or no restraint, insurance policies could be denied based on incomplete or inaccurate medical records. The states may be preempted from enacting or enforcing their own medical privacy laws.

A large number of adults in California have admitted lying to their doctors or withholding information about their health for fear of being denied jobs or insurance coverage. With laws like Ganske's amendment, that number is certain to rise. As a result, medical records will be less complete or simply wrong.

Ganske's measure has raised a chorus of protest from physicians, psychiatrists and therapists, as well as the American Civil Liberties Union.

The House should not only defeat the amendment, but also refuse to consider making the confidentiality of medical records a mere adjunct to unrelated legislation. This issue deserves full deliberation at public hearings.

Legislators usually become angry and defensive when ulterior motives are ascribed to legislation. But if voters are to believe that this measure is unrelated to the fact that the insurance industry was the single largest soft-money donor to Republicans in 1997-98, then let Dreier and Ganske explain how this anti-consumer amendment benefits those voters.

Executive Office of the President of the United States
Office of Management and Budget
Office of Information and Regulatory Affairs
Information Policy and Technology Branch
New Executive Office Building
Rm. 10236
Washington, D.C. 20503

FAX TRANSMITTAL

FAX: 202-395-5167

DATE: July 1

TO: Deborah Adler

FROM: Peter Swire

Total number of pages (Including Transmittal Sheet): 3

Recipient's Fax Number: 456 - 5557.

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Comments:

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

July 1, 1999
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 10 - Financial Services Act of 1999
(Leach (R) IA and 12 co-sponsors)

The Administration supports H.R. 10, the Financial Services Act of 1999. The Administration has been a strong proponent of financial modernization legislation that would best serve the interests of consumers, business, and communities, while protecting the safety and soundness of the financial system. H.R. 10 would:

- allow affiliations among banks, securities firms, and insurance companies, thereby increasing the competitiveness of the U.S. financial services sector and giving consumers greater choice and lower prices;

- preserve the relevance of the Community Reinvestment Act by requiring that banks have and maintain a satisfactory CRA record as a condition for their affiliates or subsidiaries engaging in new financial activities;

- uphold a bipartisan compromise allowing financial services firms to conduct financial activities in the structure -- subsidiaries or affiliates of banks -- that best serves their customers, in a way that is best for safety and soundness;

- generally provide for the continued separation of banking and commerce.

The President has stated the importance of adopting protections to ensure the privacy of consumers' financial records. The amendment to be considered by the House would improve the bill by including new privacy protections, although it does not address all of the issues involved. The Administration will continue to pursue additional protections.

The Administration strongly opposes the medical privacy provisions of the bill. Unfortunately, those provisions would preempt important existing protections and do not reflect the extensive legislative work that has already been done on this complex issue. The Administration thus urges striking the medical privacy provisions and will pursue medical privacy in other fora.

The Administration strongly opposes the Barr-Paul-Campbell Amendment, which would seriously erode our ability to fight financial criminals and the drug cartels. The amendment would effectively eliminate suspicious activity reporting by financial institutions --one of our most important tools in fighting money laundering and fraud. The amendment would mark a significant retreat in our fight against narcotraffickers.

The Administration strongly opposes the bill's Federal Home Loan Bank System provisions, particularly a provision that would allow each Home Loan Bank to cut its capital requirement in half and thereby effectively increase the System's taxpayer subsidy without any commensurate return in public benefits. In addition, the Administration believes that the System must focus more on lending to community banks and less on arbitrage activities and short-term lending that do not advance its public purpose. The Administration opposes granting the Federal Housing Finance Board independent litigating authority, which would be inconsistent with the Attorney General's authority to coordinate and conduct litigation on behalf of the United States.

The Administration strongly objects to the refusal to allow House consideration of Representative Lee's anti-redlining amendment, which would help deter violations of the Fair Housing Act. The Administration strongly supports the amendment.

The Administration is concerned that the bill would unduly restrict banks' authority to sell insurance, thereby diminishing competition and reducing choice for consumers.

Because of its commitment to maintaining a separation of banking and commerce, the Administration continues to favor a clear prohibition on existing unitary thrift holding companies selling their subsidiary thrifts to non-financial firms. Allowing such sales could lead to substantial non-financial ownership of insured depository institutions.

The Administration opposes section 154 because it could be seen as undermining principles of normal trade relations and national treatment, which could weaken efforts to negotiate further market access liberalization and expose U.S. firms to additional restrictions abroad.

* * * * * *

DATE: 6-14-99

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVE., SW
WASHINGTON, D.C. 20201

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REMARKS:

DRAFT DRAFT

Dear Chairman Jeffords,

On behalf of the Administration, I want to thank you and the other members of the Committee for working in a cooperative, bipartisan manner to bring the "Health Information Confidentiality Act of 1999" to markup. While we are unable to support this legislation in its current form, we hope to continue working with you and your colleagues to resolve our remaining concerns prior to Committee action. With further improvements, this legislation has the potential to help us to achieve the goal of so many Americans – the right to privacy for medical and health information.

The President has indicated his strong desire to see the Congress enact a comprehensive medical privacy bill this year. At the same time, we are working hard to make sure the Department is prepared to go forward with the regulations specified under HIPAA, if Congress is unable to pass such a bill. As the President said in his State of the Union Address:

> "As more of our medical records are stored electronically, the threats to all our privacy increase. Because Congress has given me the authority to act if it does not do so by August, one way or another, we can all say to the American people, we will protect the privacy of medical records and we will do it this year."

In this regard, we are pleased to see that the Chairman's mark places important limits on the ways that health plans, providers and other health care-related organizations and individuals use and disclose personal health information. The mark incorporates changes that clarify that these

limits apply both to disclosures between health care organizations as well as to disclosures and uses within such organizations, requiring that protected health care information be provided to and used by only those individuals necessary to accomplish the purpose for which the information was obtained. For example, an employer generally could not disclose protected information gathered for the purpose of health care treatment and payment by the employer's group health plan to managers charged with job performance or job placement functions. These limits are vital if Americans are to have confidence that they can seek treatment under their health insurance without fear that their personal information could be used against them in the workplace.

Similarly, we are very encouraged to see the Committee recognize that it should be unlawful for someone to disclose information that is not identifiable with the knowledge that the recipient of the information will reidentify it. We could not support a bill that includes loopholes that allow disclosure of information from which identifiers have been stripped or encoded to people who intend to reidentify that information.

We are also encouraged that the notice and authorization provisions together will provide consumers with the crucial information they need to understand how their health information will be used and their rights and responsibilities with respect to that information. While the notice provisions are vastly improved, we continue to have concerns regarding a provision that would make use of a model notice an "absolute defense" to a claim of inadequate notice, even if the information contained in the notice was not accurate for the circumstances in which it was used. While use of the model should provide some special legal protection, it should only do so if it accurately reflects use of the model. We remain concerned that, as a practical matter, the mark's framework for obtaining authorizations and revocations could prove unworkable. In particular, it is not clear how important information about a patient's authorization and revocation is communicated among the plans and provider who need that information in order to make the bill's protections real.

With respect to non-federally funded health research, we are pleased that the Committee has included a review mechanism for researchers who wish to use medical records without obtaining a patient's prior authorization. We believe this section would be strengthened to provide greater protection for the public if some form of independent oversight were incorporated into this new process.

We are also pleased that the bill now makes clear that the allowable uses of protected health care information for health care operations apply only within the health plan or provider (and their agents) that originally obtains the information. Any sharing beyond that entity requires a separate authorization. Even within the entity, the allowable uses could not be expanded beyond those for the purpose of the delivery of health benefits.

In today's ever expanding, technology-based environment, it is becoming easier and easier to identify individuals with only tidbits of either demographic or personal information. Because the Chairman's mark has a loose definition of "non-identifiable information", it is imperative that it be a crime for anyone to transmit the 'key' that allows such information to become identifiable. Disclosing the key to reidentifying such information is no different than disclosing the identified information itself, and should be just as unlawful. The bill to be considered today reflects your concern for this issue and we appreciate recognition of this important prohibition.

While the improvements to your legislation have been significant, we have serious concerns and believe changes are necessary in important areas of the bill. First, we believe that the strength of any law conveying rights to individuals is their ability to enforce such rights. Our medical records hold the most intimate information about us. Yet the framework in the Chairman's mark through which individuals could enforce their rights is significantly weaker than the Video Privacy Protection Act. That statute, passed just one month after introduction and signed by President Reagan in 1988, includes a better standard of proof for individuals, a wider array of uncapped damages, as well as attorneys' fees. I think we would all agree that an individual's

rights to medical records privacy should be at least as strong as the privacy protections governing his or her video rentals.

The current standard in the Chairman's mark for civil remedies – "willful and intentional"-- is unprecedented in any federal statute. In addition, the limited remedies available under the bill could severely impair an individual's ability to find counsel to assist them in enforcing their rights. And while we might agree that it is appropriate for an individual to have to demonstrate some level of harm in order to recover, restricting the award of non-economic damages to $50,000 is unreasonable. Not all harms are easily quantifiable. For example, an individual with a genetic marker, whose insurer discloses such information resulting in the loss of a job, and who's child is not able to obtain health insurance. The emotional distress for parent and child, along with the stigmatization which could potentially accompany such an action, cannot easily be measured.

Under the private right of action language included in the Chairman's mark, if a nurse or orderly sold the names of patients to an outside organization, or if a computer programmer developed software to copy and transfer medical records to an outside company, in order for a patient to recover for unauthorized disclosures he or she would be required to prove that the person disclosing the names had knowledge of the law.

We also have serious concerns with the effect of language included in the Chairman's mark on state laws that pertain to minors and their rights to either permit or prevent access to their health information. We urge that the bill strike a balance and not disrupt any state law currently in effect.

Mr. Chairman, as you know, the Administration's general view is that federal statutes that establish new health protections for individuals should set a floor upon which states can build to address their unique circumstances. While we appreciate your inclusion of provisions to protect existing and future State laws governing public and mental health, we are concerned, in general,

about a statutory design that preempts State laws. We intend to consider this issue carefully as we work with you to further strengthen the federal protections included in this legislation.

Finally, we are extremely concerned that this bill would allow unfettered access to and use of genetic information, under the guise of underwriting, in a way that undermines state laws prohibiting such discrimination. Given the Committee's past interest in addressing such discrimination, we urge that the language be dropped from the bill, so that no one can misconstrue the intent of the bill.

In closing, let me reiterate that we appreciate the bipartisan progress that has been made, but regret that we cannot support the bill moving forward in Committee at this time. We look forward to working with you and the other Committee members to address the Administration's remaining concerns.

Sincerely,

Donna E. Shalala

OMB

EXECUTIVE ORDER 12866 SUBMISSION

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1. Agency/Subagency originating request
Department of Justice
Immigration and Naturalization Service

2. Regulation Identifier Number (RIN)
1115-AF45
1115-A509

3. Title
Deportability and Inadmissibility on public charge grounds

4. Stage of Development
____ Prerule
__X__ Proposed Rule
____ Interim Final Rule
____ Final Rule
____ Final Rule - No material change
____ Notice
____ Other

Description of Other

5. Legal Deadline for this submission
a) ☐ Yes ☒ No
b) Date ____/____/____ (DD / MM / YYYY)
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Alice Smith
Phone (202) 305-9353

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The authorized regulatory contact and the program official certify that the agency has complied with the requirements of E. O. 12866 and any applicable policy directives.

Signature of Program Official	Date
Alice A. Smith	
Signature of Authorized Regulatory Contact	Date
Richard A. Sloan, Director Policy Directives & Instructions	4/15/99

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DEPARTMENT OF JUSTICE

Immigration and Naturalization Service

8 CFR Parts 212 and 237

INS No. ; AG Order No.

RIN 1115- AF45

Deportability and Inadmissibility on Public Charge Grounds

AGENCY: Immigration and Naturalization Service, Justice.

ACTION: Proposed rule.

SUMMARY: This rule proposes to amend the Immigration and Naturalization Service (Service) regulations to establish clear standards governing a determination that an alien is inadmissible or ineligible to adjust status, or has become deportable, on public charge grounds. This proposed rule is necessary to alleviate growing public confusion over the meaning of the currently undefined term "public charge" in immigration law and its relationship to the receipt of Federal, State or local public benefits. By defining "public charge," the Service seeks to reduce the negative public health consequences generated by the existing confusion and to provide aliens with better guidance as to the types of public benefits that will and will not be considered in public charge determinations.

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DATES: Written comments must be submitted on or before [Insert date 60 days from date of publication in the FEDERAL REGISTER].

ADDRESSES: Please submit written comments, in triplicate, to the Director, Policy Directives and Instructions Branch, Immigration and Naturalization Service, 425 I Street NW., Room 5307, Washington, DC 20536. To ensure proper handling, please reference INS No. ****-99 on your correspondence. Comments are available for public inspection at the above address by calling (202) 514-3048 to arrange an appointment.

FOR FURTHER INFORMATION CONTACT: **[To Be Determined]**, Immigration and Naturalization Service, 425 I Street NW., Room _____, Washington, DC 20536; telephone (202)_____.

SUPPLEMENTARY INFORMATION:

Background and Necessity for Definition of "Public Charge"

Recent immigration and welfare reform laws have generated considerable public confusion about whether the receipt of Federal, State, or local public benefits for which an alien may be eligible renders him or her a "public charge" under the immigration statutes governing admissibility, adjustment of status, and deportation. See 8 U.S.C. 1182(a)(4); 8 U.S.C. 1227(a)(5). See also Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), Pub. L. No. 104-208, Div. C, Title V, section 501 et seq., 110 Stat. 3009-3668 (codified as

amended in different sections of 8 U.S.C.) (1996); Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), Pub. L. No. 104-193, sections 400-451, 110 Stat. 2260 (codified as amended generally at 8 U.S.C. 1601, et seq.) (1996).

Under section 212(a)(4) of the Immigration and Nationality Act (the Act), the determination of whether an individual alien "is likely to become a public charge at any time" is made by a Department of State consular officer at the time his or her visa application is adjudicated overseas, by a Service officer at the time an alien seeks admission into the United States, and by the Service at the time an alien applies for adjustment of status if he or she is already in the U.S. 8 U.S.C. 1182(a)(4). The statute further states that the decision shall be "in the opinion of" the consular officer or the Attorney General, who has delegated this authority to the Service. Id.; 8 CFR 2.1. Under section 237(a)(5) of the Act, an alien also may be deported if he or she "has become a public charge" within five years after his or her "date of entry" (i.e. admission) into the United States for causes not shown to have arisen since entry. 8 U.S.C. 1227(a)(5). An immigration judge will make the determination if any of these issues arise during removal proceedings for an alien.

On August 22, 1996, the President signed the Welfare Reform Act. The Welfare Reform Act and its amendments imposed new restrictions on the eligibility of aliens -- whether present in the United States legally or illegally -- for many Federal, State, and local public benefits. 8 U.S.C. 1601-1646 (as amended). Despite these new restrictions, many legal aliens remain eligible for at least some forms of public assistance, such as Medicaid, Food Stamps, Supplemental Security Income (SSI), Temporary Aid to Needy Families (TANF), and the Children's Health Insurance Program (CHIP), among other benefits. Congress also chose not to apply the alien eligibility restrictions in the Welfare Reform Act to emergency medical assistance; short-term, in-kind, non-cash emergency disaster relief; public health assistance related to immunizations and to treatment of the symptoms of a communicable disease; certain in-kind services (e.g. soup kitchens, etc.) designated by the Attorney General as necessary to the protection of life and safety; and assistance under certain Department of Housing and Urban Development (HUD) programs. 8 U.S.C. 1611(b)(1).

