Testimony of
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House Energy and Commerce Subcommittee on Health
Hearing on
H.R. 3014

June 24, 2008

Thank you for the opportunity to comment on H.R. 3014, the Health Equity and Accountability Act. This is wide-reaching legislation and perhaps overly ambitious, given that some of its proposals are likely to reap untold consequences. This bill falls at the intersection of welfare, health care, and immigration policy. Any one of these is difficult to craft prudently and responsibly, so as to minimize adverse effects. Attempting to delve into all three policy areas at once could well prove risky.

I will focus my remarks on Section 503 of this bill, as well as translation provisions. I will place the first section in broader, historical context.

This section would amend both Medicaid and the State Children's Health Insurance Program statutes. States could opt to provide medical care through Medicaid to an unartfully described class. Waiving the 1996 Welfare Reform Act's bar on immigrant eligibility for taxpayer-funded welfare programs, in this case Medicaid, this bill extends this entitlement eligibility to "undocumented residents who are lawfully residing in the United States." For anyone involved in immigration policy, that description is curious, to say the least, since every legal immigrant and nonimmigrant visa holder is either issued documents by the federal government or required to possess a valid visa with an entry stamp. This new category is unacceptably vague and, therefore, dangerously abuse-prone.

Who is this curious group? It would seem a description of one-time illegal aliens who have managed to secure an interest in a bureaucratic process, which delays their

removal. As you know, “undocumented alien” or “undocumented resident” usually is a euphemism for illegal alien. This could be someone who unlawfully crossed the border or who arrived on a valid, temporary visa and never left when the visa expired. Thus, such people would be “undocumented” — they have no valid immigration or other document authorizing their presence in the United States. Illegal aliens may seek to delay or avoid deportation or prosecution by requesting formal removal proceedings rather than voluntary departure, or by filing an application to adjust their status to some other category, such as lawful permanent residence (a “green card”), one of the many temporary nonimmigrant categories, or asylum. Since aliens may not be deported until their formal removal, adjustment application, or asylum claim is processed and a final determination is made, it could be argued that these aliens are, technically, “lawfully residing in the United States.” Without further clarification, however, this category is open to interpretation.

The Medicaid expansion further specifies that welfare eligibility is to be extended to “pregnant women,” during and for two months following the term of their pregnancy. It should be noted that HHS regulations on SCHIP issued in 2002 already provide for prenatal care to fetuses of illegal aliens; so, the care is already available to unborn babies and their pregnant mothers, and this provision is unnecessary. This bill also qualifies “children” under age 21, which would include people old enough to drive, to vote, in many states to drink alcohol, and to enlist in the military.

It is important to note that welfare reform barred nonimmigrants (or holders of temporary visas) and illegal aliens from means-tested programs, including Medicaid. So, H.R. 3014 rolls back welfare reform by loosening up the qualifications for people of highly questionable legality. This seems fundamentally unfair to lawful immigrants, who abided by the law to get here and must rely on their sponsor, not the government or the American taxpayer, for their financial well-being. Green card holders are barred from

Medicaid for five years, as both they and their sponsors agreed in a legally binding affidavit of support. The exception written in this section seems to take the guise of "compassion" to mask unfairness — toward working Americans, taxpayers, and lawful immigrants.

The next provision of this section explicitly exempts "any sponsor" of these "undocumented residents" from their liability to repay the medical costs these people will impose on the public treasury. This financial liability is sworn, legally enforceable debt willingly agreed to as a condition of the American people's generosity in allowing sponsored aliens the privilege of residing in our nation. This bill undermines the clear principles of individual responsibility and balance that welfare reform put into place.

Importantly, if any legalization bill were to pass, it would apparently multiply greatly the number of people who would qualify under this poorly worded eligibility category. Under every major amnesty plan discussed in the past several years, illegal aliens would receive some sort of interim status while waiting for longer term documentation. This would mean these "undocumented" residents were now "lawfully residing in the United States." The consequences, the costs, the impact of added demand on scarce medical resources in every locality would be serious.

