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UNDOCUMENTED ALIENS

Estimating the Cost of Their Uncompensated Hospital Care

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The Honorable Vic Fazio
Chairman, Subcommittee on Legislative,
Committee on Appropriations,
House of Representatives

The Honorable Ronald D. Coleman
House of Representatives

In your letter of June 6, 1986, you asked us (1) to examine the methodological and conceptual bases of estimating the costs of uncompensated health care provided to undocumented aliens, and (2) if possible, to develop an improved approach.

This report is based on our review of prior estimates and studies of both illegal immigration and uncompensated health care; interviews with federal, state and local health care officials; the results of GAO's past and ongoing immigration work; the procedures used by two hospitals to manage uncompensated care; and the immigration-related legislation enacted and regulations proposed during the period October 1986 through May 1987.

Prior to the implementation of the Immigration Reform and Control Act of 1986 (IRCA), we formulated but did not test a possible alternative approach for estimating these costs. As agreed, we postponed testing that approach until the situation under the new law stabilizes and it can be determined whether such a study is still needed. A summary of our results follows.

Background

Unreimbursed costs incurred by hospitals and other health care providers who treat uninsured undocumented aliens have become an important health policy issue in urban areas as well as in U.S.-Mexico border communities. Concern that undocumented aliens may be a drain on community resources and concern over their equitable and humane treatment have combined to create a patchwork of federal, state, and local laws and practices.

Hospital care provided to patients without private insurance is typically financed through various combinations of philanthropy, cost-shifting to private insurers, specific federal and state programs, and general subsidies from state and local governments. Until recently, aliens who were

not legal permanent residents of the U.S. or permanently residing under color of law were specifically excluded from eligibility for the major federal-state medical assistance program for low-income persons (i.e., Medicaid). As a result, states and counties—which generally have ultimate responsibility for providing and financing indigent health care— have had to shoulder much of the burden. For example, in 1986, El Paso and Los Angeles counties estimated their annual cost of caring for undocumented indigents at $7.5 million and $100 million, respectively.

Problems in Estimating the Cost of Care Provided

We found that most methods previously used to estimate the costs of care provided to undocumented aliens were flawed by a lack of accurate data and reliance upon tenuous assumptions. The most direct approach to identifying these patients—simply asking all uninsured patients for proof of their legal immigration status—was not feasible (outside the Medicaid program) in most areas. Consequently, most methods depended on subjective judgments or unreliable estimates of the population's size, health care utilization, and demographic characteristics. On the cost side, hospitals and health economists differ on what to include in the definition of uncompensated care and how to assign dollar values to it. Some include, for example, bad debt incurred by non-paying patients, as well as free care provided on a charity basis. Additionally, costs were frequently reported on the basis of "usual" hospital charges per service, although usual charges are generally higher than actual costs in order to help finance, for example, indigent care.

Options for Gaining Improved Estimates

Under current hospital procedures, few options exist for gaining improved estimates of the uncompensated cost to hospitals of treating undocumented aliens. One component of this care can be estimated by identifying Medicaid applicants who are denied coverage because of their alien status. However, not all uninsured patients apply for (nor would they necessarily be eligible for) Medicaid benefits.

As a possible improvement, we have formulated an alternative method involving an empirically based analysis of indicators of probable immigration status. The indicators could be derived by adding a limited set of questions to the hospital or clinic's routine patient admission process. The approach also assigns dollar values to the services rendered to these patients by discounting the usual charge per service. These adjustments are based on hospital cost data calculated for reports required of hospitals participating in the Medicare program. However, our method requires testing to assure it provides valid and reliable estimates.

When the new immigration law is fully implemented, new opportunities may arise for deriving improved estimates of immigration status in addition to those noted above. Under the new law, applicants for employment and for full Medicaid benefits will have to provide documents showing that they are citizens or have legal immigration status in the U.S. Those documents presented in application for Medicaid will have to be verified. As these requirements are implemented, similar procedures—for the purpose of record-keeping only—could be adopted by hospitals for all uninsured patients, regardless of Medicaid eligibility. The information obtained could then be used to generate more reliable estimates than are currently available of the number of undocumented uninsured patients served. Our proposed approach to assigning dollar values to services rendered is, of course, not affected by these changes.

The New Immigration-Related Legislation Expands Reimbursement Options

The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) amended Medicaid law to permit health care providers to be reimbursed for child birth care (labor and delivery services) and emergency medical services provided to all immigrants (regardless of their legal status) who otherwise meet the state's Medicaid program eligibility criteria. IRCA further provides for full Medicaid eligibility to certain groups of persons granted amnesty, if they meet the state's other program requirements. In addition, $1 billion a year was budgeted for four years to help offset the costs to federal, state and local governments of providing health and other services to aliens who—through amnesty—can now participate in some programs from which they were previously excluded.

It is not known what proportion of aliens will be granted amnesty, nor what proportion of amnestied aliens, or of those remaining undocumented, will be eligible through the new avenues for Medicaid coverage. However, these changes are likely to reduce somewhat both the size of the uncompensated care problem and the portion of that problem uniquely attributable to aliens. As patients' citizenship status becomes a less important factor in determining whether reimbursement is available for their health care, other factors that have traditionally affected the health insurance coverage of citizens will take on more significance. Such factors include family circumstances, employment opportunities, and the availability of employer-sponsored health insurance.

Because of differences across localities in such factors, however, the new immigration and Medicaid policies can be expected to have quite different effects in various regions of the country. Certain areas—such as communities of more recent immigrants and border communities—

may continue to have problems deserving special attention. Any future study should address the methodological problems described above as well as recognize the impact of other factors which contribute to the problem of uncompensated health care.

Conclusions

We believe that (1) efforts to test and finalize new approaches to the identification of undocumented aliens' use of health care should await full implementation of the new laws, and (2) future estimates of the uncompensated cost of such care, if still needed, should be considered in the context of other issues contributing to uncompensated care, and should address the methodological problems associated with previous cost estimates.

Views of Program Officials

Program officials of the Immigration and Naturalization Service of the U.S. Department of Justice and the Health Care Financing Administration of the U.S. Department of Health and Human Services reviewed a draft of this report. They provided some technical comments pertaining to our characterization of relevant IRCA and OBRA-86 provisions, which were incorporated in this report.

As arranged with your office, unless you publicly announce its contents earlier, no further distribution of this report will be made until 30 days from the date of the report. At that time we will send copies to the Attorney General, the Secretary of Health and Human Services and to other interested parties. We will also make copies available to others who request them. If you have any questions or would like additional information, please call me (202-275-1854) or Dr. Lois-ellin Datta (202-275-1370).