Numerous States and localities also have funded public benefits, particularly medical and nutrition benefits, for aliens who are now ineligible for certain Federal public benefits. Congress further authorized States to enact laws after August 22,

1996 that affirmatively provide illegal aliens with certain State and local public benefits. 8 U.S.C. 1621(d). A complete overview of all the public benefits and programs that remain available to various categories of aliens under the welfare reform laws is beyond the scope of this discussion.

Although Congress has determined that certain aliens remain eligible for some forms of medical, nutrition, child support services, and other public assistance, numerous legal immigrants and other aliens are choosing not to apply for these benefits because they fear the negative immigration consequences of potentially being deemed a "public charge." This tension between the immigration and welfare laws is exacerbated by the fact that "public charge" has never been defined in statute or regulation. Without a clear definition of the term, aliens have no way of knowing which benefits they may safely access without risking deportation or inadmissibility.

Additionally, the Service has been contacted by many State and local officials, Members of Congress, immigrant assistance organizations, and health care providers who are unable to give reliable guidance to their constituents and clients on this issue. According to Federal and State benefit-granting agencies, this growing confusion is creating significant, negative public health consequences across the country. This situation is

becoming particularly acute with respect to the provision of emergency and other medical assistance, children's immunizations, and basic nutrition programs, as well as the treatment of communicable diseases. Immigrants' fear of obtaining these necessary medical and other benefits is not only causing them considerable harm, but also jeopardizing the general public. Concern over the public charge issue is further preventing aliens from applying for available supplemental benefits, such as child care and transportation vouchers, that are designed to aid individuals in gaining and maintaining employment. In short, the absence of a clear public charge definition is undermining the Government's policies of increasing access to health care and helping people to become self-sufficient. The Service seeks to remedy this problem with this proposed rule.

Overview of the Proposed Rule

First, the proposed rule provides a definition for the ambiguous statutory term "public charge" that will be used for purposes of both admissibility and adjustment of status under section 212(a)(4) of the Act and for deportation under section 237(a)(5) of the Act. Second, the proposed rule describes the kinds of public benefits that, if received, could make a person a "public charge." The proposed rule also provides examples of the types of public benefits that will not be considered in public

charge determinations. Third, the proposed rule adopts long-standing principles developed by the case law. As discussed below, the cases have established prerequisites and factors to be considered in making public charge determinations.

The Meaning of "Public Charge" and Public Benefits That Demonstrate Primary Dependence on the Government for Subsistence

Following extensive consultation with benefit-granting agencies, the Department is proposing to define "public charge" to mean an alien who has become (for deportation purposes) or who is likely to become (for admission or adjustment purposes) "primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense." This interpretation of "public charge" is reasonable because it is based on the plain meaning of the word "charge," the historical context of public dependency when the "public charge" immigration provisions were first enacted more than a century ago, and the expertise of the benefit-granting agencies that deal with subsistence issues. It is also consistent with factual situations presented in the public charge case law.

When a word is not defined by statute and legislative history does not provide clear guidance, courts often construe it

in accordance with its ordinary or natural meaning as contained in the dictionary. See, e.g., Sutton v. United Air Lines, Inc., 130 F.3d 893, 898 (10th Cir. 1997), cert. granted 119 S.Ct. 790 (1999)(citations omitted). The word "charge" has many meanings in the dictionary, but the one that can be applied unambiguously to a person and best clarifies the phrase "become a public charge" is "a person or thing committed or entrusted to the care, custody, management, or support of another." Webster's Third New International Dictionary of the English Language 377 (1976). The dictionary gives the following apt sentence as an example of usage: "He entered the poorhouse, becoming a county charge." Id. See also 1 Oxford English Dictionary 381 (Compact ed. 1981) (definition # 13 for "charge" - "the duty or responsibility of taking care of (a person or thing); care, custody, superintendence").

This language indicates that a person becomes a public charge when he or she is committed to the care, custody, management or support of the public. The dictionary definition suggests a complete, or nearly complete, dependence on the government rather than the mere receipt of some lesser level of financial support. Historically, individuals who became dependent on the government were institutionalized in asylums or placed in "almshouses" for the poor long before the array of

limited-purpose public benefits now available existed. This primary dependence model of public assistance was the backdrop against which the "public charge" concept in immigration law developed in the late 1800s.

Although no case has specifically identified the types of public benefits that can give rise to a public charge finding, a definition based on primary dependence on the government is consistent with the facts found in the deportation and admissibility cases. See, e.g., Matter of L.R., 7 I. & N. Dec. 124 (BIA 1956)(deportation based on public mental hospital institutionalization); Matter of Harutunian, 14 I. & N. Dec. 583 (R.C., Int. Dec. 1974)(receipt of old age assistance for principal financial support was important factor in denying admission).

The Service has also sought the advice and relied on the expertise of various Federal agencies that administer a wide variety of public benefits. The Department of Health and Human Services (HHS), which administers TANF, Medicaid, CHIP, and many other benefits, has advised that the best evidence of whether an individual is relying primarily on the government for subsistence is either the receipt of public cash assistance for income maintenance purposes or institutionalization for long-term care at government expense. (See Letter to INS Commissioner Doris

Meissner from HHS Deputy Secretary Kevin Thurm, dated March 25, 1999, reprinted below)(hereinafter "HHS Letter" and reprinted at the end of this Supplementary Section **or at end of reg.?**). The Department of Agriculture (USDA), which administers Food Stamps, the Social Security Administration (SSA), which administers SSI, and other benefit-granting agencies have concurred with the HHS advice to the Service that receipt of cash benefits is the best evidence of primary dependence on the government. **[Add references to USDA, SSA letters and others once obtained; we plan to reproduce letters either at end of the reg. itself or the Supp. Section, according to appropriate placement instructions from OMB/Federal Register.]** Cash benefits for income maintenance include SSI, TANF, and State or local cash assistance programs (often called "General Assistance" programs). Acceptance of these forms of public assistance could make a person a public charge, provided the additional requirements for deportation or inadmissibility discussed later in this Supplementary Section and in the regulation are also met.

According to the HHS and other benefit agencies consulted by the Service, non-cash benefits generally provide supplementary support in the form of vouchers or direct services to support diet, health, and living condition needs. (See HHS Letter). These benefits are often provided to low-income working families

to sustain and improve their ability to remain self-sufficient. A few examples of these non-cash benefits that do not directly provide subsistence are Medicaid, Food Stamps, CHIP, and their related State analogues, housing assistance, transportation vouchers, and certain kinds of limited non-cash assistance provided under the TANF program. These forms of assistance, and others discussed below and in the proposed regulation, will not be considered for public charge purposes. The HHS has further stated that "...it is extremely unlikely that an individual or family could subsist on a combination of non-cash support benefits or services alone. . . . HHS is unable to conceive of a situation where an individual, other than someone who permanently resides in a long-term care institution, could support himself or his family solely on non-cash benefits so as to be primarily dependent on the government." (See HHS Letter).

The one exception identified by the HHS to the principle that non-cash benefits do not demonstrate primary dependence is the instance where Medicaid or related programs pay for the costs of a person's institutionalization for long-term care (other than imprisonment for conviction of a crime). Such institutionalization costs, therefore, may be considered in public charge determinations.

This distinction between cash benefits that can lead to primary dependence on the government and non-cash benefits that do not create such dependence is already applied by the State Department with regard to Food Stamps, a non-cash benefit program. The Foreign Affairs Manual (FAM) for consular officers excludes Food Stamps from public charge admissibility consideration because it is an essentially supplementary benefit that does not make recipients dependent on the government for subsistence. See 9 FAM section 40.41, N.9.1. The proposed definition of "public charge" is consistent with this existing State Department policy and that agency's recognition that certain supplemental forms of public assistance should not be considered in a public charge determination.

Receipt of Non-cash Public Benefits That Do Not Demonstrate Primary Dependence on the Government for Subsistence

It has never been Service policy that the receipt of any public service or benefit must be considered for public charge purposes. The nature of the program is important. For instance, attending public schools, taking advantage of school lunch or other supplemental nutrition programs, obtaining immunizations, and receiving public emergency medical care typically do not make a person inadmissible or deportable. Non-cash benefits, such as these and others, are by their nature supplemental and frequently

support the general welfare. By focusing on cash assistance for income maintenance, the Service can identify those individuals who are primarily dependent on the government for subsistence without inhibiting access to non-cash benefits that serve important public interests. Certain Federal, State, and local benefits are increasingly being made available to families with incomes far above the poverty level, reflecting broad public policy decisions about improving general health and nutrition, promoting education, and assisting working-poor families in the process of becoming self-sufficient. Thus, participation in such programs is not evidence of poverty or dependence.

The proposed rule identifies the major forms of cash benefits that may be considered for public charge purposes and several examples of non-cash benefits that will not be considered. Due to the complexity and ever-changing character of the Federal, State and local public benefits still available to aliens, it is not possible to name every benefit that will or will not be considered for public charge purposes. Aliens and their advisors should carefully consider the nature of the specific public benefits involved. If they could be construed as cash benefits for income maintenance, as distinguished from in-kind services, medical or food assistance, vouchers or other forms of non-cash benefits, then a Service officer may consider

their receipt in making a public charge decision, even if the benefit is not specifically addressed by name in the proposed rule. Again, receipt of SSI, cash TANF, and State or local cash assistance programs for income maintenance (e.g., "General Assistance") will be considered as part of the public charge analysis. The Service will also consider public assistance (including Medicaid) for supporting aliens who reside in an institution for long-term care (i.e., a nursing home or mental health institution).

Other non-cash public benefits that will not be considered and that are listed in the proposed rule include, but are not limited to: Medicaid; CHIP; emergency medical assistance; other health insurance and medical services for the testing and treatment of symptoms of communicable diseases; emergency disaster relief; nutrition programs, including Food Stamps and the Special Supplemental Nutrition Program for Women, Infants and Children (WIN); housing assistance; energy assistance; job training programs, and non-cash benefits funded under the TANF program. State and local non-cash benefits of a similar nature to the identified benefits also will not be considered. It is the underlying nature of the program, not the name adopted in a particular State, that will determine whether it is relevant for public charge consideration.

Additional Requirements for Public Charge Determinations

After defining "public charge," the separate deportation and inadmissibility sections of the proposed rule incorporate principles established by case law and statute for each of those public charge determinations.

A. Admission and Adjustment of Status

The provisions that relate to admission and adjustment of status incorporate the "totality of the circumstances" analysis that officers must employ in making a prospective public charge decision. See, e.g, Matter of Perez, 15 I. & N. Dec. 136, 137 (BIA 1974). Under section 212(a)(4)(B) of the Act, officers are required to consider specific minimum factors in determining whether the alien's circumstances indicate that he or she is likely to become a public charge. These factors include the alien's age, health, family status, assets, resources, financial status, education, and skills. No single factor will determine whether an alien is a public charge, including past or current receipt of public benefits.

In addition, most aliens intending to immigrate or adjust status in family-based and certain employment-based categories after December 19, 1997, are required to file the new Form I-864, Affidavit of Support signed by their sponsor(s). 8 U.S.C. 1182(a)(4)(C-D); 8 U.S.C. 1183(a); 8 CFR 213a. The new Affidavit

of Support is legally binding and requires sponsors to maintain the sponsored alien at an annual income of not less than 125 percent of the Federal poverty line for the relevant family size. 8 U.S.C. 1183(a); 8 CFR 213a. If an Affidavit of Support is not filed, the intending immigrant will be denied admission or adjustment on public charge grounds, unless he or she is exempt from the Affidavit of Support requirement under section 212(a)(4)(C-D) of the Act. As one of the circumstances considered in determining whether a person is likely to become a public charge, officers may also consider any Affidavit of Support filed by a sponsor on behalf of an alien under section 213A of the Act and are encouraged to do so. See 8 U.S.C. 1182(a)(4)(B)(ii). Certain categories of aliens seeking to become lawful permanent residents are exempt from the Affidavit of Support requirement -- including those who qualify as widow(ers) of citizens or as battered spouses, and their children. Id.

In one significant respect, a public charge determination for purposes of inadmissibility differs from the context of deportability. As the next section describes in detail, deportation on public charge grounds requires the Service to prove that the alien or another obligated party has failed to repay a legal demand for the public benefits at issue. The

proposed rule adopts the case-developed doctrine that this failure-to-reimburse requirement does not apply to inadmissibility on public charge grounds. See Matter of Harutunian, 14 I. & N. Dec. 583 (BIA 1974). Applicants for admission or adjustment of status, therefore, could be found inadmissible or ineligible to adjust status on public charge grounds even if there is no duty to reimburse the agency that provides assistance. Again, this receipt of public benefits will result in such a finding only if the totality of the alien's circumstances, including the minimum factors in section 212(a)(4)(B) of the Act, indicate that he is likely to become a public charge.

B. Deportation

The provisions on deportation in the proposed rule incorporate the Attorney General's decision in the leading case, Matter of B-, 3 I. & N. Dec. 323 (AG and BIA 1948), that the Service can prove public charge deportability only if there has been a failure to comply with a legally enforceable duty to reimburse the assistance agency for the costs of care. In addition, the demand for repayment of the specific public benefit must have been made within the alien's initial five-year period after admission, unless it is shown that demand was unnecessary because there was no one against whom payment could be enforced.

Matter of L, 6 I. & N. Dec. (BIA 1954). Under the proposed definition for public charge previously discussed, only the failure to meet an agency's demand for repayment of a cash benefit for income maintenance or for the costs of institutionalization for long-term care will be considered for deportation. If the alien can show that the causes for which he or she received one of these types of public benefits during his initial five years after admission arose after admission, he or she will not be deportable on public charge grounds. See 8 U.S.C. 1227(a)(5).

The proposed rule also provides that the Affidavit of Support is relevant to the public charge inquiry for deportation purposes. Under the new Affidavit of Support rules, if a sponsored alien obtains Federal, State, or local means-tested public benefits, the sponsor is obligated to repay those benefits if the benefit-granting agency makes a demand for repayment. Various Federal agencies have designated certain assistance programs that they administer to be "means-tested public benefits." For example, SSI, TANF, Medicaid, Food Stamps, and CHIP have been designated as Federal means-tested public benefits and could give rise to a repayment obligation under the Affidavit of Support. If States designate means-tested public benefits in the future, such benefits also could give rise to such an

obligation. Although an Affidavit of Support may cover other matters, only demands for repayment of cash benefits, such as SSI, TANF and State General Assistance, or other cash benefits for income maintenance purposes will be relevant for deportation determinations under the proposed definition of "public charge."

The Department of Justice has determined that the existing three-part Matter of B test for public charge deportations also applies to demands for repayment of means-tested benefits under the new Affidavit of Support. The government entity providing the benefit must have a legal right to seek repayment under the Affidavit of Support; the agency must have made a demand for repayment; and the obligated party or parties must have failed to meet this demand. The rule also requires that, before a deportation action may be initiated, the agency seeking repayment must have taken all steps necessary to obtain a final judgment requiring the sponsor or other person responsible for the debt to pay. Without such a requirement, an alien could be wrongly deported as a public charge based on a debt that a court might later determine was not legally enforceable. Although the demand for repayment must be made within five years of the alien's admission, there is no time limit on obtaining a final judgment as long as it is obtained prior to the public charge proceedings.

Welfare Reform and Other Significant Factors that Limit Potential for Aliens to Become "Public Charges"

The proposed rule is not expected to alter substantially the number of aliens who will be found deportable or inadmissible as public charges. Deportations on public charge grounds have always been rare due to the strict Matter of B requirements that agencies first must demand repayment, assuming they have a legal right to do so, and the obligated party or parties must have failed to pay. This is unlikely to change.

