

U.S. BORDER PATROL MEDICAL SCREENING STANDARDS  
ACT

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SEPTEMBER 18, 2019.—Committed to the Committee of the Whole House on the  
State of the Union and ordered to be printed

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Mr. THOMPSON of Mississippi, from the Committee on Homeland  
Security, submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 3525]

[Including cost estimate of the Congressional Budget Office]

The Committee on Homeland Security, to whom was referred the bill (H.R. 3525) to amend the Homeland Security Act of 2002 to direct the Commissioner of U.S. Customs and Border Protection to establish uniform processes for medical screening of individuals interdicted between ports of entry, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

	Page
Purpose and Summary .....	3
Background and Need for Legislation .....	4
Hearings .....	4
Committee Consideration .....	5
Committee Votes .....	6
Committee Oversight Findings .....	7
New Budget Authority, Entitlement Authority, and Tax Expenditures .....	7
Congressional Budget Office Estimate .....	7
Statement of General Performance Goals and Objectives .....	8
Duplicative Federal Programs .....	8
Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits ...	8
Federal Mandates Statement .....	
Preemption Clarification .....	
Disclosure of Directed Rule Makings .....	

Advisory Committee Statement .....	
Applicability to Legislative Branch .....	
Section-by-Section Analysis of the Legislation .....	8
Changes in Existing Law Made by the Bill, as Reported .....	9
Minority Views .....	12

The amendment is as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the “U.S. Border Patrol Medical Screening Standards Act”.

**SEC. 2. UNIFORM PROCESSES FOR MEDICAL SCREENING OF INDIVIDUALS INTERDICTED BETWEEN PORTS OF ENTRY.**

(a) IN GENERAL.—Subtitle C of title IV of the Homeland Security Act of 2002 (6 U.S.C. 231) is amended by adding at the end the following new section:

**“SEC. 437. MEDICAL SCREENING OF INDIVIDUALS INTERDICTED BETWEEN PORTS OF ENTRY.**

“(a) IN GENERAL.—To improve border security and the processing of individuals and families interdicted by the U.S. Border Patrol between ports of entry, the Commissioner of U.S. Customs and Border Protection, in coordination with the Chief Medical Officer of the Department, shall, not later than 30 days after the date of the enactment of this section, establish uniform processes and training to ensure consistent and efficient medical screening of all individuals, with priority given to children who have not yet attained the age of 18, so interdicted before transfer from U.S. Customs and Border Protection custody, but in no case longer than 12 hours after such interdiction, or 6 hours in the case of a high priority individual. Such screening should be conducted by a medical professional and should be developed in collaboration with non-governmental experts in the delivery of health care in humanitarian crises and in the delivery of health care to children.

“(b) SCREENING PROCESS COMPONENTS.—At a minimum, the uniform processes and training established under subsection (a) shall include the following:

“(1) Requirements for initial in-person screening that includes documentation of the following:

“(A) Visual assessment of overall physical and behavioral state, including any possible disability.

“(B) A brief medical history, including demographic information, current medications (including a list of confiscated medications and whether such have been replaced), and any chronic or past illnesses.

“(C) Any current medical complaints.

“(D) A physical examination that includes the screening of vital signs such as body temperature, pulse rate, and blood pressure.

“(2) Criteria for determining when to make a referral to higher medical care and a process to execute such referral.

“(3) Recordkeeping requirements regarding how information is to be recorded for each initial screening under paragraph (1), including information on the use of interpretation services.

“(4) Review by a medical professional of any prescribed medication that is in the detainee’s possession or that was confiscated upon arrival to determine if such medication may be kept by such detainee for use during detention, properly stored with appropriate access for use during detention, or maintained with a detainee’s personal property.

“(5) Chaperones for the physical examination of minors, including, as appropriate, the parent, legal guardian, or the such minors’ closest present adult relative, or a U.S. Border Patrol agent of the same gender.