Eleanor Chelimsky
Director

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Abbreviations

AFDC	Aid to Families with Dependent Children
GAO	General Accounting Office
HCFA	Health Care Financing Administration
INS	Immigration and Naturalization Service
IRCA	Immigration Reform and Control Act of 1986
OBRA-86	Omnibus Budget Reconciliation Act of 1986
SSI	Supplemental Security Income

Introduction

Undocumented aliens—also referred to as illegal aliens— include persons violating the terms of their legal permission to enter the U.S., as well as persons entering the country without permission. It has been claimed that undocumented aliens are indispensable to the U.S. economy because many work at jobs most citizens will not accept at current wages. Yet for many years undocumented aliens have also been a cause for public concern both because they are violating the law and because of the social problems believed to be associated with their presence. The kinds of problems discussed in the literature include the creation of an underclass, displacement of some U.S. workers, depression of wages and employment conditions for others, and increased expenditures of community resources.

Problem Background

Unreimbursed costs incurred by hospitals and other health care providers who care for uninsured undocumented aliens have become an important health policy issue in urban centers as well as in communities along the U.S.-Mexico border. In 1977, the Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce, held hearings on five bills which would have authorized the Public Health Service to provide financial assistance to medical facilities for emergency medical treatment provided to indigent undocumented aliens. While none of those bills passed, numerous government officials and health-care providers from Florida, Illinois, New York, and the Southwest testified about the heavy costs they bore. In 1986, El Paso County in Texas requested $7.5 million from the federal government to help recoup the annual costs of uncompensated health care provided to undocumented aliens, while Los Angeles County requested $100 million. There is controversy, however, about the magnitude of the problem at both the national and local levels, reflecting uncertainty about the number of patients, range of services provided, and their associated costs.

Congressional Request

In the context of legislative proposals in the 99th Congress that would provide federal monies for part of the cost of uncompensated health care provided to undocumented aliens, on June 5, 1986, Congressman Ronald D. Coleman and Chairman Vic Fazio requested GAO to (1) examine the methodological bases of prior estimates of the costs incurred by hospitals treating undocumented aliens, and (2) if possible, develop and test an improved approach. (See appendix I.) The Immigration Reform and Control Act of 1986 (IRCA), enacted November 6, 1986, and the Omnibus Budget Reconciliation Act of 1986 (OBRA-86), enacted October

21, 1986, both provide for partial federal reimbursement of the costs of this health care. These laws will not be fully implemented before the fall of 1988. At that time, certain state agencies (unless granted an exemption) must verify the immigration or citizenship status of all applicants to certain assistance programs through an INS verification system or some other more effective means. This report primarily describes the situation prior to the enactment of these laws, but also considers their implications for expected changes in collecting data on and compensating providers for treating this population.

Objectives, Scope and Methodology

To respond to this request to develop an improved cost estimation approach, we:

- Reviewed the literature on the use of public services by undocumented aliens, on uncompensated health care and issues in measuring it, and on previous estimates of the cost of uncompensated care provided to undocumented aliens.
- Critiqued previous cost estimates from conceptual, methodological and data availability perspectives.
- Formulated an alternative, indirect estimation method that hospitals could use as part of their routine admissions process, and developed procedures for testing the method's reliability and validity.

In response to the immigration-related legislation enacted during the course of these activities, we:

- Reviewed that legislation and interviewed agency and hospital officials to assess the implications for uncompensated care provided to undocumented aliens and efforts to measure it.

From our review of the circumstances surrounding the implementation of IRCA, it became clear that it was inadvisable to attempt a test of our proposed cost-estimation approach during a period of disruption for the alien community. Press reports since IRCA's enactment suggested that undocumented aliens have changed their behavior regarding migration and employment in response to the anticipated effects of the new immigration law. Specifically, there were reports that confusion about the procedures for implementing (1) amnesty for some undocumented aliens and (2) sanctions on employers for hiring those not amnestied, has raised anxiety among undocumented aliens about deportation and their ability to continue to work in this country.

During the present climate of change, we believe that the size of the undocumented alien population generally might be temporarily lower than normal; and among those remaining, aliens might be less willing to come to hospitals for care, and certainly less willing to participate in our study or respond openly to questions about their immigration status. Therefore, if we went ahead with our study as planned, we could not confidently generalize from our findings in this period to the period after implementation of the relevant provisions of both OBRA and IRCA is complete. And, second, these threats to the reliability of the data collected would lessen the credibility of our test of the accuracy of the method. Therefore, in agreement with the congressional requestor, a test of our approach was postponed until the situation stabilizes and it can be determined whether such a study is still needed.

The focus of this briefing report, therefore, is on (1) the methodological and conceptual problems of estimating the costs of uncompensated care provided to undocumented aliens, (2) an improved cost estimation approach, and (3) the implications of the new immigration-related legislation for this problem and its measurement.

Health Care Reimbursement and Undocumented Aliens Prior to the 1986 Legislation

Uncompensated health care is commonly defined as the unreimbursed costs of treating uninsured patients. Hospitals cover these costs through a mixture of public and private sources, including: (1) insured patients whose rates are raised to reflect uncompensated costs; (2) state and local governments which fund indigent care providers directly or provide assistance to indigent persons not eligible for Medicaid (the federal-state program which underwrites health care for certain low-income persons); and (3) private philanthropy. Prior to 1986, undocumented immigrants were excluded from participating in the Medicaid program.

Financing Indigent Health Care

There is no universally accepted definition of uncompensated health care, but a commonly accepted definition used by the American Hospital Association includes care provided to those who cannot pay (charity care) and those who can, but will not (bad debt). Hospitals are not the only providers of uncompensated care, but they are the focus of attention because inpatient hospital care is more expensive than care provided by outpatient clinics or private physicians. Also, more data are available on uncompensated care provided by hospitals. Other definitions of uncompensated care simply take the difference between the total dollar amounts of patient charges and patient revenues. Because the scope of our study is limited to the uncompensated costs due to treating undocumented aliens, we employ the more restrictive definition of uncompensated care, beginning with: charity or indigent care provided to uninsured patients and bad debts resulting from their treatment. Within this group, our ultimate interest is those uninsured patients who are likely to be improperly documented. Restricting the definition this way avoids confounding this issue with other issues contributing to uncompensated care, including underinsurance and below-cost reimbursement rates negotiated with insurers.

Philanthropy helps cover the costs of charity care in both public and private hospitals. Hospitals also attempt to shift some of the costs of non-paying patients to paying patients by billing private insurers at rates exceeding actual costs (called cost-shifting). Private hospitals can make better use of this option than public hospitals because a larger proportion of their patients are insured. Nevertheless, hospitals' ability to cost-shift has been constrained in recent years by various health cost-containment measures. Increasing competition among hospitals for insured patients and businesses' concern over the rising costs of health benefits to their employees have limited hospitals' ability to shift costs to other payors. In addition, hospital revenues have been reduced by spending cutbacks in federal and state medical education and health

care programs. The percentage of the population with private health insurance has also declined (Sulvetta and Schwartz, 1986). All of these factors constrain hospitals' ability to absorb the costs of unreimbursed services to undocumented aliens as well as those provided to citizens. The main public options for reimbursing hospitals for indigent care are the federal-state Medicaid program and state- and local-government programs.