Several recently enacted welfare and immigration reform measures have also contributed to reducing the possibility that aliens will be found likely to become public charges under section 212(a)(4) of the Act. Due to the increased restrictions of the welfare reform laws, many aliens are no longer eligible to receive public benefits formerly available to them. Under new "deeming" rules, some aliens who might otherwise have been able to obtain certain Federal, State or local means-tested public benefits can no longer do so because their sponsors' resources now count as resources available to the aliens (i.e. the sponsors' resources are "deemed" available to the alien). In addition, the requirement of a legally binding Affidavit of Support obligating sponsors to support their immigrating family members above the poverty level before they will be granted

admission or adjustment has significantly raised the bar for people who might, in the past, have entered and become public charges. These new laws work together to limit the potential for immigrants to become dependent on the government. The proposed rule defining "public charge" will not change or negatively affect the operation of these provisions.

Conclusion

The Department believes that this rule, if adopted, will provide for better overall administration of the public charge provisions of the Act. It will also help alleviate the increasing, negative public health and nutrition consequences caused by the confusion over the meaning of "public charge." The rule, if adopted, will provide rules of decision that will apply in proceedings before the Executive Office for Immigration Review (EOIR), as well as proceedings before the Service.

At a later date, the Department plans to propose additional revised sections for part 212 concerning the other grounds of inadmissibility under section 212 of the Act. Sections 212.100 - 212.111 of this proposed rule are being issued in advance as subpart G. The Department will amend the labeling of this subpart or section numbers, if necessary, at the time of final publication of any revised sections to this part.

Regulatory Flexibility Act

The Attorney General has determined, in accordance with 5 U.S.C. 605(b), that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities. The factual basis for this determination is that this proposed rule, if adopted, will apply to individual aliens, who are not within the definition of small entities established by 5 U.S.C. 601(6).

Unfunded Mandates Reform Act

This rule will not result in the expenditure by State, local and tribal governments, in the aggregate, or by the private sector, of $100 million or more in any one year, and it will not significantly or uniquely affect small governments. Therefore, no actions were deemed necessary under the Unfunded Mandates Reform Act of 1995. 2 U.S.C. 658(7)(A)(ii).

Small Business Regulatory Enforcement Fairness Act of 1996

This rule is not a major rule as defined in 5 U.S.C. section 804. This rule will not result in an annual effect on the economy of $100 million or more; a major increase in costs or prices; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based companies to compete with foreign-based companies in domestic and export markets.

Executive Order 12866

This rule is considered by the Department of Justice to be a "significant regulatory action" under Executive Order 12866, section 3(f)(4) Regulatory Planning and Review. Accordingly, this proposed rule has been submitted to the Office of Management and Budget for review.

Executive Order 12612

This proposed rule, if adopted, would not have substantial direct effects on the States, on the relationship between the National Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposed rule, if adopted, would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Executive Order 12988 Civil Justice Reform

This proposed rule meets the applicable standards set forth in section 3(a) and 3(b)(2) of Executive Order 12988.

Plain Language in Government Writing

The President's June 1, 1998, Memorandum published at 63 FR 31885, concerning Plain Language in Government Writing, applies to this proposed rule.

List of Subjects:

8 CFR Part 212, Subpart G

Administrative practice and procedure; Aliens; Admission; Adjustment of Status; Public charge determinations.

8 CFR Part 237, Subpart A

Administrative practice and procedure; Aliens; Deportation; Public charge determinations.

Accordingly, chapter I of title 8 of the Code of Federal Regulations, is proposed to be amended by adding new part 212, subpart G to read as follows:

1. Part 212 is amended by inserting a new subpart G and list of section contents, to read as follows:

PART 212, Subpart G--PUBLIC CHARGE INADMISSIBILITY

§ 212.100 What issues does this subpart G address?

§ 212.101 What law governs a determination of whether I am inadmissible on public charge grounds?

§ 212.102 What is the meaning of "public charge" for admissibility and adjustment of status purposes?

§ 212.103 What specific benefits are considered to be "public cash assistance for income maintenance purposes?"

§ 212.104 What factors will make me inadmissible or ineligible to adjust status on public charge grounds?

§ 212.105 Are there any forms of public assistance that I can receive without becoming inadmissible as a public charge, if I should later apply for a visa, admission, or adjustment of status?

§ 212.106 If I have received public cash assistance for income maintenance, have been institutionalized at government expense, or have been deemed a public charge in the past, will I be inadmissible or ineligible to adjust status on public charge grounds now or in the future?

§ 212.107 Will I be required to pay back any public benefits that I have received before an immigration officer or immigration judge will find me admissible or eligible to adjust status?

§ 212.108 Are there any special requirements for aliens who are seeking to immigrate based on a family relationship or on employment?

§ 212.109 Will I be considered likely to become a public charge because my spouse, parent, child, or other relative has become, or is likely to become, a public charge or has received public assistance?

§ 212.110 Are there any individuals who are exempt from the public charge ground of inadmissibility?

§ 212.111 Are there any waivers for the public charge ground of inadmissibility?

Authority: 8 U.S.C. 1182(a)(4).

2. Subpart G, sections 212.100 - 212.111 are added to read as follows:

Subpart G -- Inadmissibility as a Public Charge

§ 212.100 What issues does this subpart G address?

(a) Subpart G addresses the public charge grounds of inadmissibility under Section 212(a)(4) of the Immigration and Nationality Act ("the Act"). It applies to all aliens seeking admission to the United States or adjustment of status to lawful permanent residency, except for the categories of aliens described in section 212.110 of this subpart or other categories of aliens who may be exempted by law.

(b) In this subpart, the terms "I," "me" and "my" in the section headings and "you" and "your" in the text of each section refer to an alien who may be inadmissible or ineligible to adjust status on public charge grounds.

§ 212.101 What law governs a determination of whether I am inadmissible on public charge grounds?

The public charge grounds of inadmissibility are found under section 212(a)(4) of the Act. A Department of State consular officer makes the public charge determination if you are applying

for a visa overseas. An Immigration and Naturalization Service (Service) officer makes the public charge determination if you are applying for admission at a port-of-entry to the United States, or for adjustment of status to that of a lawful permanent resident. Under section 212(a)(4), you will be found inadmissible or ineligible to adjust status if, "in the opinion of" the consular officer or Service officer making the decision, you are considered "likely at any time to become a public charge." If you have been placed in removal proceedings where issues of your admissibility or eligibility to adjust status arise, an immigration judge will decide whether you are likely to become a public charge.

§ 212.102 What is the meaning of "public charge" for admissibility and adjustment of status purposes?

(a) "Public charge" for purposes of admissibility and adjustment of status means an alien who is likely to become primarily dependent on the government for subsistence as demonstrated by either

(1) the receipt of public cash assistance for income maintenance purposes, or

(2) institutionalization for long-term care at government expense (other than imprisonment for conviction of a crime).

(b) For purposes of this subpart, the term "government" refers to any Federal, State or local government entity or entities. The term "cash" includes not only funds you receive in the form of cash from a government agency, but also funds received from a government agency by check, money order, wire transfer, direct deposit to your bank account, or any other means provided that the funds are for purposes of maintaining your income.

(c) As described in sections 212.103 and 212.105 of this subpart, not all forms of public assistance will be considered for public charge purposes because they do not result in primary dependence on the government. Immigration officers and immigration judges must also consider many other factors, as described in this subpart, before making a final public charge determination.

§ 212.103 What specific benefits are considered to be "public cash assistance for income maintenance purposes?"

(a) For purposes of determining inadmissibility on public charge grounds, the public benefits considered to be "public cash assistance for income maintenance" include, but may not be limited to:

1) Supplemental Security Income (SSI), 42 U.S.C. § 1381, et seq.;

2) Temporary Aid for Needy Families (TANF), 42 U.S.C. § 601, et seq., other than non-cash assistance or services provided through the TANF program; and

3) State and local cash assistance programs that provide for income maintenance (often called State "General Assistance," but may exist under other names).

(b) Due to the complexity and constantly changing nature of the numerous Federal, State and local benefits for which you may be eligible, it is not possible to give a complete listing of such benefits that could be considered for public charge purposes. If you are receiving, or contemplating receiving, any public cash assistance (as "cash" is described in section 212.102(b) of this subpart) for purposes of maintaining your income, an immigration officer or immigration judge may consider it as a factor in making a decision as to whether you are likely to become primarily dependent on the government.

§ 212.104 What factors will make me inadmissible or ineligible to adjust status on public charge grounds?

(a) Under Section 212(a)(4)(B) of the Act, the immigration officer or consular official must consider, "at a minimum," your age, health, family status, assets, resources, financial status, education, and skills in making a decision on whether you are likely to become a public charge. The decision-maker may also

consider any Affidavit of Support filed by your sponsor(s) on your behalf under section 213A of the Act and 8 CFR 213a. The decision-maker will consider the "totality of circumstances" before determining whether you are likely to become a public charge. No single factor, including past or current receipt of public benefits, will control this decision.

(b) You are inadmissible or ineligible to adjust status on public charge grounds if, after consideration of your case in light of all of the minimum factors in section 212(a)(4)(B) of the Act, any Affidavit of Support (Form I-864) filed on your behalf under part 213a of this Chapter, and any other facts that may be relevant, the immigration officer, consular officer, or immigration judge determines that it is likely that you will become primarily dependent for your subsistence on the government, at any time, as demonstrated by

(1) receipt of public cash assistance for income maintenance (e.g., SSI, cash TANF, or State, or local cash assistance programs for income maintenance, such as General Assistance); or

(2) institutionalization for long-term care (other than imprisonment for conviction of a crime) at government expense.

§ 212.105 Are there any forms of public assistance that I can receive without becoming inadmissible as a public charge, if I should later apply for a visa, admission, or adjustment of status?

(a) The only benefits that are relevant to the public charge decision are public cash assistance for income maintenance and institutionalization for long-term care at government expense. Non-cash public benefits will not be considered because they are of a supplemental nature and do not demonstrate primary dependence on the government.

(b) Although it is not possible to list all of the non-cash public benefits that will not be considered, you will not risk being found inadmissible as an alien likely to become a public charge by receiving the following non-cash public benefits:

(1) The Food Stamp program, 7 U.S.C. § 2011, et seq.;

(2) The Medicaid program, 42 U.S.C. 1396, et seq. (other than payments under the Medicaid program for long-term institutional care);

(3) The Child Health Insurance Program (CHIP), 42 U.S.C. § 1397aa, et seq.;

(4) Emergency medical services;

(5) Other health insurance and medical services, including public assistance for immunizations and for testing and

treatment of symptoms of communicable diseases, and use of health clinics; but not including public assistance for costs of institutionalization for long-term care;

(6) The Women, Infants and Children (WIC) program, 42 U.S.C. § 1786;

(7) Other nutrition programs, including, but not limited to, the National School Lunch Act, 42 U.S.C. 1751 et seq.;

(8) Emergency disaster relief;

(9) Housing assistance;

(10) Child care services;

(11) Energy assistance, such as the Low Income Home Energy Assistance Program (LIHEAP);

(12) Foster care and adoption assistance;

(13) Transportation vouchers or other non-cash transportation services;

(14) Educational assistance, including benefits under the Head Start Act and aid for elementary, secondary, or higher education;

(15) Non-cash assistance funded by the TANF program;

(16) Job training programs;

(17) In-kind, community-based programs, services, or assistance designated by the Attorney General as

necessary for the protection of life or safety, including soup kitchens, crisis counseling and intervention, and short-term shelter; See "Specification of Community Programs Necessary for Protection of Life or Safety under Welfare Reform Legislation," 61 FR 45985 (August 30, 1996);

(18) State and local supplemental, non-cash benefits that serve purposes similar to those of the Federal programs listed above;

(19) Any other Federal, State or local public assistance program, under which benefits are provided in-kind, through vouchers, or any other medium of exchange other than payment of cash benefits for income maintenance to the eligible person.

(c) Although the non-cash public benefits described in subsection (b) will not be considered for admissibility purposes, you may still be inadmissible or ineligible to adjust status if, in the opinion of the officer making the decision, you are likely to become a public charge following his or her analysis of the totality of the circumstances, as described in section 212.04 of this subpart. This includes consideration of all the

minimum statutory factors described in section 212(a)(4)(B) of the Act.

§ 212.106 If I have received public cash assistance for income maintenance, have been institutionalized at government expense, or have been deemed a public charge in the past, will I be inadmissible or ineligible to adjust status on public charge grounds now or in the future?

Such past circumstances do not necessarily mean that you will be found inadmissible or ineligible to adjust status on public charge grounds based on a present application for admission or adjustment. The immigration officer, consular officer, or immigration judge who makes the decision must consider all of the relevant facts of your case. Past receipt of public cash assistance or institutionalization under circumstances that made you a public charge would support a finding that you are inadmissible only if, in light of all the factors listed in section 212.104 of this subpart, it is likely that you will continue to be, or become again, a public charge in the future.

§ 212.107 Will I be required to pay back any public benefits that I have received before an immigration officer or immigration judge will find me admissible or eligible to adjust status?

Immigration officers and immigration judges do not have the authority to require that you reimburse public benefit-granting agencies for assistance that you have received. However, they may consider your receipt of public cash assistance for income maintenance purposes or your institutionalization for long-term care at government expense as factors in deciding whether you are likely to become a public charge in the future, regardless of whether the agency granting the benefit has sought reimbursement from you or any another party obligated to pay back the benefit on your behalf. If there is a final judgment against you for failure to repay the costs of public cash assistance or institutionalization that has not been satisfied, immigration officers or judges may also consider this failure to repay as one of the relevant factors in deciding whether you are likely to become a public charge.

§ 212.108 Are there any special requirements for aliens who are seeking to immigrate based on a family relationship or on employment?

Under section 212(a)(4)(C) and (D) of the Act, you must file an Affidavit of Support (Form I-864) from your sponsor(s) in accordance with section 213A of the Act and part 213a of this chapter if you are seeking to immigrate in certain family-based visa categories or as an employment-based immigrant who will work

for a relative or a relative's firm. If you do not file the Affidavit of Support as required, you will be inadmissible or ineligible to adjust status on public charge grounds. Certain battered spouses and children of U.S. citizens and lawful permanent residents are currently exempt under section 212(a)(4)(C) of the Act from filing an Affidavit of Support.

§ 212.109 Will I be considered likely to become a public charge because my spouse, parent, child, or other relative has become, or is likely to become, a public charge or has received public assistance?

(a) The fact that one, or all, of your close relatives has become, or is likely to become, a public charge will not make you inadmissible as a public charge, unless the evidence shows that you, individually, are likely to become a public charge.

(b) Public cash assistance benefits received by your relatives will not be attributed to you, unless they also represent your sole support.

§ 212.110 Are there any individuals who are exempt from the public charge ground of inadmissibility?

(a) The Act and various other statutes contain exceptions to the public charge ground of inadmissibility for the following categories of aliens:

(1) refugees and asylees at the time of admission and adjustment of status to legal permanent residency according to sections 207, 208 and 209 of the Act;

(2) Certain Amerasian immigrants at admission as described in the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988, section 584, contained in section 101(e), Pub. L. No. 100-202, 101 Stat. 1329-183 (1987) (as amended); 8 U.S.C. 1101 note;

(3) Cuban and Haitian entrants at adjustment as described in the Immigration Reform and Control Act of 1986 (IRCA), Pub. L. 99-603, Title II, section 202, 100 Stat. 3359 (as amended);

(4) Nicaraguans and other Central Americans who are adjusting status as described in the Nicaraguan Adjustment and Central American Relief Act (NACARA), Pub. L. 105-100, section 202(a), 111 Stat. 2193 (1997)(as amended);

(5) Haitians who are adjusting status as described in the Haitian Refugee Immigration Fairness Act of 1998, section 902, Title IX, Pub. L. No. 105-277 (1998), 112 Stat. 2681 (Oct. 21, 1998).