Another important concern with regard to Section 503 is the incentive for fraud and abuse that it creates. The flimsy description of who qualifies for Medicaid adds yet another incentive to enter or remain in the country illegally, to perpetrate what is known as "immigration benefits fraud," or both. Immigration benefits fraud is one of the most unsung, but heavily abused areas where our immigration laws are broken. It results in additional costs to American taxpayers, and it adds to the already lengthy times that law-abiding immigrants and nonimmigrants must wait to receive their visas, since it diverts personnel and resources at U.S. Citizenship and Immigration Services (USCIS). This provision compounds that problem and would likely lead to more of this fraud.

Given the uncertainty in and open-ended nature of the description of who would qualify under H.R. 3014 Section 503, it is hazardous to guess how much this provision will cost taxpayers. A provision similar to this section was in the CHAMP Act, H.R. 3162. It extended Medicaid and SCHIP coverage to lawfully permanent resident pregnant women and children up to age 19. The Congressional Budget Office scored that provision, Section 132, at $2.2 billion over 10 years. The state spending that provision would require nearly doubled the cost. Four billion dollars is a significant amount. One would expect costs at least as great, if not greater, than CHAMP. I would urge lawmakers to question the advisability of extending any entitlement program, such as Medicaid. Such is an open-ended commitment. At a time when entitlement programs — Medicare, Medicaid, and Social Security — careen on a course of fiscal unsustainability and overwhelming debt, would it not seem fiscally irresponsible to compound the unfunded liability exposure? Rather, prudence would dictate reducing financial liability and narrowing program eligibility.

Stepping back a bit, this provision, and other parts of the bill, diminishes one of the oldest, central principles of American immigration law — a principle whose essence is promoting individual responsibility and self-sufficiency: public charge doctrine.

A “public charge” is someone who cannot or will not support himself and instead is reliant on society. Massachusetts adopted the earliest American public charge laws, in 1645. The colonies protected themselves against public charges by excluding, or refusing to allow to settle, people who were regarded as likely to become dependent on the public’s resources. Colonies required arriving ships to provide the list of passengers or required that ship captains post bonds for potential public charges. Otherwise, the ship had to return the “lame, impotent, or infirm” passengers “incapable of maintaining

themselves."[1] These types of colonial laws were incorporated as state laws following American independence. Over time, as Congress became more active in making immigration policy, Congress and states acted concurrently to bar likely public charges or to deport immigrants who became public charges. By the late 19th century, Congress took on the responsibility of setting immigration policy, and promptly enacted in the 1882 Immigration Act the exclusion of any immigrant "unable to take care of himself or herself without becoming a public charge."

The reason for such a "tough love" standard is compassion, properly understood, toward the native-born and capable immigrants. They must work harder, pay more taxes (or health insurance premiums), etc. to subsidize people who otherwise would not live here; it is the same as Captain John Smith's "tough love" rule in Jamestown, Virginia, that those new arrivals who were not willing to work and pull their weight were excluded from meals.

This section of H.R. 3014 swims against the stream of our history. It weakens public charge doctrine. It diminishes the concept that America is the land of opportunity for those we, the American people, decide to admit. We have traditionally rejected the idea that Americans should have to accept all comers or materially support immigrants. No, immigrants have normally been held to the standard of self-reliance that we expect of our fellow Americans.

The 1996 immigration law (P.L. 104-208) and welfare reform (P.L. 104-193) remained true to and strengthened that venerable standard. These laws required: Most immigrants, relationally based and employment-based accompanying family members, must secure an affidavit of support from the sponsor. The affidavit of support, which a sponsor signs accepting financial responsibility for an immigration applicant, became

[1] James R. Edwards, Jr., "Public Charge Doctrine: A Fundamental Principle of American Immigration Policy," *Backgrounder*, Center for Immigration Studies, May 2001.

legally binding. Sponsor income must be at least 125 percent of the federal poverty line. All sponsor income is "deemed" as available to the immigrant. Government agencies could seek reimbursement of the costs the sponsored alien imposes on the taxpayer, until the sponsored alien naturalizes or has established a 10-year work history. The legislation that is the subject of this hearing substitutes an opposite standard.