Federal Programs

Medicaid is a joint federal-state program providing medical assistance for low-income persons who are aged, blind, disabled, or members of families with dependent children. There is substantial variation among state Medicaid programs in terms of persons covered, types and scope of benefits offered, and levels of payments to providers. This is because each state designs and administers its own program within federal guidelines.

Medicaid programs in all states (except Arizona, which does not operate a traditional program) cover the "categorically needy". In general, the categorically needy are persons receiving (or eligible for) cash assistance under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs, children under 5, and some pregnant women, if they meet the AFDC income and resources requirements. States may also cover the "medically needy"; these are persons who meet the same criteria for assistance as the categorically needy, except for income, and who have incurred relatively large medical expenses. As of December 1, 1986, 38 states and jurisdictions provided medically needy coverage.

It has been estimated that only about a third of the U.S. population whose household income is below 150 percent of the federal poverty threshold is covered under the Medicaid program, while another third have no insurance at all. For example, unmarried non-disabled adult males are not categorically eligible and generally are also ineligible for medically needy coverage. Thus, there is a sizable number of people without insurance who might not have the resources to pay for needed hospital care.

Another, smaller, federal contribution derives from the Hill-Burton program. This program provided funds to medical facilities to make improvements or build new facilities. Receipt of these funds obliged a facility to provide a certain level of free care each year to indigent

patients, usually for 20 years. Although new funding is no longer available, the free care obligation continues if the specified time period has not expired. Thus, persons whose family income is less than 100 percent of the federal poverty threshold could be eligible for free care, if the hospital had not already met its yearly obligation. By law or custom, however, public hospitals are generally required to provide medical treatment, regardless of the patient's ability to pay.

Exclusion of Undocumented Aliens From Medicaid Coverage

Until enactment of IRCA and OBRA-86, the Medicaid, SSI, AFDC, and several other federal assistance programs whose eligibility is based on financial need have generally excluded undocumented aliens, as well as (legal) temporary visitors, from participation. These programs have required an applicant to be a citizen of the U.S., an alien lawfully admitted as a permanent resident (i.e., by the INS), or a PRUCOL alien (i.e., an alien "permanently residing in the U.S. under color of law"). Each affected program had to arrive at its own definition of a PRUCOL alien, because this was not an INS term. For the Medicaid program, the Health Care Financing Administration (HCFA) defined PRUCOL aliens as those aliens in continuous residence since June 1948, refugees, parolees, and certain others. New exceptions to these requirements are discussed in section 5.

In an important exception to the prior general exclusion of undocumented aliens from participation in the Medicaid program, California hospitals have been reimbursed for care provided to undocumented and temporary immigrants while the patient's claim to satisfactory immigration status is verified. A 'presumptive eligibility' provision of the state Medicaid program permits reimbursement of inpatient care provided by hospitals to these aliens if they are otherwise eligible for the program. This provision only applies to patients who meet all the other criteria for Medicaid eligibility, but who fail to provide documents to support their claim to satisfactory immigration status. The California Medicaid program reimbursed hospitals for services provided while INS verified that claim; however, whether these services are eligible for federal matching funds is currently being questioned.

State and Local Programs

In general, state and/or local governments finance the remaining indigent care through specific assistance programs or general subsidies of hospitals' operations. In California, the state provides block grant subsidies to counties, which have no tax levying authority. In Texas, counties or hospital districts (generally, a subdivision of one or more counties) are a major source of indigent care funds from their own tax revenues.

In addition, state funds have been budgeted in Texas to provide a special supplement to hospitals which are considered to provide a disproportionate share of indigent care. In FY87, $13 million was allocated for the entire state.

The state or county may establish income and residence requirements for patients to be eligible for full or partial subsidy of their hospital charges through these funds. In both California and Texas, programs targeted to specific health-care needs (for example, care for crippled children) have residency, but not immigration status, requirements. In Texas, to be eligible for discounts on non-emergency care, patients must show proof of county residence, such as a wage stub or utility bill. In California, only state residence is required, and oral claims are accepted. In both states, eligibility for a discount and the size of that discount are based on family income and size. Therefore, in a non-emergency situation, admissions staff screen patients' financial status and residence to develop payment arrangements prior to admitting the patient or providing outpatient services. In emergencies, this screening is conducted after providing treatment.

Problems in Estimating Undocumented Aliens Served and Associated Costs

We found several previous estimates of the numbers of undocumented aliens who received uncompensated care, using several different estimation methods. Some estimates were derived for the nation as a whole; others, for a single hospital. Due to the general lack of reliable data on the number of undocumented aliens, most estimates are considered tentative even by their authors. Assessing the actual cost of services delivered is also not without controversy. Below we explain some of the methodological and conceptual problems associated with previous approaches.

Identifying Undocumented Aliens and Their Use of Services

Without reliable records of patients' immigration status, most estimates of undocumented patients' use of services depend on admittedly unreliable estimates of the population's size, health care utilization, and demographic characteristics. (See table 3.1; full references for published estimates are included in our bibliography.)

Table 3.1: Approaches Used to Identify Undocumented Patients and Their Use of Medical Services

Approach	Comments
Census Bureau estimates of the size of the national undocumented alien population[a]	Readily available, but more accurate for "settled" than for other undocumented aliens. Also, its use as a simple multiplier assumes that health care utilization patterns are the same for undocumented and other residents
INS estimates of the size of a region's undocumented alien population[b]	Readily available and possibly more accurate for a region, particularly an area with many transient undocumented aliens. Has a limited evidentiary basis. Use as a simple multiplier assumes, however, the same health care utilization patterns for undocumented and other residents
Health providers' subjective estimates of undocumented aliens as a proportion of all patients[c]	Estimates may vary widely, even within a hospital, across sources; no evidentiary basis is provided
Reports by undocumented aliens of having received free medical services[d]	Data come from nonrandom samples and may over (or under) estimate the amount and type of services to an unknown degree; also no information is provided regarding specific type and cost of services
Records of apprehended aliens' application for or participation in other public assistance programs[e]	Nonrandom samples; approach assumes similar utilization patterns for health and other programs when used as a simple multiplier to estimate health service use
Rates of formal denials and refusals to apply for Medicaid due to immigration requirement[f]	Probably accurate classifications of immigration status, obtained as part of Medicaid application procedure, but limited to patients otherwise eligible for Medicaid. Also, state variability in Medicaid eligibility standards would mean variable interpretations of estimates
Inpatient interviews about immigration status, combined with bill collection investigations[g]	Provides probably accurate classifications and an evidentiary basis, as well as ranges of estimates. However, very expensive and requires patient cooperation and availability for interview

[a]Congressional Budget Office, 1986.