(b) Other categories of aliens may also be excepted from the public charge provisions in section 212(a)(4) of the Act, now or by subsequent legislation. The list of such aliens in subsection (a) may not include every excepted category.

(c) In addition, aliens who have been previously admitted for lawful permanent residence ("LPRs") and who re-enter the U.S. are not applicants for admission and, therefore, are not subject to the grounds of inadmissibility, unless they are covered by one of the six categories described in section 101(a)(13)(C) of the Act, including being absent from the U.S. for over 180 days.

§ 212.111 Are there any waivers for the public charge grounds of inadmissibility?

There are no waivers available for the public charge grounds of inadmissibility, except for the waiver for certain aged, blind, or disabled applicants for adjustment of status under section 245A of the Act. See 8 U.S.C. 1255(d)(2)(B)(ii)(IV). However, various laws have exempted certain categories of aliens from the requirements of section 212(a)(4) of the Act. Several of these categories are described in section 212.110 of this part.

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3. Part 237 is added to read as follows:

PART 237--DEPORTABLE ALIENS

(Additional subparts continue to be reserved)

Subpart A -- Public Charge Ground of Deportation

§ 237.10 What issues does this subpart A address?

§ 237.11 What law governs whether I am deportable on public charge grounds?

§ 237.12 What does it mean to be a public charge, for purposes of removal as a deportable alien?

§ 237.13 What specific benefits qualify as "public cash assistance for the purpose of income maintenance?"

§ 237.14 Are there any forms of public assistance that I can receive, without becoming deportable as a public charge?

§ 237.15 What other conditions must be met for me to be deportable as a public charge?

§ 237.16 Is the Affidavit of Support (Form I-864) under section 213A of the Act relevant to public charge deportation?

§ 237.17 Does the five year period in section 237(a)(5) of the Act run only from my first admission to the United States?

§ 237.18 Will I be considered a public charge because my spouse, parent, child, or other relative has accepted public benefits or has become a public charge?

Authority: 8 U.S.C. 1227(c)(5).

§ 237.10 What issues does this subpart A address?

(a) This subpart addresses the public charge ground of deportation under section 237(a)(5) of the Act.

(b) In this subpart, the terms "I," "me" and "my" in the section headings and "you" and "your" in the text of each section refer to an alien who may be deportable on public charge grounds.

§ 237.11 What law governs whether I am deportable on public charge grounds?

(a) Section 237(a)(5) of the Act describes which aliens are deportable on public charge grounds. If the Service brings a removal proceeding against you charging that you are subject to deportation on public charge grounds, the Service must prove that you became a public charge within five years of your entry (i.e. admission) to the U.S.

(b) If you can prove that the causes that led to your becoming a public charge arose after your admission to the U.S., you will not be deported.

§ 237.12 What does it mean to be a "public charge" for purposes of removal as a deportable alien?

(a) "Public charge" for purposes of deportation means "an alien who has become primarily dependent on the government for subsistence as demonstrated by either

(1) the receipt of public cash assistance for income maintenance purposes, or

(2) institutionalization for long-term care at government expense (other than the costs for imprisonment for conviction of a crime)."

(b) For purposes of this subpart, the "government" refers to any Federal, State or local governmental entity or entities. "Cash" includes not only funds you receive in the form of cash from a government agency, but also funds received from a government agency by check, money order, wire transfer, direct deposit to your bank account, or any other means, provided that the funds are for purposes of maintaining your income.

(c) As described sections 237.13 and 237.14 of this subpart, not all forms of public assistance will be considered for public charge purposes because they do not result in primary dependence

on the government. In addition, you will not be found deportable on public charge grounds unless the other conditions described in section 237.15 of this subpart have been met.

§ 237.13 What specific benefits qualify as "public cash assistance for the purpose of income maintenance?"

(a) Public benefits considered to be "public cash assistance for income maintenance" include, but may not be limited to:

(1) Supplemental Security Income (SSI), 42 U.S.C. § 1381, et seq.;

(2) Temporary Aid for Needy Families (TANF), 42 U.S.C. § 601, et seq., other than non-cash assistance and services provided by the TANF program, and

(3) State and local cash assistance programs that provide for income maintenance (often called State "General Assistance", but may be called other names).

(b) Due to the complexity and constantly changing nature of the numerous Federal, State and local benefits for which you may be eligible, it is not possible to give a complete listing of such benefits that could be relevant for public charge purposes. If, within five years of your admission into the U.S., you have received any public benefit that is provided in the form of cash (as that term is described in § 237.12(b) of this subpart) for

purposes of maintaining your income, it may serve as a basis for your deportation on public charge grounds, provided that all of the requirements of Section 237(a)(5) of the Act and the other conditions for deportation described in this subpart have been satisfied.

§ 237.14 Are there any forms of public assistance that I can receive, without becoming deportable as a public charge?

(a) The only benefits that are relevant to the public charge decision are public cash assistance for income maintenance and institutionalization for long-term care at government expense. Non-cash public benefits will not be considered because they are of a supplemental nature and do not lead to primary dependence on the government for subsistence.

(b) Although it is not possible to list all of the non-cash public benefits that are irrelevant for public charge purposes, you will not risk being found deportable by receiving the following non-cash public benefits:

(1) The Food Stamp program, 7 U.S.C. § 2011, et seq.;

(2) The Medicaid program, 42 U.S.C. 1396, et seq. (other than payments under the Medicaid program for long-term institutional care);

(3) The Child Health Insurance Program (CHIP), 42 U.S.C. § 1397aa, et seq.;

(4) Emergency medical services;

(5) Other health insurance and medical services, including public assistance for immunizations and for testing and treatment of symptoms of communicable diseases, and use of health clinics; but not including public assistance for costs of institutionalization for long-term care;

(6) The Women, Infants and Children (WIC) program, 42 U.S.C. § 1786;

(7) Other nutrition programs, including, but not limited to, the National School Lunch Act, 42 U.S.C. 1751 et seq.;

(8) Emergency disaster relief;

(9) Housing assistance;

(10) Child care services;

(11) Energy assistance, such as the Low Income Home Energy Assistance Program (LIHEAP)

(12) Foster care and adoption assistance;

(13) Transportation vouchers or other non-cash transportation services;

(14) Educational assistance, including benefits under the Head Start Act and aid for elementary, secondary, or higher education;

(15) Non-cash assistance or services provided by the TANF program;

(16) Job training programs;

(17) In-kind, community-based programs, services, or assistance designated by the Attorney General as necessary for life and safety, including soup kitchens, crisis counseling and intervention, and short-term shelter; See Specification of Community Programs Necessary for Protection of Life or Safety under Welfare Reform Legislation," 61 FR 45985 (August 30, 1996);

(18) State and local supplemental, non-cash benefits that serve purposes similar to those of the Federal programs listed above;

(19) Any other Federal, State or local public assistance program, under which benefits are provided through vouchers or any other medium of exchange other than payment of cash benefits to the eligible person.

§ 237.15 What other conditions must be met for me to be deportable as a public charge?

(a) In addition to the requirements of section 237(a)(5) of the Act, and except as provided in paragraph (b), you are not deportable as a public charge unless the Service shows that

(1) the government entity that provided, or is providing, either the public cash assistance for your income maintenance as described in sections 237.12 and 237.13 of this subpart or the costs of institutionalization for your long-term care as described in section 237.12 of this subpart, has a legal right to seek repayment of those benefits against either you or another obligated party, such as a family member or a sponsor; and

(2) within five years of your admission to the U.S., the public entity providing the benefit demanded that you or another obligated party repay the benefit; and

(3) you or another obligated party failed to repay the benefit demanded; and

(4) there is a final administrative or court judgment obligating you or another party to repay the benefit. (As long as the demand for repayment under paragraph (a)(2) occurred within five years of your admission, the final judgment may be rendered against you or another obligated party at any time thereafter).

(b) If a legal right to seek repayment of the public benefits described in sections 237.12 and 237.13 of this subpart is

established, but the Service proves that there was no one against whom repayment could be enforced, thereby making a demand for repayment unnecessary, then the Service need not show that a demand was made and a final judgment for repayment of the public benefits rendered.

§ 237.16 Is the Affidavit of Support (Form I-864) under section 213A of the Act relevant to public charge deportation?

(a) The Affidavit of Support required under section 213A of the Act (Form I-864)and 8 CFR 213a is relevant to the public charge grounds for deportation in certain circumstances. Section 213A of the Act provides that the Affidavit of Support may support a legally enforceable claim against your sponsor(s)for repayment of certain Federal, State or local means-tested public benefits provided to you. You may be found deportable on public charge grounds if the Service proves that

(1) an Affidavit of Support under Section 213A was filed on your behalf and is currently in effect; and

(2) within five years after your admission to the U.S., you (i) obtained SSI, cash TANF benefits, or other Federal, State, or local means-tested public benefits that were cash assistance benefits for income maintenance purposes and that, at the time the Affidavit of Support was signed, had been designated as "means-tested" by

- the government entity responsible for administering the benefit; or

(ii) were institutionalized for long-term care at government expense (other than imprisonment for conviction of a crime); and

(3) such benefits have not been repaid as provided in section 235.15.

§ 237.17 Does the 5-year period in section 237(a)(5) of the Act run only from my first admission to the United States?

(a) The 5-year period begins again each time you are admitted to the United States.

(b) If you have been lawfully admitted for permanent residence (LPR status), you are not considered an applicant for admission upon return to the U.S. after a trip abroad unless you are covered by one of the categories specified in Section 101(a)(13)(C) of the Act, including an absence of 180 days or more from the U.S. If you do not fall into one of the categories listed in section 101(a)(13)(C) of the Act, the 5-year period for deportation purposes would still be counted from your last admission to the U.S.

§ 237.19 Will I be considered a public charge because my spouse, parent, child, or other relative has accepted public benefits or has become a public charge?

(a) The fact that one, or all, of your close relatives has received public benefits, or has become a public charge, will not make you deportable as a public charge, unless the evidence shows that you, individually, have become a public charge.

(b) Public cash assistance benefits received by your relatives will not be attributed to you, unless they also represent your sole support.

Dated:

_____

Janet Reno

Attorney General

[Reproduce HHS, SSA, USDA, etc. letters that support cash/non-cash benefits analysis as evidence of primary dependence on the government. See Supplementary Section for discussion. Appropriate placement of these letters to be determined with OMB.]

CLOSE HOLD - FOR INTERAGENCY REVIEW ONLY

THE DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 25 1999

Commissioner Doris Meissner
Immigration and Naturalization Service
Department of Justice
425 Eye Street NW
Washington, D.C. 20536

Dear Commissioner Meissner:

According to my colleagues at the U.S. Department of Health and Human Services (HHS), I understand that the Immigration and Naturalization Service (INS) plans to issue some form of guidance explaining the public charge ground of inadmissibility to and deportation from the United States. The guidance is critical to clarifying for immigrant families and communities what the potential immigration consequences are of receiving certain government benefits.

Over the past several years, there has been a significant decline in the receipt of welfare, health, and nutrition benefits by immigrant families and their citizen children, even though many of these families (or individuals within these families) are eligible for such benefits. HHS has received numerous reports from state and local government officials, program administrators, and community leaders around the country that a significant factor contributing to this decline in participation is the confusion and fear that immigrant families have in relation to public charge policies. There is particularly concern that this lack of access to critical services may lead to negative health outcomes for immigrant families and children, as well as potentially undermining public health.

HHS supports the efforts of INS and the Department of Justice to clarify the meaning of "public charge" in a way that meets the objectives of both the immigration laws and the Administration's health policies. The INS, as we understand it, is proposing to define "public charge" to mean an alien who has, or is likely to become, "primarily dependent on the government for subsistence." An important issue that has arisen is receipt of which benefits is evidence of this dependency. HHS agrees that in making such an assessment about an individual, it is important to articulate a principle that distinguishes clearly those public benefits that should be relevant to public charge determinations from those that should not be of any consequence. We further understand that under immigration law, receipt of benefits is only one of many factors that INS and Department of State officers consider in making public charge determinations.

This letter responds to your request for advice from benefit-granting agencies with expertise in subsistence matters about which types of benefit receipt would demonstrate that an individual is primarily dependent on the government for his or her support. The best available evidence of whether someone is primarily dependent on government assistance for subsistence is whether that individual is receiving cash assistance for income maintenance purposes, (i.e., cash assistance under the Temporary Assistance to Dependent Families program (TANF)), the Supplemental Security Income (SSI), and state general assistance programs), or is institutionalized in a long-term care facility at government expense.[1]

The receipt of cash benefits or long-term care institutionalization are the most effective proxies for identifying an individual as one who is primarily dependent on government assistance for subsistence.

First, nearly all individuals or families receiving cash assistance for purposes of income maintenance are also receiving other non-cash support benefits and services as well, (e.g., Medicaid, Food Stamps, housing assistance, child care, energy assistance), and they are likely not to be receiving any income from other sources. For example, virtually all of those receiving AFDC cash assistance in 1995 were also receiving Medicaid (97 percent) and Food Stamps (89 percent). *(1998 Green Book).* By the end of 1997, 82 percent of families receiving TANF reported having no earned income. *(AFDC/TANF Quality Control Data).* In these cases, the individuals or families receiving cash assistance would meet the standard of "primarily dependent on government assistance for subsistence."

Second, it is extremely unlikely that an individual or family could subsist on a combination of non-cash support benefits or services alone. Without cash assistance, it is extremely unlikely that the individual or family could meet the basic subsistence requirements related to food, clothing and shelter. These non-cash assistance programs typically provide only supplemental and marginal assistance, (e.g., Food Stamps, housing assistance, energy assistance) or services, (e.g., health insurance coverage, medical care and child care) that do not directly provide subsistence and together are insufficient to provide primary support to an individual or a family absent additional income. Moreover, programs such as Child Care enable parents to work and earn income in order to be self-sufficient. In addition, depending on eligibility rules, some programs, such as Medicaid, may or may not be available to all family members or for all periods of time. HHS is unable to conceive of a situation where an individual, other than someone who permanently resides in a long-term care institution, could support himself or his family solely on non-cash benefits so as to be primarily dependent on the government. Thus, virtually all families receiving non-cash support benefits, but not receiving cash assistance, must rely on other income (usually earned income) in order to meet their subsistence needs.

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[1] Note that SSI is administered by the Social Security Administration, and general assistance programs are administered by the several states. However, we believe these are the relevant cash assistance programs that support the analysis in this letter.

Finally, non-cash support benefits and services are generally designed to supplement and support the diet, health, and living conditions of recipients, many of whom are low- to middle-income working families, and are generally provided as vouchers or direct services.[2] Also, these non-cash services often have a primary objective of supporting the overall community or public health, by making services generally available to everyone within a community, providing infrastructure development and support, or providing stable financing for services and systems that benefit entire communities. Compared to cash benefit programs, non-cash support programs generally have more generous eligibility rules so as to be available to individuals and families with incomes well above the poverty line. For example, states have a great deal of flexibility to set income eligibility rules under Medicaid and the Children's Health Insurance Program, and many states cover certain populations, such as children and pregnant women, up to 200 percent of the poverty line and sometimes higher. Moreover, in 1997 nearly half (49 percent) of Medicaid recipients were not receiving any cash assistance (SSI or AFDC/TANF), and two-thirds (64 percent) of adult recipients reported working full or part time. *(March 1998 Current Population Survey)*. Similarly, about one-third of Food Stamp recipients in 1997 did not receive cash assistance and reported earnings in 1997. *(Characteristics of Food Stamp Recipients, 1998)*. In these cases the individual or family receiving non-cash benefits, but not receiving cash assistance, would not meet the standard of "primarily dependent on government assistance for subsistence."