Briefly, please allow me to touch on the bill's translation provisions. First, Medicaid already covers translator services. So, this appears an unnecessary addition. Second, there could be unintended consequences. Medicaid already provides very low provider reimbursements, less than actual costs. Thus, in certain locations Medicaid has difficulty attracting doctors to see Medicaid patients. Adding translation mandates could force more providers to decline acceptance of new Medicaid patients.

The American Medical Association has voiced this very concern, the reduction of access due to government mandated translation services:

> . . . It is extremely inequitable to require physicians to fund written and oral interpretation services. The cost of hiring an interpreter, which our state survey shows can greatly vary between $30 and $400, is significantly higher than the payment for a Medicaid office visit, which in many states ranges between $30 and $50. Physicians would sustain severe economic losses if forced to cover the cost of interpretation services and thus may no longer be able to provide services to LEP [limited English proficient] patients. Indeed, AMA data shows that two-thirds of physician offices are small business. If a business, especially a small business, continues to lose revenue and begins to operate on a negative balance sheet, the business cannot be maintained.[2]

The AMA noted the cost differential between the costs doctors bear and revenue from Medicaid, the difficulty finding interpreters in many states, and impracticalities such as cancelled appointments where arrangements were made to secure an interpreter (who still expects to be paid for his or her time). The potential for these kinds of factors do not seem to have been fully contemplated in H.R. 3014.

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[2] Comment letter from American Medical Association to Office of Management and Budget, Dec. 21, 2001

Further, Section 101 translation provisions effectively codify Executive Order 13166. This very controversial order directs every federal agency to provide "access to federally conducted or federally assisted programs for persons who, as a result of national origin, are limited in their English proficiency." E.O. 13166 amounts to an unfunded mandate on hospitals, public health clinics, and health care providers who receive federal funds. Also, the government uses a highly suspect definition of "limited English proficient," which can unnecessarily escalate the costs to taxpayers. The definition should generally be fixed so interpreter and multilingual materials mandates apply only in common-sense ways and only assist those who in fact do not speak English "very well." The other impact of these policies is to work against assimilation. They cool the melting pot, whereby people from other lands learn to speak English, adopt American political virtues, and become, in Lincoln's words, "blood of the blood, and flesh of the flesh of the men who wrote that Declaration [of Independence]."

Should the committee choose to move this legislation, in addition to addressing the matters I have raised, the bill should not be enacted without coupling it with at least one of two other bills. Either of these other bills would mitigate the potential harm caused by H.R. 3014. Ranking Member Deal's H.R. 1940, the Birthright Citizenship Act, would eliminate the incentive some illegal aliens have of birthing their offspring in the United States. The policy of granting automatic U.S. citizenship to the "anchor baby" effectively foils the parent's deportation, qualifies the illegal parent to derive benefits accorded to the newborn based on his or her citizenship, and allows that illegal alien to begin his own chain of relatives, once the citizen child turns 21. The child can sponsor the illegal alien mother, as well as extended relatives. Ending automatic citizenship on account of birth here would help alleviate this abuse. The other bill that should accompany this legislation is H.R. 938, the Nuclear Family Priority Act. Congressman Gingrey's bill would enact the recommendations of the Barbara Jordan Commission. It

would eliminate extended relative visa categories (chain migration visas), instead placing priority on the nuclear family's reunification: spouses and minor children. Without one or both of these bills as counterbalance, H.R. 3014 should not move at all.

In summary, in 1996, a Democratic President and a Republican Congress came to agreement on landmark immigration and welfare reform legislation. That bipartisan accomplishment was not easy. Sadly, H.R. 3014 seems to fall short of that model. This bill may be well intentioned — most of us would like to see reductions in disparities in the health of minorities and other demographic subgroups, expansion of the reach of health information technology, especially to rural areas, and so forth. But H.R. 3014 goes about it in certain ways that are more divisive than unifying.

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