[b]Mendez and Esquer 1983, U.S General Accounting Office, 1980.

[c]Community Research Associates, 1980, U S House of Representatives, 1977 and Weintraub and Cardenas, 1984.

[d]Mendez and Esquer, 1983

[e]North, 1983

[f]Los Angeles County, 1986

[g]Community Research Associates, 1980, Ericksen, Vayda, and Borden, 1983; and Orange County Task Force, 1978

Apart from the Medicaid application process, many hospitals avoid or are precluded from asking about patients' immigration status out of concern for community relations, patients' privacy, the public health or potential lawsuits. For example, one concern is that, if undocumented aliens fear discovery and apprehension at a hospital, they might fail to seek needed treatment, creating a health risk to themselves and others. Where hospitals do attempt to classify patients' status without INS verification, they are likely to misclassify patients, because hospital staff are not trained in immigration law. Even if hospital staff's subjective judgments are accurate, they usually lack the data required for independent verification. Moreover, because such estimates frequently serve requests for reimbursement, hospitals are likely to overestimate the number who are undocumented.

Estimates by the Bureau of the Census of the size of the illegal or undocumented alien population residing in the U.S. are admittedly imprecise partly due to this population's understandable reluctance to have its presence observed and recorded (see GAO/IPE-82-9). Multiplying such population estimates by assumed rates of health care utilization may be the only practical approach to making national estimates, but it is less appropriate for regional estimates. Census estimates of the undocumented population for cities are less precise than for states. Those for communities near the U.S.-Mexico border poorly reflect aliens who cross the border solely to obtain health care.

Without identifying individual patients who are undocumented, it would be difficult to obtain reliable data on the amounts and types of services they receive, compared to the services received by the rest of the population. Therefore, previous estimates have usually assumed that their utilization of health care is similar to that of the general population. Available studies, however, suggest that the use of hospital services by undocumented aliens is lower than average (although the data are questionable). Additionally, evidence on the probable age distribution of the alien population supports this hypothesis. According to the Bureau of the Census, the undocumented aliens included in the 1980 Census were highly concentrated in the young adult working ages: 70 percent were between 15 and 39 years old; only 11 percent were aged 40 and over. Since persons over age 65 in the general population account for a disproportionate share of hospital costs, the younger undocumented population would be expected to have lower than average hospital costs.

The best approaches we found to identifying undocumented aliens and their use of health services asked patients directly about their immigration status and verified their claims either with the INS or through the hospital bill collection process. The Medicaid program requires such a direct approach, and recording the number of persons who fail the permanent resident alien requirement for the Medicaid program probably produces the most accurate estimate of the number of undocumented patients among Medicaid applicants. To provide valid results, this method requires that applications be taken for all potential program eligibles, that the hospital ask patients for proof of legal immigrant status, and that all such documents be verified by the INS.

This method is only applicable to a portion of the uninsured population, however, and would be less useful in some states than in others because program eligibility criteria vary across states. Its results would only apply to the proportion of uninsured patients who apply for Medicaid benefits. Since income and resource requirements for program eligibility vary greatly across states, the proportion of uninsured patients who apply (and, hence, the utility of this approach) will vary greatly. Assumptions would have to be made to generate analogous estimates among persons who do not meet the program's income and other criteria: non-disabled unmarried adult males, for example, and those patients whose income is too high. Alternatively, similarly direct questions about immigration status could be asked of uninsured patients who are not willing or eligible to apply for Medicaid.

As an alternative to INS verification of residency claims, gaining valid information on all uninsured patients would require indepth interviews regarding patients' immigration status which were standardized, highly structured, and conducted by trained persons. This approach may be too expensive to be performed on a regular basis and impractical in some communities.

Defining the Cost of Uncompensated Care

Table 3.2 describes the approaches used to attach costs to the services provided to undocumented aliens in the studies we reviewed. The simplest approach multiplies a numerical estimate of the undocumented population by per capita public expenditures for health care. Public expenditures, however, include the costs of administering public programs as well as providing health services. Frequently, "uncompensated care" is simply defined as the sum of gross charges billed to patients minus the payments received. When combined over all patients in a hospital, these estimates include the costs of bad debt and the effects of

underinsurance. This is also true of estimates based on an average charge per patient day or stay. Because hospital charges are set to maximize revenues, they tend to exceed costs and include the cost of serving other uninsured patients. In addition, all cost estimates based on averages assume that undocumented patients use the same level and type of care as documented patients.

Table 3.2: Approaches Used to Estimate the Costs Associated With Health Services Provided

Approach	Comments
Per recipient or per capita, national or state public expenditures on health care[a]	Readily available, however, public expenditures typically include more than just uncompensated care so may be too comprehensive
Estimates by individual hospitals and others, based on amounts of uncompensated or indigent care[b]	Hospitals, payors and health economists differ on what should be included Cross-subsidies may be ignored, overhead and bad debts are often included, while late collections are not Also, cost accounting procedures vary
Average charge per patient day or stay[c]	Readily available but charges do not necessarily reflect cost This approach has the same problems as the one above and, in this application, assumes that health care utilization patterns are the same for undocumented and other patients
Individual patient length of stay multiplied by Medicaid per diem reimbursement rate[d]	This is an improvement over average charge per patient and also is readily available. However, it only partially accounts for different levels of use that may exist and may be below cost
Estimated cost of health and/or other public services, subtracted from estimated tax contribution, the latter being derived from reports by undocumented aliens of taxes withheld from earnings, and consumption of taxable goods[e]	Unlike all measures above, includes potentially offsetting tax revenues from aliens. However, it does not partial out the uncompensated health services from the other services Also, there are non- random samples in the studies to date

[a]Congressional Budget Office 1986 U S General Accounting Office, 1980

[b]Community Research Associates 1980 Mendez and Esquer, 1983 and Orange County Task Force, 1978

[c]Los Angeles County 1986

[d]Ericksen Vayda and Borden 1983

[e]Orange County Task Force 1978 Weintraub and Cardenas 1984

The best method we found measured undocumented patients' use of services by their individual length of stay, multiplied by the Medicaid per diem reimbursement rate. This method is an improvement because it partially accounts for different utilization patterns. In the application we observed, the undocumented patients had slightly shorter average hospital stays than the documented patients, and therefore accounted

for a smaller proportion of costs than of patients. Although employing the Medicaid program's daily reimbursement rate attempts to discount the charges in order to more closely resemble the costs to the hospital, this solution is not perfect either. Length of hospital stay is only a rough indicator of the intensity of hospital resources used. While Medicaid reimbursement rates are set in consideration of the cost to the hospital of providing services, it has been suggested that in some cases, the reimbursements are below "cost".