The one circumstance in which receipt of non-cash benefits would indicate that an individual is primarily dependent on government assistance for subsistence, and therefore potentially a public charge, is the case of an individual permanently residing in a long-term care institution and relying on government assistance for those long-term care services. In this case, all of the individual's basic subsistence needs are assumed by the institution, and the individual has no need for cash assistance. Aside from this narrow instance, the receipt of non-cash support benefits and services should not be relevant to a public charge determination under INS' proposed definition.

Based on these considerations, HHS recommends that benefit receipt should only be relevant to public charge determinations when an individual receives the benefits defined below:

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[2] Although most support programs provide vouchers or direct services, it should be noted that at HHS some of these programs can also provide cash for the reimbursement of specific costs. For example, the Low Income Home Energy Assistance Program (LIHEAP) and the Child Care Development Fund (CCDF) are authorized to make cash payments, but these payments are for specific purposes other than income maintenance. LIHEAP is authorized to provide cash payments for energy costs, and providers do so in very limited circumstances such as when a vendor (such as a log supplier) does not have an agreement with the administering entity, (i.e. state, county or nonprofit organization). In the case of CCDF, in FY 1997 that program gave cash payments to recipients in 7% of all cases specifically for the reimbursement of beneficiaries' child care costs. Under the proposal articulated here, cash payments in these programs would not give rise to a public charge determination since such payments are not provided for income maintenance purposes.

1. **Cash-Assistance for Income Maintenance**: Cash assistance under TANF, SSI, and state/local equivalents (including state-only TANF).

2. **Long-Term Institutionalized Care**: The limited case of an alien who permanently resides in a long-term care institution (e.g., nursing facilities) and whose subsistence is supported substantially by public funds (e.g., Medicaid).

Thank you for your time and consideration. Please let me know if I or HHS staff can be of any further assistance regarding this important policy issue.

Sincerely,

Kevin Thurm

Tuesday, June 22, 1999

Many Patients Suffer Language Gap

Hospitals: Despite state and federal laws, lack of interpreters denies equal access to care to immigrants, critics say. Some get wrong treatment, or none.

By ANNETTE KONDO, Times Staff Writer

Despite state and federal laws requiring hospitals to provide interpreters and bilingual medical forms, many patients end up unable to talk with doctors and confused by documents written only in English, advocates and officials said.

The problem is especially acute in multilingual California, where a lack of language services has confounded not only speakers of such emergent tongues as Lao and Russian, but of Spanish as well, experts said.

"This is a nationwide problem," said Tom Perez, director of the Office for Civil Rights at the U.S. Department of Health and Human Services. "I've been in all 10 of our offices and visited 200 advocacy groups, and this is a problem everywhere. By far, this is the most prevalent issue that has been raised."

After heavy lobbying by advocacy groups, the California state auditor recently launched a wide-ranging investigation of publicly funded agencies, including county clinics and hospitals, state employment offices and the Department of Motor Vehicles. The audit will seek to determine if they are complying with a 1973 state law requiring them to provide interpreters and standardized forms in languages spoken by their clients.

A separate California law requires hospitals serving a population that is 5% or more bilingual to provide similar services.

A federal law, Title VI of the Civil Rights Act of 1964, is also applied to medical providers who use federal funding, such as Medicaid and Medicare, Perez said. The U.S. Supreme Court has ruled that people with limited English proficiency may not be discriminated against because of their language.

"These laws exist on paper, but not in practice," said Jane Perkins, director of legal affairs for the National Health Law Program, a public interest law firm based in Los Angeles. "There are a surprising number of laws addressing it, but people just don't know about them and they aren't being enforced."

Health care workers and legal advocates describe patients who have endured painful or inappropriate treatments, others who were turned away and told to return with an interpreter, and waiting room bystanders pressed into service as interpreters.

A San Fernando Valley house painter sued Mission Community Medical Center in May, charging that he was pressed to sign papers he did not fully understand, holding him liable for his 78-year-old

father's emergency medical treatment in April 1997.

Pedro Perez, 38, said the Panorama City hospital told him his father would not qualify for Medi-Cal coverage and that he needed to be transferred to another facility, according to the suit. A year after his father died, he was jolted by an unexpected $13,000 bill, only to learn later that his father had been eligible for the state-funded insurance after all.

A Spanish-speaking employee was present with the Perez family, hospital chief financial officer Bruce Donaldson said, but officials could not verify Perez's assertion that the form had not been translated.

"It is not our intent, nor was it our intent, to cause him any hardship," Donaldson said.

The lawsuit was filed by San Fernando Valley Neighborhood Legal Services and the Western Center on Law and Poverty on behalf of Perez, who supports his family of four on an annual salary of $23,000. An El Salvador native, he became a U.S. citizen several years ago.

"When I received the bill I didn't understand what it was," he said through a translator. "Where am I going to get this money from?"

Although advocacy groups say that the language access problem is persistent and widespread, few complaints have reached state licensing agencies and accreditation organizations.

The state Department of Health Services said it has not received a single such complaint in the last year from any hospital in Los Angeles, Orange or Ventura counties. One complaint was logged from a Kern County facility.

Experts say that few violations are reported, and even fewer cases reach lawyers because many victims are poor immigrants who are unfamiliar with their rights or fearful of the government.

"People don't know to file complaints," said Ira Pollack, regional manager for the Office of Civil Rights. "Most complaints are not filed by individuals; they are filed by community groups and advocacy groups."

Hospitals often fall out of compliance because of staff turnover and cost-cutting measures, Perez said.

"That's often the first thing that is cut: translator services," he said.

Symptoms of language obstacles to health care are common, experts said:

* In Los Angeles County, an aging Korean man with psoriasis underwent painful treatments at a county facility for more than a year because he did not have an interpreter and the medical staff was unaware of the pain he endured, sometimes for days, said Heng Foong, program director for Pacific Asian Language Services in Los Angeles.

* A young boy in Los Angeles recently interpreted for his Spanish-speaking father who could not read a consent form. The son thought the form meant a nurse would make daily home visits to care for his mother. Instead, they learned the mother was sent to a nursing home, Foong said.

* In Maine, the National Health Law Program and the Maine Civil Liberties Union sued the Maine Medical Center in Portland, charging that two Spanish-speaking and two Farsi-speaking patients were not provided with interpreters or documents in their languages.

California is a daunting Tower of Babel for health care providers.

The state audit examining whether agencies are complying with the Dymally-Alatorre Bilingual Services Act of 1973 was approved by a legislative committee in April. Scheduled to be completed in October, it will be submitted to selected legislative committees for review.

The 1973 law requires state agencies to provide bilingual services and encourages local agencies to do the same, said California state Auditor Kurt Sjoberg.

"We want to look at how agencies are responding to changing demographics and changing linguistic needs," Sjoberg said last week.

Pacific Asian Language Services in Los Angeles, a language bank specializing in health care interpreting, has forwarded 15 cases of alleged violations at county and private health care facilities to the state auditor.

"We think it will really shine a spotlight on some of these horrible problems that have been going on for years," said Karin Wang, an attorney with the Asian Pacific American Legal Center in Los Angeles.

In many California communities where Spanish is well-established as the lingua franca, hospitals and service agencies provide adequate language services.

But the smaller the language community, the fewer the services and agencies to help them, Wang said, citing the isolation of some Laotian, Armenian and Russian immigrants.

Hospitals have an obligation to inform all patients of their rights, said Neal Dudovitz, executive director of San Fernando Valley Neighborhood Legal Services.

"The form that was thrown in front of Mr. Perez," Dudovitz said, "he didn't understand and felt he didn't have a choice."

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Guidance Memorandum
January 29, 1998
Title VI Prohibition Against National Origin
Discrimination--Persons with Limited-English Proficiency

- Introduction to Limited-English-Proficiency Guidance
- I. Background
- II. Discussion
  - A. Who is Covered
  - B. Ensuring Equal Access to LEP Persons
  - C. Interpreter Services
- III. Compliance and Enforcement

Introduction to Limited-English-Proficiency Guidance

The Office for Civil Rights (OCR) has issued the following guidance memorandum on national origin non-discrimination and Limited-English-Proficiency (LEP) to OCR staff to ensure consistent application of Title VI of the Civil Rights Act of 1964 to health and social services programs funded by HHS. The import of the memorandum is that it addresses language assistance that may be required for effective communication between health and social service providers and persons of Limited English Proficiency (LEP). Pursuant to Title VI, such assistance is appropriate where language barriers cause LEP persons to be excluded from or denied equal access to HHS-funded programs.

In reviewing the memorandum, you will note that it spells out factors that OCR staff will consider when working with HHS-funded programs to ensure that persons of Limited English Proficiency (LEP) are not discriminatorily denied equal access to or an equal opportunity to benefit from health and social services programs on the basis of national origin. The guidance also describes a variety of options that may be used in addressing the language assistance needs of LEP persons. In presenting these options, the guidance stipulates that health and social service providers are not required to use all of the suggested methods listed. However, providers should establish and implement policies and procedures for fulfilling their Title VI equal opportunity responsibilities to LEP persons. OCR developed this guidance based on tested practices identified in compliance reviews and negotiated settlements with recipients to provide language services.

Sincerely,

Dennis Hayashi
Director
Office for Civil Rights

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I. Background

This memorandum is intended to offer guidance to staff of the Office for Civil Rights (OCR) with respect to its enforcement of the responsibilities of recipients of Federal financial assistance from HHS to persons with Limited-English Proficiency (LEP), pursuant to Title VI of the Civil Rights Act of 1964, 2000d et seq. ("Title VI"). Such recipients include hospitals, managed care providers, clinics and other health care providers as well as social service agencies and other institutions or entities that receive assistance from HHS. This document will provide guidance to OCR investigators in assessing compliance, negotiating voluntary compliance, and providing technical assistance. It also stresses flexibility, particularly for small providers, in choosing methods to meet their responsibilities to LEP persons. Through OCR's investigative activities in this area, both recipients and LEP beneficiaries will be made more aware of their respective obligations with respect to the provision and receipt of services.

The guidance is intended to clarify standards consistent with case law and well established legal principles that have been developed under Title VI.

Section 601 of Title VI states that "no person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Regulations implementing Title VI which are published at 45 C.F.R. Part 80, specifically provide that a recipient may not discriminate and may not, directly or through contractual or other arrangements, use criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color or national origin, or have the effect of

defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular, race, color or national origin.

The statute and regulations prohibit recipients from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of beneficiaries in their programs, benefits or activities on the basis of race, color or national origin. Accordingly, a recipient must ensure that its policies do not have the effect of excluding from, or limiting the participation of, such persons in its programs and activities, on the basis of national origin. Such a recipient should take reasonable steps to provide services and information in appropriate languages other than English in order to ensure that LEP persons are effectively informed and can effectively participate in and benefit from its programs.

English is the predominant language of the United States and according to the 1990 Census is spoken by 95% of its residents. Of those residents who speak languages other than English at home, the 1990 Census reports that 57% of U.S. residents above the age of four speak English "well to very well." The United States is also, however, home to millions of national origin minority individuals who are limited in their ability to speak, read, write and understand the English language. The language barriers experienced by these LEP persons can result in limiting their access to critical public health, hospital and other medical and social services to which they are legally entitled and can limit their ability to receive notice of or understand what services are available to them. Because of these language barriers, LEP persons are often excluded from programs or experience delays or denials of services from recipients of Federal assistance. Such exclusions, delays or denials may constitute discrimination on the basis of national origin, in violation of Title VI.

LEP persons can and often do encounter barriers to health and social services at nearly every level within such programs. The primary reason for this difficulty is the language barrier that often confronts LEP persons who attempt to obtain health care and social services. Many health and social service programs provide information about their services in English only. Many LEP persons presenting at hospitals or medical clinics are faced with receptionists, nurses and doctors who speak English only, and often interviews to determine eligibility for medical care or social services are conducted by intake workers who speak English only.

The language barrier faced by LEP persons in need of medical care and/or social services severely limits their ability to gain access to these services and to participate in these programs. In addition, the language barrier often results in the denial of medical care or social services, delays in the receipt of such care and services, or the provision of care and services based on inaccurate or incomplete information. Services denied, delayed or provided under such circumstances could have serious consequences for an LEP patient as well as for a provider of medical care. Some states recognize the seriousness of the problem and require providers to offer language assistance to patients in certain medical care settings.

This guidance sets out factors for OCR staff to consider in determining whether federally-assisted providers of medical care or social services are taking steps to overcome language barriers to health care and social services encountered by LEP persons. The guidance emphasizes flexibility to providers in choosing the language assistance options they will employ. Thus, small providers and/or providers who serve only one or two language groups may be able to meet their responsibilities by choosing fewer or different options than the options selected by larger providers or those providers serving many language groups.

The U.S. Supreme Court, in Lau v. Nichols, 414 U.S. 563 (1974), recognized that recipients of Federal financial assistance have an affirmative responsibility, pursuant to Title VI, to provide LEP persons with meaningful opportunity to participate in public programs. In Lau v. Nichols, the Supreme Court ruled that a school system's failure to provide English language instruction to students of Chinese ancestry who do not speak English denied the students a meaningful opportunity to participate in a public educational program in violation of the Civil Rights Act of 1964. [1]

Since the Lau decision, OCR has conducted a number of complaint investigations and compliance and pre-grant reviews involving language barriers that impede the access of LEP persons to federally-assisted health and medical care and social services. OCR has found that where language barriers exist, eligible LEP persons are often excluded from programs, denied medical services or suffer long delays in the receipt of health and social services. Where such barriers discriminate or have had the effect of discriminating on the basis of national origin, OCR has required recipients to provide language assistance to LEP persons.

OCR's position as set forth in this document is fully consistent with a government-wide Title VI regulation issued by the Department of Justice (DOJ) in 1976, "Coordination of Enforcement of Nondiscrimination in Federally Assisted Programs," 28 C.F.R. Subpart F. The DOJ regulation addresses the circumstances in which recipients must provide language assistance, in written form, to LEP persons.[2] The DOJ regulation does not

address the question of oral language assistance. OCR's experience in conducting complaint investigations and compliance and pre-grant reviews demonstrates that oral communication between recipients and program beneficiaries is an integral part of the exchange that must occur in order for assisted programs and activities to appropriately function. Thus, OCR's longstanding position has been that recipients may be required to provide oral language assistance in languages other than English. This statement affirms this position.

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II. Discussion

A. Who is Covered

All entities that receive Federal financial assistance from HHS, either directly or indirectly through a subgrant or subcontract, are covered by this guidance. Covered entities would thus include any state or local agency, private institution or organization, or any public or private individual that operates, provides or engages in health, medical or social service programs and activities that receive or benefit from HHS assistance.

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B. Ensuring Equal Access to LEP Persons

All recipients have the responsibility for ensuring that their policies and procedures do not deny or have the effect of denying such LEP persons equal access to federally assisted health, medical and social service programs, benefits and services for which such persons qualify.