Some health economists believe that "marginal costs" would be the more appropriate measure where the uninsured are a small proportion of a hospital's patients. "Marginal costs" refer to the cost of treating an additional patient above and beyond the costs already incurred by treating other patients. However, such an approach would require a special study of a particular hospital in order to assign a dollar figure to the care provided. No such approach was taken in the studies we reviewed.

Finally, most of the approaches we reviewed did not consider the offsetting impact of tax contributions from undocumented aliens to the public funds which help finance uncompensated health care. In one of the few studies to address this issue (Weintraub and Cardenas, 1984), the state (Texas) was estimated to incur a net gain, while the urban counties were estimated to incur a net loss. This occurred because the taxes paid by undocumented aliens contributed primarily to state and federal coffers, while the services they received were funded primarily by local revenues.

An Alternative, Indirect Approach

As noted in the previous section, most existing estimation procedures are flawed because they (1) lack accurate records of all uninsured patients' immigration status, and (2) overestimate the costs of the services provided by not discounting hospital charges. The Medicaid program's eligibility tests permit identification of a portion of the undocumented patients. Based on the concept of unobtrusive measures, we have formulated an indirect approach for use by hospitals in localities where few uninsured patients would meet the other Medicaid eligibility requirements and where it is not feasible to ask all patients for proof of immigration status. This approach also discounts hospital charges in a standardized manner in order to better reflect the true costs of the services provided.

Description

Our approach would classify patients on the basis of indirect information as to their probable immigration status and then discount the charges for services provided to those patients classified as probably undocumented to reflect the actual cost of care. This approach would generate ranges of cost estimates, reflecting the uncertainty of the patient classification process. The approach involves five distinct steps.

Identify Undocumented Aliens

- Administer a brief screening instrument to all uninsured patients during the admissions interview routinely given during hospital intake. (See appendix II for a copy of the draft instrument.)
- Classify each patient's probable immigration status by applying a formal scoring guide to information obtained from the screening instrument. (See appendix III.)

Estimate the Costs Associated With the Health Services Provided

- Tally the actual billed charges for services provided to patients classified as "probably undocumented" and any payments made by or for them.
- Discount the summed charges per hospital department by the respective cost-to-charge ratios from the hospital's Medicare cost report.
- Subtract the sum of payments made to obtain the unreimbursed cost of services provided.

The key difference between this method and others which lack accurate records of patients' immigration status is that, once it is validated, this approach would characterize the entire group of uninsured patients on

the basis of empirical information of known reliability, rather than on the basis of unvalidated, subjective judgments.

Rationale

The rationale for this strategy is that when reliable data on patients' actual immigration status cannot realistically be obtained, the next best approach is to gain data with a known degree of reliability on variables associated with immigration status. These data may then be used to estimate probable immigration status. Therefore, the questions for the screening instrument were selected to represent variables which either: (1) logically implied legal permanent residency or citizenship; or (2) were identified in previous research or interviews with immigration researchers as being highly associated with illegal residency status. The draft instrument in appendix II incorporates the suggestions of reviewers who have conducted field research with undocumented aliens in New York City and the Southwest.

This indirect measure was designed for use in a situation where it is not feasible to solicit residency information which some patients might perceive as incriminating. None of the data items in our proposed instrument would provide information sufficient to justify taking actions with regard to a patient's immigration status or decisions about providing health care or financial assistance to individuals. Applying the same procedures to all uninsured patients should avoid even the appearance that the hospital is discriminating against particular persons. Additionally, the normal privacy protections applied to patient records should protect this information from inappropriate use.

To estimate the costs of care provided to patients classified as probably undocumented, we propose to record the hospital's usual charge for each billable service provided, and then to discount those charges using the appropriate departmental cost-to-charge ratio. These ratios are components of the annual cost reports required by the Medicare program of participating hospitals. This form of discounting charges to costs was selected because these ratios are calculated in a standardized manner and should reflect the natural variation between hospitals in their costs of providing services.

Limitations

The classification of individual patients' probable immigration status is intended to permit characterization of the uninsured patient populatior as a group, rather than to influence decisions about care or assistance for individuals. Due to the fact that the data to be collected are only

associated with, and not conclusive about, immigration status, there are likely to be a certain number of errors made in classifying individual patients. But, since one can expect that most errors made in classifying individuals will balance out when combined within a group, this measure's characterization of the group may be sufficiently accurate for our purpose.

However, this method has not been tested and the estimates are likely to be less precise than those using the Medicaid program's test for permanent resident alien status. Thus, the design of our validation study includes rather elaborate procedures to check the accuracy of the information gathered during the admission process. For example, we propose to interview all uninsured patients about their immigration status, and then verify patients' U.S. birthplaces or alien identification numbers, as appropriate. (See appendix III.) A validation study would also determine whether some items should be eliminated or scored differently than initially planned.

It is crucial that all uninsured patients be included in both the validation and any later applications, in order to ensure the validity of the resulting estimates. In a validation study, the error inherent in the method is measured, and these measurements are used to define the range within which the cost most probably lies. If some patients are excluded from the study on the basis of the hospital staff's beliefs about them, subjective bias may be introduced into the method and additional unmeasured error could be included in the resulting estimates.

There are certain limitations in the use of data from the Medicare cost reports. Since hospitals complete these reports to aid in determining their reimbursement through the Medicare program, hospitals can use the flexibility permitted in some procedures to maximize their reimbursement. The basis for allocating costs from departments which do not produce revenue to those that do varies across hospitals, reflecting differences among hospitals in types of payors and their reimbursement policies, for example. Also, hospitals have various means for compensating physicians, so physician costs may not be included in a given hospital's cost report. Such factors should be kept in mind when comparing results across hospitals.

Without having tested this approach, we cannot estimate the additional expense to a hospital employing it. The costs would primarily derive from administering and scoring the screening instruments, tabulating

the charges and payments per patient classified as probably undocumented, and projecting the annualized estimates from the period studied. We anticipate that only marginal additional staff time would accrue from the addition of questions to the usual intake interview for uninsured patients. Once a guide for scoring each item is validated, patients could be easily classified from the screening instrument. Tabulating the discounted costs of services provided could be prohibitively expensive, however, if patient billing records are not automated and a large number of patients are classified as probably undocumented. The value of incurring these additional expenses would, of course, have to be weighed against the magnitude of a hospital's estimate of the cost it already bears in providing such care to undocumented aliens.

The utility of this approach should be reconsidered, however, after the new immigration-related legislation is fully implemented. Anticipated changes in the reimbursement of this care under Medicaid, as well as in the data available on patients' immigration status, may permit a more direct approach, should such information still be needed.

Implications of the New Immigration-Related Legislation

IRCA and OBRA-86 have a number of implications for the problem of uncompensated care provided to undocumented aliens and how to measure it. In general, these changes to immigration and Medicaid law are likely to reduce the size of the problem, somewhat, and to change the type of care remaining unreimbursed. As a result of removing some immigration barriers to reimbursement, it will be even more difficult to isolate the unique contribution of undocumented aliens to the problem of uncompensated care. The impacts of these changes, however, are likely to be felt quite differently across localities. Finally, these changes may also improve the quality of information available about patients' immigration status, which could yield more precise estimates of the services received by undocumented aliens.

Reductions in the Size of the Problem

First, by granting amnesty to certain undocumented aliens, IRCA should reduce the size of the undocumented alien population. Aliens who can provide acceptable evidence of having resided in this country continuously since January 1, 1982, may apply (starting May 5, 1987) for temporary legal resident status. This status would permit them to remain and work legally in the U.S. After 18 months of temporary legal residency, temporary residents may apply for permanent resident status. However, they must do so within a year of becoming eligible. In addition, aliens who can provide acceptable evidence of having performed 90 days or more of specified agricultural work during at least the year ending May 1, 1986, may also apply (from June 1, 1987 to December 1, 1988) for temporary legal status. These agricultural workers will be adjusted to permanent resident status without application after specified time periods.

Second, for the first time, both IRCA and OBRA-86 allow Medicaid reimbursement of some health services provided to undocumented aliens. Table 5.1 depicts which groups of immigrants will be affected.

Table 5.1: Anticipated Medicaid Coverage for Selected Subpopulations Before and After the 1986 Law Changes

Subpopulation	Eligibility for Medicaid Coverage	
	Before	After
Medicaid-eligible[a]		
Citizen	Yes, full coverage	Yes, full coverage
Permanent resident alien, lawful or residing in the U S. under color of law	Yes, full coverage after three years	Yes, full coverage after three years
Alien eligible for amnesty		
Under 18	No	Yes, full coverage
Aged/blind /disabled	No	Yes, full coverage
Cuban/Haitian	No	Yes, full coverage
Others	No	Yes, emergency and pregnancy-related services only
Alien not eligible for amnesty	No	Yes, emergency services only
Temporary visitors, workers, others not described above	No	No
Not Medicaid-eligible		
Permanent resident alien or citizen	No	No
Alien eligible for amnesty	No	No
Alien not eligible for amnesty	No	No
Temporary visitors workers, others	No	No

[a]I e . the patient meets the state Medicaid program s income, asset and other criteria for eligibility

1. OBRA-86 lifts the permanent resident requirement for treatment of an emergency medical condition (including childbirth). Therefore, a hospital can be reimbursed for certain emergency medical treatment provided to a temporary or permanent resident, or undocumented alien who meets the other Medicaid program eligibility criteria. But undocumented and temporary aliens cannot acquire a Medicaid card entitling them to the full services of the program.

2. Aliens granted amnesty are excluded for five years from receiving full financial assistance from several major federal assistance programs, including Medicaid. In the case of Medicaid, three specific groups are treated differently. Aliens granted amnesty who are: (1) children under 18; (2) aged, blind or disabled; or (3) a Cuban or Haitian entrant; if otherwise eligible, are entitled to the full range of Medicaid benefits. All other amnestied aliens, if otherwise eligible, may receive emergency services or pregnancy-related services. (States have the option to cover treatment of conditions that could complicate a pregnancy, in addition to usual prenatal and postpartum care.)

3. New requirements for several federal assistance programs to verify an applicant's satisfactory immigration status allow benefits to begin and continue until INS provides notification that the applicant is not in a legal status. Reimbursement of benefits provided under Medicaid while awaiting INS' response are subject to the usual federal payment rate. This is very similar to the practice in California described in section 2.

Third, IRCA set aside $1 billion a year for four years to reimburse some of the costs to federal, state, and local governments of providing services to aliens who—through amnesty—could now receive benefits from which previously they may have been excluded. In FY88, the federal government is to receive $70 million of this $1 billion to cover the additional expenses anticipated in federal assistance programs, with the remainder being distributed to the states through Legalization Impact Assistance grants. For the remaining three years the amount of the federal offset is to be specified in the President's annual budget.

Uncertainty exists, however, about the extent to which these new policies will reduce the uncompensated health care burden on providers treating these populations, in terms of:

- how many aliens will be amnestied;
- how many of those aliens who are not amnestied will remain in the country;
- what proportions of each group will meet the other eligibility criteria for the Medicaid and other state or local medical assistance programs.

Little is known about the demographic characteristics and behavior of the undocumented alien population. Some aliens granted amnesty, who may now be legally employed, may gain private health insurance. On the other hand, uncompensated care could increase if aliens granted amnesty increase their use of health care when they no longer fear apprehension and deportation.

The Changing Nature of the Problem

After implementation of these policy changes, the component of a hospital's uncompensated care burden attributable to undocumented aliens will be less distinct. Before the changes, an alien's undocumented status categorically precluded Medicaid reimbursement of any services provided. Thus, health care providers' ability to finance treatment of undocumented aliens was uniquely constrained. In the future, emergency care and care for women in labor will be reimbursed for any patient who meets the state's Medicaid criteria, without regard to their

alien status. These two categories of services are believed to comprise a large portion of the care previously provided to undocumented aliens.

Additionally, full Medicaid coverage will be extended to some of the formerly undocumented aliens who are considered categorically needy. This is because IRCA extends full coverage to two of the vulnerable subpopulations Medicaid was designed to protect, as soon as amnesty is obtained: children under 18; and the aged, blind or disabled. The only persons granted amnesty who will be denied full coverage (although otherwise eligible) will be the parents of children meeting the AFDC program requirements; but they will be eligible to apply for Medicaid five years after receiving amnesty. Pregnant women granted amnesty may receive the same services provided to pregnant citizens under the state's Medicaid program.

Thus, under the new rules, those aliens who will not be eligible for any coverage will be more similar than previously to the citizen population denied coverage; both groups will be ineligible because they do not meet the state's income and other program requirements. Aliens' lack of permanent resident status will not provide as much of a barrier to health care coverage as in the past. This suggests that, in the future, the problem of aliens' inability to pay for their health care and estimates of the unreimbursed costs associated with that care need to be considered in the context of the factors influencing uncompensated health care more generally. The most important of these factors are likely to be the state income and resource requirements for Medicaid eligibility and the declining rates of private insurance in the population as a whole. These factors vary by state, as does the concentration of undocumented aliens.