The key to ensuring equal access to benefits and services for LEP persons, is to ensure the service provider and the LEP client can communicate effectively, i.e., the LEP client should be given information about, and be able to understand, the services that can be provided by the recipient to address his/her situation and must be able to communicate his/her situation to the recipient service provider. Recipients are more likely to utilize effective communication if they approach this responsibility in a structured rather than on an ad hoc basis. [3]

Developing policies and procedures for addressing the language assistance needs of LEP persons may best be accomplished through an assessment of the points of contact in the program or activity where language assistance is likely to be needed, the non-English languages that are most likely to be encountered, the resources that will be needed to fulfill this responsibility and the location and/or availability of such resources. In identifying available resources, recipients may find it helpful to consult with national origin organizations and groups in their service areas. Achieving effective communication with LEP persons may require the recipient to take all or some of the following steps at no cost or additional burden to the LEP beneficiary:

- Have a procedure for identifying the language needs of patients/clients.
- Have a procedure for identifying the language needs of patients/clients.
- Have ready access to, and provide services of, proficient interpreters in a timely manner during hours of operation.
- Develop written policies and procedures regarding interpreter services.
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to LEP persons.

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C. Interpreter Services

In determining the type of interpreter services that will be provided, a recipient has several options. To meet its Title VI responsibility with respect to the provision of interpreter services a recipient may:

- Hire bilingual staff
- Hire staff interpreters
- Use volunteer staff interpreters
- Arrange for the services of volunteer community interpreters
- Contract with an outside interpreter service
- Use a telephone interpreter service such as the AT&T Language Line
- Develop a notification and outreach plan for LEP beneficiaries.

Factors that may be considered by a recipient in determining which option(s) will best meet its needs and the

needs of its LEP beneficiaries are its size, the size of the LEP population it serves, the setting in which interpreter services are needed, the availability of staff members and/or volunteers to provide interpreter services during its hours of operation and the proficiency of available staff members or volunteers available to provide the needed services.

A recipient should not require a beneficiary to use friends or family members as interpreters. Use of such persons could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations, to family or friends. In a medical setting, reluctance or failure to reveal critical personal information could have serious, even life threatening, health consequences. In addition, family and friends may not be competent to act as interpreters, since they may lack familiarity with specialized terminology. However, a family member or friend may be used as an interpreter if this approach is requested by the LEP individual and the use of such a person would not compromise the effectiveness of services or violate the beneficiary's confidentiality, and the beneficiary is advised that a free interpreter is available.

A recipient should ensure that it uses persons who are competent to provide interpreter services. Competency does not necessarily mean formal certification as an interpreter, though this certification generally is preferable. However, the competency requirement does contemplate proficiency in both English and the other language, orientation or training which includes the ethics of interpreting, and fundamental knowledge in both languages of any specialized terms and concepts peculiar to the recipient's program or activity. For example, a hospital or medical clinic could use a nurse as a volunteer staff interpreter for a Hispanic beneficiary if the nurse speaks both English and Spanish proficiently. It can be assumed that in addition to language skills enabling the relay of critical information about the patient to medical personnel, the nurse will be sufficiently familiar with medical terminology to convey the medical meaning and importance of what is being communicated to the LEP patient. However, it would be inappropriate to use a person who had little knowledge of medical terms or a person who spoke English poorly. Similarly, it would be inappropriate to rely on a medical student who worked part-time and had learned some Spanish but did not speak the language proficiently. While the student would understand the medical terminology, and the use of part-time staff would be appropriate in many circumstances, it is unlikely that such a student would have sufficient Spanish language skills to communicate what is being said and its importance, by and to the LEP patient.

The options available to recipients for providing interpreter services to LEP persons have differing weaknesses and strengths depending on the situation. Hiring bilingual staff for certain critical positions, e.g., for patient or client contact positions, would facilitate participation by LEP persons. However, where there are several LEP language groups in a recipient's service area this option may be impractical as the only interpreter option, and additional language assistance options may be required.

Use of staff or community volunteers may provide recipients with a cost-effective method for providing interpreter services. However, recipients should ensure that such a system is sufficiently organized so that interpreters are readily available during all hours of its operation. In addition, recipients should ensure that such volunteers are qualified, trained and capable of ensuring patient confidentiality.

The use of contract interpreters may be an option for recipients that are small, have a significant but small LEP population, have less common LEP language groups in their service areas, or need to supplement their in-house capabilities on an as needed basis. Such contract interpreters should be readily available, qualified and trained.

Paid staff interpreters are especially appropriate where there is a very large LEP presence in a few major language groups. As in other options, these persons should be qualified and available. In most instances these employees are salaried and are entitled to the same benefits received by other employees.

A telephone interpreter service such as the AT&T language line may be a useful option as a supplemental system, or may be useful when a recipient encounters an unusual language that it cannot otherwise accommodate. Such a service often offers interpreting services in many different languages and usually can provide the service in quick response to a request. However, recipients should be aware that such services may not always have readily available interpreters who are familiar with the terminology peculiar to the particular program or service or may require special arrangements to use such persons.

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III. Compliance and Enforcement

The recommendations outlined in Section II(B) are not intended to be exhaustive. Recipients are not required to use all of the suggested methods and options listed. However, recipients should establish and implement policies and procedures for fulfilling their Title VI equal opportunity responsibilities to LEP persons in the population

eligible to be served.

In determining a recipient's compliance with Title VI, OCR's concern will be whether the recipient's system allows LEP beneficiaries to overcome language barriers and thus have equal access to, and an equal opportunity to participate in, health care and social service programs and activities. While a recipient is not required to use the options listed, and may use options that are equally effective, a recipient's appropriate use of the options and methods discussed in this guidance, will be viewed by OCR as evidence of a recipient's intent to comply with its Title VI obligations.

For example, a small health care clinic that accepts patients by appointment only and serves a small but significant LEP population may be able to meet its responsibility to its LEP clients by making arrangements for interpreter services on an as needed basis, and appropriately publicizing the availability of such arrangements.

On the other hand, the emergency room in a large hospital located in an area with a larger and more diverse LEP population may require a combination of language assistance options. In this setting, there are likely to be a variety of patient contact points, and immediate and accurate information to and from patients is usually critical. In such a situation the recipient also should have staff that are bilingual in English and other frequently encountered languages, in critical patient contact positions. If available staff is insufficient, the recipient should employ other staff interpreters and/or make other language assistance arrangements to ensure that there are no delays in providing medical care and no misunderstandings when conveying information to, or obtaining information or informal consent from, patients.

The procedural provisions of the regulations implementing Title VI, found at 45 C.F.R. Sections 80.6 through 80.10, are applicable to all complaints or compliance reviews regarding a recipient's compliance with its Title VI responsibility to LEP beneficiaries.

Questions regarding this guidance memorandum should be directed to the Office for Civil Rights Regional Managers

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[1] The Lau decision affirmed the U.S. Department of Education's Policy Memorandum issued on May 25, 1970, titled "Identification of Discrimination and the Denial of Services on the Basis of National Origin", 35 Fed. Reg. 11,595. The memorandum states in part: "Where the inability to speak and understand the English language excludes national origin minority group children from effective participation in the educational program offered by a school district, the district must take affirmative steps to rectify the language deficiency in order to open its instructional program to these students."

[2] The DOJ coordination regulations at 28 C.F.R. Section 42.405 (d)(1) provide that "[w]here a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program (e.g. affected by relocation) needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to written material of the type which is ordinarily distributed to the public."

[3] A requirement to ensure effective communication is also found in the area of disability discrimination law. See 28 C.F.R. Section 35.160(a), 45 C.F.R. Section 84.52(c) and 45 C.F.R. Section 85.51(a).

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DRAFT 4/2/99

OCR TITLE VI CASES: DISPARITIES IN HEALTH CARE

Past and pending OCR cases involving racial discrimination in the health care context fall into a variety of categories:

I. Redlining

Interim Healthcare, Inc. (Settlement reached in 1996)

Interim Healthcare is a national home health care agency based in Florida that had a franchise in Connecticut which had refused to provide home health care service to an African-American family. Further investigation revealed that the franchisee had effectively drawn a circle around a predominantly minority area of town and instructed its employees that they were not required to service the area because of "safety" concerns. OCR negotiated a compliance agreement with the company which ensured that all residents would have access to home health care.

Staff Builders, Inc. (Settlement reached in 1993)

Staff Builders is a home health agency with a branch office in New Haven, Connecticut. A woman who had been receiving home health services from Staff Builders contacted them that she would be moving into a low income housing development in New Haven. Staff Builders refused to provide service to her in this new residence, because they did not service the area "for safety reasons." OCR reached a settlement agreement that ended this unlawful redlining practice.

II. Health Disparities

Newsday Series on Health Care Divide

From 11/29/98-12/6/98, Newsday ran a series of articles which chronicled a serious gap between the quality of the medical care delivered to the various racial and ethnic groups in the United States and particularly within the Long Island, New York region. The series especially highlights the "health gap" for African Americans. It can be concluded that African Americans in the geographic area described receive on average less care and poorer care in many critical areas. This is especially true in the fields of cardiac care, diabetic care, obstetrics (leading to a much higher infant mortality rate), organ transplant, and infectious disease control.

This region has some of the best hospitals and doctors in the world, as well as a sophisticated health care structure. According to the Newsday series, however, African Americans are being left behind and are not finding their way to the better hospitals and doctors. African Americans are not receiving the benefits of the health care system at the same level as the majority of the population. OCR has initiated a review of this situation to determine what part

racial discrimination plays in the apparent disparities in access to health care.

As part of this review, OCR has been in contact with various hospital associations in the New York area. These associations have expressed great concern about the disparities documented in the Newsday reports, and would like to work collaboratively with OCR on addressing this issue. This important dialogue remains ongoing, and we are hopeful that associations such as the Greater New York Hospital Association will continue to be important players in our effort to eliminate disparities in Nassau County and elsewhere in the region.

III. Segregation

In Re: Matter of Mt. Sinai Hospital, (02947801)

In November 1993, OCR began an investigation of Mt. Sinai after receiving information which alleged violations of Title VI of the Civil Rights Act of 1964 and the Hill-Burton Act. Information drawn from a statistical analysis indicated that room assignments on the hospital's two maternity floors resulted in one floor accommodating primarily minority patients, and the other, non-minority patients. It also appeared that the hospitals explanation of the policy of assigning Medicaid beneficiaries and uninsured patients to a specific floor, leading to the disparity did not significantly further any legitimate objective. OCR's investigation included an analysis of a one-year patient census that identified the patient population by floor distribution, race and method of payment.

As a result of OCR's investigation, an agreement was reached with the hospital which ensured that the hospital's maternity floors are fully integrated. The provisions of the agreement included assurances that the hospital would not discriminate against minority and Medicaid patients, that non-discrimination notices would be posted within the facility and that a two-hour training session to staff on appropriate civil rights protections would be developed by the hospital.

IV. Limited English Proficient (LEP) Cases

GREENVILLE HOSPITAL SYSTEM, GREENVILLE, SC, (04-98-3136) (Settlement Reached 1998)

An investigation was conducted of a complaint dated July 10, 1998, filed by Ms. Jane Perkins of the National Health Law Program against the Greenville Memorial Hospital, Greenville, South Carolina. The complaint alleged that the Greenville Memorial Hospital was implementing policies and practices that banned epidurals for women in labor who did not speak English well and, therefore, could not communicate with the physician.

The allegation was the result of a memorandum issued by the anesthesiologists to the obstetrical, labor and delivery and outpatient clinic staff setting forth their policy on the administering of epidurals for non-English speaking patients in labor and delivery. The memorandum was issued because of the concern that a complication may have developed with the epidural and the patient would not have been able to express symptoms or was not

knowledgeable enough to know what symptoms they needed to inform the Anesthesiologist about.

The memorandum was revised. The anesthesiologist must be able to communicate with the patient, either by speaking directly or through an interpreter. OCR has requested that the recipient maintain and submit to OCR on a quarterly basis, a record to specifically document their efforts to provide interpreter services.

Asian American Legal Defense and Education Fund v. Montefiore Medical Center (02983085)(settlement reached 1998)

On April 23, 1998, the region received a timely complaint from the Asian American Legal Defense and Education Fund alleging that the recent elimination of two translator positions at the Montefiore Family Health Center ("MFHC"), would have the effect of restricting or denying LEP Cambodian and Vietnamese persons from receiving medical services at the Center.

MFHC is one of 29 primary care practice sites operated by the Montefiore Medical Center ("MMC"), one of the largest and most comprehensive integrated health delivery networks in New York City. Through its many participating providers, MMC provides 15 percent of all inpatient and more that 30 percent of all tertiary care in Bronx county.

Prior to the conclusion of OCR's investigation of the matter, MMC expressed its desire to voluntarily bring MFHC in compliance with Title VI and reach a mutually satisfactory resolution with the region. To this end, MMC has taken or agreed to take the following voluntary corrective actions:

(1) Creation of an Access Policy, (2) Translation of Audio and Printed Materials, (3) Staff Training, (4) Employment Vacancy Announcement (5) Identification of a Title VI Coordinator, and (6) Monitoring of the access policy for one year

This case is significant because the recipient will have established an improved LEP policy which assures that LEP persons are afforded equal access to care at MFHC and which serves as a model for other, similarly-situated, primary care sites in the region.

Acosta v. Temple University Hospital, (03983030)(Settlement reached 1998)

The complainant alleged that the emergency staff of TUH discriminated against her on the basis of her national origin and race (Hispanic) by providing her with inadequate services, by subjecting her to inconsiderate treatment, and by failing to provide language assistance in Spanish.

Specifically, she alleged that when she presented herself at TUH's Emergency Room with vaginal bleeding and lower abdominal pain due to her high risk pregnancy; the medical services she received were inadequate, and the treatment was inconsiderate and inferior to that received by non-Hispanics. She stated that she waited approximately eight (8) hours before she was seen by

a student resident and that she was never seen by a certified physician. The complainant stated that when she inquired about the length of time, a staff person yelled at her and pushed her with his finger. She further alleged that while she waited in the Emergency Room, she was referred to as the "Dominican lady" and that the student resident refused to provide her with any instructions or explanations pertaining to her medical problem. She also stated that she was not offered any type of language assistance and that she was asked to sign discharge papers in English and did not receive any discharge instructions in English or Spanish.

The complainant stated that on the following day her condition worsened. She returned to TUH's Emergency Room and lost her baby that night. She was given a room for the night and was discharged. The complainant explained that she did not request any language assistance since she was not aware that it was available.

As a result of negotiations between OCR and the hospital, the hospital has taken a number of steps to increase access to health care by members of ethnic populations. The region is monitoring.

V. Managed Care Issues

Illinois Dept of Public Aid (Uptown Office), Chicago, IL (05-96-7001)

This review was one of several in Illinois related to the managed care program for Medicaid clients. The review focused on whether hearing-impaired and LEP persons have equal access to all services and whether the agency ensures that its subrecipients, e.g. Medicaid HMOs, do not engage in marketing practices which deny information or enrollment opportunities to LEP persons. OCR found a wide variety of potential violations of Title VI and Section 504/ADA, including: lack of guidance to caseworkers about interpreters for LEP clients resulting in clients being told to bring their own interpreter; unclear policy about obtaining interpreters and using the Language Bank; lack of oversight of the marketing practices of HMOs; lack of clarity to subrecipients about civil rights obligations; and lack of consistent provision of interpreters to Asian-American clients in the Uptown office.