Differential Impact Across Localities

The IRCA and OBRA-86 changes are likely to have different impacts across the country on the cost of uncompensated health care generally and the portion of it attributable to undocumented aliens. This is because of the wide geographical differences in the distribution of undocumented aliens in the U.S. (GAO/PEMD-86-9 BR) as well as regional differences in the characteristics of both the undocumented populations and state Medicaid and other assistance programs.

Regional differences in the proportion of currently undocumented aliens who gain amnesty are likely because of differences in the proportion who are long-term residents. For health-care providers in U.S.-Mexico border communities, legalization will probably have little impact on the

number of residents of Mexico who cross the border with valid documents and then require health care. Increased border-control activities might, however, decrease the number of surreptitious border-crossings made for the purpose of acquiring health care.

Income criteria for Medicaid eligibility for the categorically needy are tied to federal SSI and state AFDC income-eligibility standards and vary widely across states. Therefore, in states with lower income-eligibility standards, one can expect smaller proportions of the amnestied population to acquire full Medicaid coverage and smaller proportions of the aliens remaining undocumented to be eligible for reimbursement of emergency medical services. Additionally, reimbursement rates and the number of services covered also differ across state Medicaid programs. Consequently, regardless of their patients' immigration status, health care providers in states where coverage is more limited will have fewer costs covered through Medicaid than providers in states providing greater access to benefits.

Finally, several issues regarding allocation of the Legalization Impact Assistance grants affect the availability of funds to offset the cost of care remaining unreimbursed by the Medicaid program. These include:

- How much of the $1 billion will be allocated to the federal government after FY88. Increases in this allocation would reduce the amount available for state grants;
- Whether states finance their share of the new costs to federal-state assistance programs out of these funds. This would reduce the amount available for financing the exclusively state and local programs;
- Whether fund allocations will reflect differences in generosity of both the federal-state programs and the states' own assistance programs. Allocations made simply on the basis of expected number of aliens granted amnesty could possibly penalize states with more generous programs by covering a smaller proportion of their costs;
- Whether fund allocations among the states will reflect the sum of both state and local government expenditures. If only state government expenditures are considered, localities in states with decentralized responsibility for financing these services could be penalized;
- Whether determining eligibility for grants would require recording and verifying applicants' immigration status. Where programs had no previous immigration status requirement, it could conceivably cost states more to administer than they would gain through these grants; and,

- Whether grants will be made directly to the jurisdictions responsible for financing services (i.e., county health departments, in some states) or whether states will be free to create their own allocation formulas.

Potential New Data Sources

New data collection procedures required by IRCA or initiated to implement it may improve the quality of the hospitals' information on patients' immigration status. To improve the accuracy of current procedures for checking the permanent resident alien requirement for several major federal assistance programs, the INS must create an automated alien verification system. The proposed Immigration Status Verification System (the SAVE system) will be a short-form version of the INS' alien registration master files, which eligibility workers for state and local assistance programs could access locally through on-site terminals. Several pilot projects have been tested over the past few years. IRCA requires that the INS make this system available to states for checking alien applicants' program eligibility by October 1987, and requires state agencies to use that system by October 1988. (States can obtain a waive to use some other means of verification.) When implemented, this system might not only improve the immigration classification of Medicaid applicants, but also improve the feasibility of verifying documents for persons not applying for Medicaid.

States employing the SAVE system would verify alien admission or alien file numbers. Therefore, use of this method would require hospital staff to ask patients about their immigration status directly. However, when employers routinely ask for proof of documented status and more aliens have such documents, more hospitals may find it feasible to directly ascertain their patients' immigration status.

In addition, the Legalization Impact Assistance grants which will offset some of the costs of services provided to amnestied aliens by states and localities may indirectly aid in estimating the costs of services to undocumented aliens. An HHS Task Force on Immigration Reform has been charged with developing regulations covering program eligibility, distribution formula, and uniform data collection requirements before the program can begin (scheduled in the law for FY88). If HHS requires that hospitals report the actual number of amnestied patients they serve, then hospital procedures to identify amnestied patients, in conjunction with Medicaid application procedures, might also identify (directly or indirectly) the number of undocumented aliens served. On the other hand, if regional population estimates are used to allocate

funds to localities, the procedures to obtain these estimates (for example, analyzing amnesty applications) might also provide an avenue for estimating the size of the population remaining undocumented. It remains to be seen whether new options for improving estimation procedures will arise and whether these options will prove workable and acceptable.

Conclusions

From our review of the problems of obtaining accurate estimates of the unreimbursed hospital costs attributable to undocumented aliens and the likely impact of the new immigration-related laws, we believe that (1) efforts to improve approaches to identifying aliens' use of services should await implementation of the new laws, and (2) if estimates of th uncompensated cost of such services are still needed, then they should be considered in the context of uncompensated care more generally.

The current period of change in INS and Medicaid requirements and procedures is inappropriate for testing the reliability and validity of a cost estimation method. Uncertainty among aliens about the implications of the new laws may affect their willingness to cooperate and respond openly in such a study. If so, the credibility of the data collected would suffer. Also, estimates derived when only some of the eligible aliens have acquired amnesty and when the criteria for Medicaid eligibility ar changing cannot be projected to the period after the situation stabilizes New data sources may become available which could provide the basis for more accurate estimation methods, should estimates be required. Therefore, our indirect approach may not be the most appropriate method of identifying undocumented aliens' use of health care when al the changes are fully implemented. These changes should have no effec however, on the advantages of the method outlined here for assigning costs to this care.

The impact of these changes on the problem of uncompensated health care for undocumented aliens needs to be monitored to ascertain whether cost estimates are still required. The size of the problem will probably lessen due to amnesty, the availability of Medicaid reimbursement, and the new opportunities for gaining employment-related health insurance. Because Medicaid may cover emergency services and childbirth care for aliens who are not permanent residents, their status may not provide as much of a barrier to health coverage as in the past.

However, certain geographical areas may continue to have problems that require special attention. In communities of more recent immigrants, a smaller proportion of aliens may qualify for amnesty; in bord communities, persons crossing the border for temporary employment c to obtain health care may not meet state requirements for medical assi tance programs. To provide accurate estimates of the costs of care for such persons, any future studies should address the problems describe above in identifying aliens' use of services and in estimating their asso ciated costs.

Request Letter

RONALD D COLEMAN
16TH DISTRICT TEXAS

COMMITTEE ON APPROPRIATIONS

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June 5, 1986

Mr. Charles A. Bowsher
Comptroller General
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Bowsher:

One important issue in proposals for immigration reform is compensation to states and local organizations for currently uncompensated health care provided to undocumented aliens. This is a particularly troublesome issue for hospitals in border communities with a heavy influx of undocumented workers.