The agency signed a resolution agreement to correct these deficiencies. The corrective actions included: 1) developing policies for LEP clients to ensure that clients are offered an interpreter; 2) providing effective interpreters either in person or by telephone in a large number of specific offices in the Chicago area; 3) notifying staff in all field offices of these revised policies, the existence of the Language Bank and the procedures for serving hearing impaired clients; 4) posting a notice in each field office of the existence of interpreters, based on OCR's model; 5) maintaining a current list of outside interpreters in each field office; 6) requiring HMOs who do marketing to Medicaid clients to provide information in the primary language spoken by the client; 7) including a nondiscrimination clause in all contracts for services; and 8) maintaining a count of total clients seen per day for a 90 day period and for the same time period, maintaining a log of LEP clients in the Uptown office to indicate whether an interpreter was provided.

Our investigation in this case was aided by a unique partnership with the Vietnamese Association which helped with interpreting and interviewing clients. This case is significant because it involves the issue of discrimination in services by a managed care entity. This case involved extensive corrective action state-wide which will result in better services to LEP clients in Illinois, especially in the Chicago area.

VI. Miscellaneous Discrimination Cases

Texas Rural Legal Aid v. McAllen Medical Center, (06913841)

The complaint alleged that the medical center, located in a Texas border town , provided its security personnel with uniforms similar to the uniforms worn by the U.S. Border Patrol. In the settlement agreement, the hospital agreed to discontinue the use of the uniform, which had the effect of discouraging the local Hispanic population from using the facility.

Dunnigan v. Eckerd Drug Store Number 2323, Fort Worth, TX. (06973010)

The complainant alleged that she was denied services by the recipient's pharmacist on the basis of her race (African American). The complainant stated that although her doctor's office confirmed that the prescription had been called in on two separate occasions, the pharmacist did not fill it. After discussions with the complainant and Eckerd Corporation officials, OCR determined that the matter could be resolved voluntarily through the ADR process. To resolve the matter the recipient voluntarily agreed to: (1) apologize to the complainant and express the companys deep regret, (2) post a notice stating that Eckerd stores do not discriminate on the basis of race, color, national origin, age, or disability in the delivery of pharmacy services; and (3) include that notice on the back of the Eckerd circular (an advertising supplement) which is sent to 25,000,000 people.

This case is significant because the nondiscrimination notice will be placed in approximately 2,800 Eckerd stores nationwide over a period of six months and the advertising circular reaches approximately 25 million people.

President Clinton and Vice President Gore: Fighting for Fairness for Legal Immigrants

Restoring Benefits to Legal Immigrants

President Clinton and Vice President Gore believe that legal immigrants should have the same opportunity, and bear the same responsibility, as other members of society. Upon signing the 1996 welfare law, the President vowed to reverse unnecessary cuts in benefits to legal immigrants that had nothing to do with the goal of moving people from welfare to work. Because of the Administration's leadership, the Balanced Budget Act and the Agricultural Research Act restored eligibility for Medicaid, SSI, and Food Stamps to hundreds of thousands of legal immigrants. The Administration's FY 2000 budget builds on this progress by restoring important disability, health, and nutrition benefits to additional categories of legal immigrants, at a cost of $1.3 billion over five years. Vice President Gore announced this budget proposal at a community center in San Francisco on January 25th. The Administration's proposal is included in the Fairness for Legal Immigrants Act of 1999 (S. 792/H.R. 1399) recently introduced by Senator Moynihan and Representative Levin.

- **Disability and Health:** The Balanced Budget Act of 1997 restored disability and health benefits to 420,000 legal immigrants who were in this country before welfare reform became law (August 22, 1996), at an estimated cost of $11.5 billion. The Administration's new budget would restore eligibility for SSI and Medicaid to legal immigrants who enter the country after that date if they have been in the U.S. for five years and become disabled after entering the United States. This proposal would cost approximately $930 million and assist an estimated 54,000 legal immigrants by 2004, about half of whom would be elderly.

- **Nutritional Assistance:** The Agricultural Research Act of 1998 provided Food Stamps for 225,000 legal immigrant children, senior citizens, and people with disabilities who came to the United States by August 22, 1996. The Administration's budget would extend this provision by allowing legal immigrants in the United States on August 22, 1996 who subsequently reach age 65 to be eligible for Food Stamps at cost of $60 million.

- **Childrens' Health Care and Maternal Care for Pregnant Women:** States currently can provide health coverage to immigrant children who entered the country before August 22, 1996. The President's FY 2000 budget would give states the option to provide health coverage to legal immigrant children who entered the country after August 22, 1996. Under this proposal, states could provide health coverage to those children through Medicaid or their CHIP allotment. The proposal would cost $220 million and serve approximately 55,000 children by FY 2004. Furthermore, the budget proposes to give states the option to provide Medicaid coverage to legal immigrant women who entered the country after August 22, 1996 and subsequently became pregnant. Such coverage would help reduce the number of high-risk pregnancies, ensure healthier children, and lower the cost of emergency Medicaid deliveries. This proposal would cost $105 million and serve approximately 23,000 women by FY 2004. A bipartisan bill (S. 1227) similar to this proposal, was introduced by Senators Chafee, McCain, Mack, Jeffords, Graham, and Moynihan.

07/08/99

New Steps to Ensure that Legal Immigrants will Have Access to Critical Health Care and Social Services without Fear

On May 25th, Vice President Gore announced a new Department of Justice regulation to assure families that enrolling in Medicaid or the new Children's Health Insurance Program (CHIP) and receiving other critical benefits, such as school lunch and child care services, will not affect their immigration status. The new policy, effective immediately, clarifies a widespread misconception that has deterred eligible populations from enrolling in these programs and undermined the nation's public health. In addition, the Vice President directed Federal agencies to send guidance to their field offices, program grantees and to work with community organizations to educate Americans about this new policy.

English Literacy / Civics Education Initiative

The Administration's Budget also contains an adult literacy initiative to help states and communities provide expanded access to high quality English language proficiency instruction, linked to practical instruction in civics and life skills including how to navigate the workplace, public education system, and other key institutions in American life. These Common Ground Partnerships are designed both to help meet the extraordinary demand for English and civics instruction among individuals with limited English proficiency and to demonstrate our shared commitment to fully integrate new Americans into our social and civic life. States, community-based organizations, local education agencies, and other non-profits will compete for grants to support English proficiency and civics instruction. With $70 million, the initiative will be able to provide English language and civics instruction to approximately 150,000 people in FY 2000. Overall, the President's FY 2000 budget contains a $190 million increase for adult education and family literacy.

The President's FY 2000 Budget Legal Immigrant Benefit Proposal: Restoring Medicaid and CHIP Eligibility for Pregnant Women and Children

Summary

The President's Budget would give States the option to provide Medicaid or CHIP health coverage to lawfully residing pregnant women and children who enter the country after August 22, 1996. This coverage will allow pregnant women to receive necessary prenatal health care and ensure healthier children.

Background

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 allowed States to provide Medicaid and CHIP coverage to all qualified immigrants who had entered the country as of August 22, 1996, but prohibited qualified immigrants entering after August 22, 1996 from being eligible for Medicaid and CHIP for 5 years after entry.

The Administration's previous successes at restoring eligibility to legal immigrants is reflected in the Balanced Budget Act of 1997 and the Noncitizens Benefit Clarification and Other Technical Amendments Act of 1998 that ensured all qualified immigrants who were in the United States as of August 22, 1996 retained their SSI and Medicaid eligibility. These proposals secured SSI and Medicaid eligibility for about 380,000 legal immigrants who otherwise would have lost eligibility under welfare reform. The Agricultural Research Act of 1998 restored food stamps to about 225,000 of the most vulnerable legal immigrants who were lawfully present in the United States on August 22, 1996. All refugees and asylees entering the country after August 22, 1996 had their SSI, Medicaid, and Food Stamp eligibility extended from 5 to 7 years after entry.

The President's FY 2000 Budget Proposal

The President's Budget gives States the option to extend Medicaid to lawfully residing immigrants who are pregnant and entered the country after August 22, 1996. Such coverage would help reduce the number of high-risk pregnancies and ensure healthier children. An estimated 23,000 legal immigrant women will be insured under this proposal by FY 2004.

This proposal also provides States the option to extend Medicaid and CHIP coverage to lawfully residing immigrant children who entered the country after August 22, 1996. Under current law, these children are not eligible for Medicaid/CHIP coverage. Enactment of this proposal would provide insurance to an estimated 55,000 legal immigrant children by FY 2004.

Under the restorations for children and pregnant women, the current law five-year ban, sponsor deeming, and affidavit of support sponsor reimbursement requirements would be waived.

In addition, the President's Budget would restore SSI for qualified legal immigrants, regardless of age, who entered the country after August 22, 1996, and who become disabled at any time after they entered. The proposal would also extend SSI eligibility to certain qualified

legal immigrant children who enter the country with a disability. To the extent that receipt of SSI benefits confers Medicaid eligibility, restoration of SSI would provide Medicaid for qualified legal immigrants. Current law affidavit of support sponsor reimbursement requirements would be waived for Medicaid benefits received by these immigrants. These Medicaid costs are $344 million through FY 2004.

Medicaid and CHIP Q&As

Q1: Under current law, does Medicaid or CHIP provide any coverage for legal immigrant children and citizen children born to immigrant parents? What about pregnant women?

A1: Any child or pregnant woman born in the United States, or naturalized, is a U.S. citizen and is eligible for public programs, the same as any other citizen. With respect to legal immigrants, including children, current law provides Medicaid or CHIP coverage for the following categories: (1) legal immigrants who were in the United States before August 22, 1996, at State option; (2) legal immigrants arriving on or after August 22, 1996 after continuous residence for 5 years, at State option; (3) refugees, asylees, and certain Cuban, Haitian and Amerasian immigrants, for their first 7 years; and, (4) unmarried, dependent children of veterans and active military duty.

Because Medicaid and CHIP are federal means-tested public benefits, they cannot be provided to immigrant children or pregnant women who entered the United States after August 22, 1996, during their first 5 years here (with certain exceptions). Because of sponsor deeming, most are likely to remain ineligible until they become citizens. *As more legal immigrants arrive every year, the numbers of uninsured children and pregnant women will continue to grow.*

States may use their own State funding to provide medical services to legal immigrant children who arrived after August 22, 1996. Also, undocumented immigrants are only eligible for emergency Medicaid.

Q2: How does the budget propose to expand health coverage to legal immigrant children and pregnant women through Medicaid and Children's Health Insurance Program (CHIP) Assistance?

A2: The budget gives States the option to provide Medicaid and CHIP assistance to legal immigrant children who enter the United States after August 22, 1996, during their first five years here. This proposal will help achieve the goal of providing access to comprehensive health care for all vulnerable children.

In addition, it would give States the option to provide Medicaid coverage to pregnant legal immigrants who enter the United States after August 22, 1996, during their first five years here. This would help us provide access to important prenatal and delivery services and therefore ensure the health of all children born in the United States.

Because these proposals are at State option, States retain flexibility in Medicaid and CHIP program design.

In sum, the proposals would eliminate:

- The "five year ban" on receipt of means-tested public benefits for CHIP and Medicaid for "lawfully residing" children and pregnant women;

- The requirement that States request reimbursement from the immigrant's sponsor for the cost of Medicaid/CHIP benefits provided; and

- The eligibility-limiting requirement to deem a sponsor's income and assets as available to the child or immigrant mother.

Q3: How much will this proposal cost? How many additional kids will it cover? How many pregnant women?

A3: Medicaid and CHIP coverage for children is estimated to cost $220 million for FY 2000 through FY 2004 and is expected to provide coverage for up to 55,000 additional children. The Medicaid proposal for pregnant women would serve 23,000 by FY 2004 and cost $105 million.

Because the proposals are structured as State options, we can not reliably estimate the specific impacts on States. However, the *attached table* shows the state-by-state population distribution of immigrant children and women of child-bearing age (based on March, 1998 CPS estimates).

Q4: What are the State impacts of the proposals? How many additional kids will be covered in my State? How many pregnant women will be covered?

A4: Because the proposals are structured as State options, and because of limitations in the data, we can not reliably estimate the specific impacts on States. We estimate that a total of 55,000 legal immigrant children, and 23,000 legal immigrant women, will be insured across the country under this proposal by FY 2004. The *attached table* shows how many immigrant children and women of child-bearing age are living in each State (based on March, 1998 CPS estimates). State-specific impact will depend on which States exercise their option to cover under their CHIP and Medicaid programs those immigrant children and women entering the country after August 22, 1996. In addition, the number of immigrants who become eligible in a State electing the new option will depend on state-established income and resource eligibility criteria under their CHIP and Medicaid programs.

State-by-State Population Distribution of Noncitizens

	Total Non-Citizens	Percent
TOTAL	16,542,147	100.0%
AK	14,989	0.1%
AL	75,903	0.5%
AR	34,311	0.2%
AZ	470,053	2.8%
CA	5,378,251	32.5%
CO	159,956	1.0%
CT	130,932	0.8%
DC	34,767	0.2%
DE	11,987	0.1%
FL	1,298,554	7.8%
GA	145,018	0.9%
HI	103,669	0.6%
IA	49,035	0.3%
ID	69,130	0.4%
IL	757,856	4.6%
IN	41,075	0.2%
KS	65,615	0.4%
KY	49,020	0.3%
LA	56,605	0.3%
MA	386,972	2.3%
MD	282,653	1.7%
ME	11,816	0.1%
MI	295,095	1.8%
MN	136,214	0.8%
MO	30,552	0.2%
MS	10,822	0.1%
MT	5,886	0.0%
NC	153,261	0.9%
ND	3,336	0.0%
NE	37,549	0.2%
NH	26,874	0.2%
NJ	683,091	4.1%
NM	73,628	0.4%
NV	127,429	0.8%
NY	2,178,581	13.2%
OH	156,082	0.9%
OK	41,416	0.3%
OR	234,996	1.4%
PA	273,210	1.7%
RI	47,130	0.3%
SC	26,916	0.2%
SD	3,400	0.0%
TN	58,519	0.4%
TX	1,622,264	9.8%
UT	93,393	0.6%
VA	242,281	1.5%
VT	8,717	0.1%
WA	235,696	1 4%
WI	99,061	0.6%
WV	6,210	0.0%
WY	2,369	0.0%

Data source: March Supplement to the 1998 CPS Survey.
Note: Figures are rounded to the nearest one-tenth of one percentage point. In states where there is a 0%, the actual figures are less than .1% and are rounded to 0%.

State-by-State Population Distribution of Noncitizen Children & Women of Child Bearing Age

	Total Non-Citizens	Percent	Non-Citizen Children	Percent	Non-Citizen Women Age 15-44	Percent
TOTAL	16,542,147	100.0%	2,461,553	100.0%	5,115,846	100.0%
AK	14,989	0.1%	2,342	0.1%	4,704	0.1%
AL	75,903	0.5%	11,584	0.5%	28,240	0.6%
AR	34,311	0.2%	4,531	0.2%	9,880	0.2%
AZ	470,053	2.8%	83,421	3.4%	159,133	3.1%
CA	5,378,251	32.5%	780,595	31.7%	1,720,921	33.6%
CO	159,956	1.0%	38,086	1.5%	54,937	1.1%
CT	130,932	0.8%	5,012	0.2%	26,305	0.5%
DC	34,767	0.2%	2,473	0.1%	10,059	0.2%
DE	11,987	0.1%	1,989	0.1%	4,454	0.1%
FL	1,298,554	7.8%	194,440	7.9%	385,599	7.5%
GA	145,018	0.9%	16,855	0.7%	60,594	1.2%
HI	103,669	0.6%	9,847	0.4%	28,746	0.6%
IA	49,035	0.3%	12,944	0.5%	15,522	0.3%
ID	69,130	0.4%	15,832	0.6%	21,827	0.4%
IL	757,856	4.6%	129,407	5.3%	203,408	4.0%
IN	41,075	0.2%	3,927	0.2%	16,726	0.3%
KS	65,615	0.4%	14,432	0.6%	20,369	0.4%
KY	49,020	0.3%	13,924	0.6%	19,626	0.4%
LA	56,605	0.3%	9,304	0.4%	19,947	0.4%
MA	386,972	2.3%	62,667	2.5%	112,606	2.2%
MD	282,653	1.7%	45,730	1.9%	78,486	1.5%
ME	11,816	0.1%	1,807	0.1%	4,852	0.1%
MI	295,095	1.8%	37,383	1.5%	92,127	1.8%
MN	136,214	0.8%	25,040	1.0%	52,336	1.0%
MO	30,552	0.2%	0	0.0%	5,740	0.1%
MS	10,822	0.1%	0	0.0%	4,987	0.1%
MT	5,886	0.0%	0	0.0%	2,027	0.0%
NC	153,261	0.9%	33,362	1.4%	56,618	1.1%
ND	3,336	0.0%	410	0.0%	1,998	0.0%
NE	37,549	0.2%	6,110	0.2%	14,554	0.3%
NH	26,874	0.2%	2,618	0.1%	5,822	0.1%
NJ	683,091	4.1%	101,934	4.1%	182,323	3.6%
NM	73,628	0.4%	12,704	0.5%	19,832	0.4%
NV	127,429	0.8%	19,590	0.8%	39,934	0.8%
NY	2,178,581	13.2%	314,639	12.8%	644,499	12.6%
OH	156,082	0.9%	6,312	0.3%	29,476	0.6%
OK	41,416	0.3%	6,228	0.3%	15,254	0.3%
OR	234,996	1.4%	42,796	1.7%	67,352	1.3%
PA	273,210	1.7%	34,634	1.4%	80,559	1.6%
RI	47,130	0.3%	5,014	0.2%	18,318	0.4%
SC	26,916	0.2%	0	0.0%	7,678	0.2%
SD	3,400	0.0%	781	0.0%	1,360	0.0%
TN	58,519	0.4%	0	0.0%	19,190	0.4%
TX	1,622,264	9.8%	242,716	9.9%	516,339	10.1%
UT	93,393	0.6%	19,069	0.8%	25,620	0.5%
VA	242,281	1.5%	33,289	1.4%	96,862	1 9%
VT	8,717	0.1%	1,109	0.0%	2,333	0.0%
WA	235,696	1.4%	44,245	1.8%	80,652	1.6%
WI	99,061	0.6%	10,267	0.4%	22,122	0.4%
WV	6,210	0.0%	0	0.0%	2,117	0.0%
WY	2,369	0.0%	148	0.0%	876	0 0%

Data source: March Supplement to the 1998 CPS Survey

Note: Figures are rounded to the nearest one-tenth of one percentage point. In states where there is a 0%, the actual figures are less than .1% and are rounded to 0%.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

July 01, 1999

The Honorable J. Dennis Hastert
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is the Administration's draft bill, the "Medicaid and Children's Health Insurance Program Amendments of 1999". The bill amends the Medicaid and Children's Health Insurance Program (CHIP) statutes under titles XIX and XXI of the Social Security Act, and programs under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to carry out proposals included in the President's Budget for FY 2000.

The bill includes amendments adding State options to expand eligibility for benefits, making program improvements, and closing loopholes in HIPAA's guarantee of extended insurance availability. Other amendments are designed to control costs, improve program administration, and address fraud and abuse. Highlights of the bill are described below; all provisions of the bill are detailed in the enclosed section-by-section summary.

The bill adds State options to extend Medicaid eligibility to youths under age 21 who have "aged out" of the Federal foster care program; to certain individuals receiving in community settings the level of care provided in inpatient institutions; and to immigrant children and pregnant women who are qualified aliens or in other designated groups of lawfully present aliens. States may also extend CHIP eligibility to these same groups of immigrants. Two other proposals in the President's FY 2000 Budget also complement this proposal by restoring important disability and nutrition benefits to additional categories of legal immigrants.

Various amendments adjust the relationship between the Medicaid program and the cash assistance programs under title IV-A of the Social Security Act (Temporary Assistance for Needy Families (TANF) and its predecessor program, Aid to Families with Dependent Children (AFDC)). The bill relaxes the rules for transitional Medicaid coverage of individuals in low-income families with children who have become ineligible based on employment. This provision will relieve State agencies and eligible families from burdensome administrative and reporting requirements, while ensuring that the safety net of Medicaid eligibility is maintained for these families. The bill provides enhanced Federal matching of costs of outreach to and eligibility determinations for children and families likely to be eligible for Medicaid and CHIP. It also adjusts Federal funding for Medicaid administrative costs to recapture the windfall given States by inclusion of amounts for these costs in TANF appropriations.

Amendments to the CHIP program include proposals to expand the cap on administrative expenditures by 3 percent, provided the increase is used for outreach, and to increase funding for territories.

Amendments to the HIPAA statutes add loss of Medicaid coverage as an event requiring group plans to offer an individual a special enrollment period; and provide that the period before an individual receives written notice that an employer has ceased making insurance payments may not be counted in calculating the length of a break in health insurance coverage.

The Omnibus Budget Reconciliation Act (OBRA) requires that all revenue and direct spending legislation meet a pay-as-you-go (PAYGO) requirement. That is, no such bill should result in a net budget cost; and if it does, it could contribute to a sequester if it is not fully offset. This proposal would increase direct spending by $61 million in FY 2000 and by a total of $526 million during FYs 2000-2004; therefore, it is subject to the PAYGO requirement.

This proposal is fully offset in the President's Budget and should be considered in conjunction with all other PAYGO proposals in the Budget. The Administration will work closely with the Congress on this and other PAYGO legislation to avoid a sequester of mandatory programs.

We urge the Congress to give the draft bill its prompt and favorable consideration. The Office of Management and Budget has advised that there is no objection to the submission of this draft bill to the Congress and that its enactment would be in accord with the program of the President.

Sincerely,

Donna E. Shalala

Enclosures

subsection.".

SEC. 102. STATE OPTIONS FOR COVERAGE OF CERTAIN ALIEN CHILDREN AND PREGNANT WOMEN.

(a) MEDICAID ELIGIBILITY OF CHILDREN AND PREGNANT WOMEN.—

(1) STATE OPTION TO PROVIDE MEDICAID.—

(A) CHILDREN.—Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(i) by striking "or" at the end of subclause (XIII); and

(ii) by adding after subclause (XIV) the following new subclause:

"(XV) who is an assistable alien child (as defined in section 1905(v)(1)) who would be eligible for medical assistance (or for a greater amount of medical assistance) under this subparagraph, but for one or more of the provisions of title IV of P.L. 104-193; but the State may not exercise such option with respect to a subcategory of such individuals."

(B) PREGNANT WOMEN.—Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is further amended—

(i) by inserting "or" at the end of subclause (XV); and

(ii) by adding after subclause (XV) the

following new subclause:

"(XVI) who is an assistable alien pregnant woman (as defined in section 1905(v)(2)) who would be eligible for medical assistance (or for a greater amount of medical assistance) under this subparagraph, but for one or more of the provisions of title IV of P.L. 104-193; but medical assistance for such an individual shall be limited to the same amount, duration, and scope as the medical assistance for any other individual described in subsection (l)(1)(A) or section 1905(n));".

(C) MEDICALLY NEEDY.—Section 1902(a)(10)(C) (42 U.S.C. 1396a(a)(10)(C)) is amended by inserting before the comma in clause (i)(I) "(and such criteria may provide for eligibility of individuals described in section 1905(v) who would be eligible for medical assistance (or for a greater amount of medical assistance) under the provisions of the plan under this subparagraph, but for one or more of the provisions of title IV of P.L. 104-193)".

(2) DEFINITION OF ASSISTABLE ALIEN CHILDREN AND PREGNANT WOMEN.—Section 1905 (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(v)(1) The term 'assistable alien child' means an individual who—

"(A) is described in subsection (a)(i); and

"(B) is described in paragraph (3).

"(2) The term 'assistable alien pregnant woman' means an individual who—

"(A) is described in section 1902(l)(1)(A) or subsection (n); and

"(B) is described in paragraph (3).

"(3) For purposes of paragraphs (1) and (2), an individual is described in this paragraph if the individual is an alien who-

"(A) entered the United States on or after August 22, 1996; and

"(B)(i) is a qualified alien (as defined in section 431 of Public Law 104-193 as amended); or

(ii) a member of any category of lawfully present aliens specified in regulations promulgated by the Secretary in consultation with the Attorney General.".

(3) ELIMINATION OF PAYMENT RESTRICTION WITH RESPECT TO CERTAIN ALIEN CHILDREN AND PREGNANT WOMEN.—Section 1903(v)(1) (42 U.S.C. 1396b(v)(1)) is amended by inserting "and except with respect to individuals described in section 1905(v) who receive medical assistance pursuant to section 1902(a)(10)(A)(ii)(XV), 1902(a)(10)(A)(ii)(XVI), or 1902(a)(10)(C)" after "paragraph (2)".

(b) CHIP ELIGIBILITY OF CERTAIN ALIEN CHILDREN.—Section 2110(b) (42 U.S.C. 1397jj(b)) is amended—

(1) in paragraph (1)(A), by inserting before the semicolon "(including, at the option of the State, a child described in paragraph (3)(B))"; and

(2) in paragraph (3)—

(A) by striking "SPECIAL RULE.—" and inserting "SPECIAL RULES.—"

(B) by designating the remainder of the text as subparagraph (A) and indenting accordingly below the paragraph heading;

(C) by adding the following after the subparagraph designation "(A)": "HEALTH INSURANCE COVERAGE.—"; and

(D) by adding at the end the following new subparagraph:

"(B) ELIGIBILITY FOR CERTAIN ALIEN CHILDREN.—For purposes of paragraph (1)(A), a child is described in this subparagraph if—

"(i) the child is an assistable alien child under section 1905(v)(1); and

"(ii) the State exercises the option to provide medical assistance to the category of individuals described in section 1902(a)(10)(A)(ii)(XV).".

(c) PROHIBITION ON SEEKING REIMBURSEMENT FROM SPONSOR.-

(1) MEDICAID.-

(A) CHILDREN.-Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—

(i) by striking "and" at the end of subparagraph (G);

(ii) by adding "and" at the end of subparagraph (H); and

(iii) by adding after subparagraph (H) the following new subparagraph:

"(I) that the State will disregard the requirements of section 213A(b) of the Immigration and Nationality Act with respect to medical assistance furnished on behalf of an individual who is eligible for such assistance under the State plan because of the provisions of clause (XV) of paragraph (10)(A)(ii) or because of the reference to such clause in paragraph (10)(C).".

(B) PREGNANT WOMEN.-Section 1902(a)(25)(I) (42 U.S.C. 1396a(a)(25)(I)) is amended by inserting "or (XVI)" after "clause (XV)".

(2) CHIP.—Section 2107 (42 U.S.C. 1397gg) is amended by adding after subsection (e) the following new subsection:

"(f) DISREGARD OF SPONSOR REIMBURSEMENT REQUIREMENT.—A State child health plan shall provide that the State will disregard the requirements of section 213A(b) of the Immigration and Nationality Act with respect to benefits under this title provided to a child who is eligible for such benefits because of

the provisions of section 2110(b)(3)(B).".

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided, the amendments made by this section shall become effective with respect to calendar quarters beginning on and after October 1, 1999.

(2) PREGNANT WOMEN.—The amendments made by subsections (a)(2)(B) (and (a)(2)(C), but only with respect to assistable alien pregnant women described in section 1905(v)(2)) and (c)(1)(B) of this section shall become effective with respect to calendar quarters beginning on and after October 1, 2000.

SEC. 103. STATE OPTION TO COVER INDIVIDUALS WHO WOULD OTHERWISE REQUIRE AN INSTITUTIONAL LEVEL OF CARE.

(a) STATE OPTION TO PROVIDE ELIGIBILITY.—Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) by striking "or" at the end of subclause (XIII);

(2) by adding "or" at the end of subclause (XIV); and

(3) by adding after subclause (XIV) the following new subclause:

"(XV) who would be eligible under the State plan under this title if they were in a medical institution, whose income does not exceed the limit specified in section 1903(f)(4)(C), and with respect to whom there

DATE: 6/22/99

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REMARKS: Per our conversation

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Privacy

Bennett Says Senate Medical Privacy Bill Markup May Not Happen Until September

A legislative markup of the Senate Health, Education, Labor, and Pensions Committee's medical records privacy proposal may not be rescheduled until September, Sen. Robert Bennett (R-Utah) said June 18.

Speaking at a conference sponsored by the Academic Medicine and Managed Care Forum in Washington, D.C., *Bennett said he was told the markup will not take place until September and he thinks Congress will have to extend or delay the deadline to pass medical information privacy included in the Health Insurance Portability and Accountability Act of 1996.*

HIPAA requires Congress to pass privacy legislation by Aug. 21 or defer responsibility to the secretary of health of human services to promulgate protection regulations by February 2000. Congressional leaders and the administration have stressed repeatedly that passing legislation by the deadline is preferable to regulations or to extending the deadline (No. 103 HCDR Page 10, 5/28/99).

HELP Committee Chairman James Jeffords (R-Vt.) drafted a committee bill with portions of three leading privacy proposals: S. 881, the Medical Information Protection Act of 1999 sponsored by Bennett; S. 573, the Medical Information Privacy and Security Act of 1999 sponsored by Sen. Patrick Leahy (D-Vt.); and S. 578, the Health Care Personal Information Nondisclosure Act of 1999, sponsored by Jeffords.

Markups of the bill have been scheduled and cancelled four times because of disagreements over portions of the legislation that threaten its bipartisan support. Jeffords has said he is committed to reporting the bill out of the committee with bipartisan support to help ensure its passage before the full Senate (No. 116 HCDR Page 6, 6/17/99).

A HELP Committee spokesman would not confirm that the markup would be postponed until September, or that the August 21 deadline would be extended. He said although it was unlikely that any action would take place before the July 4 congressional recess, it was too soon to rule out any action happening during the rest of July.

Bennett called the HELP legislation something he was "in acquiescence with" and added that House Republican leaders have told him the issue is so complex that, if he were able to get his legislation passed in the Senate, they would push it through the House, rather than creating their own bill.

Civil Action, Juvenile Rights Cause Delay

Bennett cited the two issues that members of the HELP Committee have said are holding up progress on the bill: a civil right of action for people who have had the privacy of their medical records violated and the rights of parents to access juvenile medical records.

While Democrats favor the right of action, Bennett said Republicans are opposed to such a measure or want to cap the amount of damages that could be awarded in a lawsuit. A compromise appears in the current legislative language capping damages at $50,000, but Democrats will not support the bill unless that is increased.

Bennett called this issue a "fight with the trial lawyers," something that is "always predictable."

"I am unburdened with a legal education," Bennett said, "but if you thought about it, you could predict this."

Juvenile Records Debate Unexpected

What was less predictable was the fight over who can view minor's medical records, he said.

"I'm a little surprised that this second issue is holding up action on this bill," said Bennett.

"As a parent of six children and 10 and two-thirds grandchildren, I would want to know [if a child was sick] because I would want to find the best possible solution," he said.

Although he acknowledged concerns that some young people may not seek treatment for sexually transmitted diseases, for example, if their parents potentially could find out, he said the issue should be balanced with overall concern for patient well-being and should not be controversial enough to stall the bill.

"My own bias is that making information available might have a therapeutic effect on the relationship" between parents and children, Bennett said.