In view of this program, we would like the General Accounting Office's Program evaluation and methodology division to examine the methodological difficulties in estimating the uncompensated health care costs incurred by hospitals treating undocumented aliens and to attempt to develop an improved methodology for identifying undocumented aliens using such services and estimating the associated costs. If it is possible to develop an appropriate method, we would like GAO to test it in at least one hospital in a border community where the problem appears to be particularly acute and to assess the feasibility of using the method in other hospitals. This study should help to lay a better foundation for interpreting current estimates of uncompensated health care costs and improving future cost information.

We would like this work to begin this summer and would like a briefing in December. If you have any questions, please call Nancy Padilla of Congressman Coleman's staff at 225-4831.

Sincerely,

Vic Fazio, Chairman
Subcommittee on Legislative
Committee on Appropriations

Ronald D. Coleman
Member of Congress

GAO's Draft Screening Instrument

DRAFT ADMISSIONS SCREEN: FOR COMPLETION BY HOSPITAL/CLINIC STAFF

(Admission Staff: Obtain the following information from your nospital or clinic's intake form, if available):

For Patient:
hospital ID number
social security number (SSN)
telephone: none_____ local_____ other_____
address: local_____ out-of-state_____ non-U.S._____
address verification: utility bill _____
paycheck _____ other_____ none_____
birth date/age
gender
marital status
employer: self_____ individual_____
business_____ government_____
employer's address: local____ out-of-state_____ non-U.S._____
occupation
income: _____ per year/month/week/other_____
driver's license: none_____ local_____
out of state_____ non-U.S._____
birthplace: city/county/state_____ non-U.S._____

For Guarantor: (if applicable)
SSN
address: local_____ out-of-state_____ non-U.S._____
address verification: utility bill_____
pay check_____ other_____ none_____
telephone: none____ local_____ other_____
employer: self_____ individual_____ business_____ government__
employer' address: local_____ out-of-state_____ non-U.S._____
occupation
income: _____ per year/month/week/other_____

1

Interview Number:_____ Interviewer Initials: _____

(Admissions Staff: Questions to add to intake interview, if not already covered:)

1. What is your usual occupation? (What do you do for a living?)

_____

2. What was the last grade in school that you completed?

_____

When did you complete that grade?

/ - / - /
Month Year

What school did you attend (name and location)? _____

_____

3. **(IF NOT ALREADY ASKED):** Do you have a driver's licence?
Yes ____ No _____

(IF YES ASK): Could I see it?

State or country of issue: _____

(IF YOU COULDN'T SEE THE LICENSE, ASK):

a) Where was your license issued?

State or country of issue: _____

4. Are you registered to vote in this country? Yes ____ No _____

(IF MALE ASK):

5. Are you registered with the Selective Service (Draft) Board?

Yes ____ No _____

(IF YES):

2

a) Where did you register?

Post office ____ Some other place _____

6. Have you had military service? Yes ____ No _____

(IF YES):

a) Where were you inducted or where did you start military service?

U.S., Puerto Rico, Guam, Virgin Islands _____ Other _____

7. Where were you born? (Where are you from?)

U.S., Puerto Rico, Guam, Virgin Islands (city/county/state) __
Other _____

(IF FOREIGN BORN):

a) When did you arrive in this country for the first time?

/ - / - /
Month Year

b) Have you left the country since? Yes ____ No _____

(IF YES): When did you last return?

/ - / - /
Month Year

(IF EVER-MARRIED):

8. Is your spouse living with you in the U.S.? Yes ____ No ____

(IF NO): Where does your spouse reside?

U.S., Puerto Rico, Guam, Virgin Islands _____ Other _____

3

9. Do you have any children? Yes ____ No _____

(IF YES):

a) Do all of your children under 18 live in this country?

Yes ____ No ____

b) Were any of your children born outside this country?

Yes ____ No ____

(IF YES):

c) Where was/were he/she/they born?

U.S., Puerto Rico, Guam, Virgin Islands _____ Other ____

10. Where were your parents born?

U.S., Puerto Rico, Guam, Virgin Islands _____ Other _____

11. Where do your parents reside?

U.S., Puerto Rico, Guam, Virgin Islands _____ Other _____

Both deceased _____

Thank you for your cooperation.

Design of GAO's Proposed Validation Study

Due to the experimental nature of our proposed indirect method of identifying the undocumented aliens among uninsured patients, this method requires validation as reasonably accurate before it can provide a basis for cost estimates. We had initially intended to conduct such a validation study to complete our response to the Congressmen's request. However, we believed that the changing immigration context - and the resulting confusion and anxiety reported among undocumented aliens - threatened the credibility of a validation study conducted before the situation stabilized. A description of our intended study design follows.

In general, we proposed to have hospital admissions staff administer the draft screening instrument (see appendix II) during the routine patient admission interview to a random sample of uninsured patients over a two-month period. We would then (1) score those instruments to classify patients' probable immigration status, (2) collect independent data on those patients' immigration and residency status and (3) statistically analyze the agreement between the results of these investigations.

A scoring guide for our proposed screening instrument was drafted but not included in the report so as not to encourage use of the instrument prior to establishing its validity. Plans for our validation study included comparing different scoring procedures and assessing the value of each item. Items which were found to add little information to that obtained from the remaining items could then be eliminated in order to reduce the data collection burden for hospitals.

Four additional data collection activities were proposed to provide independent and, presumably, more valid information on the immigration status of study patients:

1. Telephone verification of the patients' address and/or employment in the county (or recording the results of the hospitals' attempts to verify this information).

2. Verification with state or county Vital Statistics offices of the U.S. birthplaces claimed by patients.

3. Intensive interviews of uninsured patients directly probing immigration status, conducted under conditions of complete confidentiality by specially hired and trained interviewers.

4. Verification with the INS of alien registration or alien file numbers provided by patients during the intensive interviews.

We planned to conduct the validation study in two public hospitals, both of which claimed a special burden from providing uncompensated care to undocumented aliens. Although both potential study sites are located in the Southwestern U.S., we selected one directly adjacent to the U.S.-Mexico border, and the other outside the 25-mile limit within which border-crossing passes are valid. We believe that this would permit us to determine the ability of the screening instrument to identify both non-resident immigrants (e.g., alien commuter workers) and resident immigrants.

The indepth interview we propose to use for validation purposes was adapted with permission from the one developed by Mathematica Policy Research, Inc., for their study of the use of New York City Health and Hospitals Corporation (HHC) hospital services by undocumented aliens That study was prepared for the HHC in connection with a lawsuit title City of New York and Health and Hospitals Corporation v. Perales.

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