“(c) PEDIATRIC EXPERTISE.—A pediatric medical expert shall be on site in every U.S. Border Patrol sector, including at U.S. Border Patrol processing centers and at U.S. Border Patrol facilities at which 20 percent or more of detained individuals over the immediately preceding six month period are minors. The Chief of the U.S. Border Patrol shall prepare a plan to deploy in-person or technology-facilitated medical consultation with a licensed medical professional to U.S. Border Patrol facilities that experience an increase in apprehensions of children greater than 10 percent over the preceding 60 days.

“(d) DEFINITION.—In this section, the term ‘high priority individual’ means an individual who self-identifies as having a medical condition needing prompt attention, exhibits signs of acute illness, is pregnant, is a child, or is elderly.

“(e) TRAINING.—Not later than 60 days after the issuance of the uniform processes and training established under subsection (a), the Commissioner of U.S. Customs and Border Protection shall ensure that any individual carrying out medical screen-

ing under this section at a U.S. Customs and Border Protection facility of individuals interdicted by the U.S. Border Patrol between ports of entry shall complete training on such uniform processes.”.

(b) **RULE OF CONSTRUCTION.**—Nothing in this section or the amendment made by this section may be construed as authorizing U.S. Customs and Border Protection to detain individuals for longer than 72 hours.

(c) **CLERICAL AMENDMENT.**—The table of contents in section 1(b) of the Homeland Security Act of 2002 is amended by inserting after the item relating to section 436 the following new item:

“Sec. 437. Medical screening of individuals interdicted between ports of entry.”.

**SEC. 3. RESEARCH REGARDING PROVISION OF MEDICAL SCREENING OF INDIVIDUALS INTERDICTED BY U.S. CUSTOMS AND BORDER PROTECTION BETWEEN PORTS OF ENTRY.**

(a) **IN GENERAL.**—Not later than one year after the date of the enactment of this Act, the Secretary of Homeland Security, acting through the Under Secretary for Science and Technology of the Department of Homeland Security, in coordination with the Commissioner of U.S. Customs and Border Protection and the Chief Medical Officer of the Department, shall research innovative approaches to address capability gaps regarding the provision of comprehensive medical screening of individuals, particularly children, pregnant women, the elderly, and other vulnerable populations, interdicted by U.S. Customs and Border Protection between ports of entry and issue to the Secretary recommendations for any necessary corrective actions.

(b) **CONSULTATION.**—In carrying out the research required under subsection (a), the Under Secretary for Science and Technology of the Department of Homeland Security shall consult with appropriate national professional associations with expertise and non-governmental experts in emergency, nursing, and other medical care, including pediatric care.

(c) **REPORT.**—The Secretary of Homeland Security shall submit to the Committee on Homeland Security of the House of Representatives and the Committee on Homeland Security and Governmental Affairs of the Senate a report containing the recommendations referred to in subsection (a), together with information relating to what actions, if any, the Secretary plans to take in response to such recommendations.

**SEC. 4. ELECTRONIC HEALTH RECORDS IMPLEMENTATION.**

(a) **IN GENERAL.**—Not later than 30 days after the date of the enactment of this Act, the Chief Information Officer of the Department of Homeland Security, in coordination with the Chief Medical Officer of the Department, shall establish within the Department an electronic health record system that can be accessed by all departmental components operating along the borders of the United States for individuals in the custody of such components.

(b) **ASSESSMENT.**—Not later than 120 days after the implementation of the electronic health records system, the Chief Information Officer, in coordination with the Chief Medical Officer, shall conduct an assessment of such system to determine system capacity for improvement and interoperability.

**PURPOSE AND SUMMARY**

H.R. 3525, the “U.S. Border Patrol Medical Screening Standards Act,” improves on existing medical screenings performed by U.S. Border Patrol. The bill requires U.S. Customs and Border Protection (CBP), in conjunction with the Chief Medical Officer (CMO) of the Department of Homeland Security (DHS or Department), to establish uniform standards and training for an initial medical screening of all individuals apprehended by U.S. Border Patrol, with priority given to children under the age of 18. The bill provides deadlines for screenings to be completed and specifies elements that must be a part of the screening. These efforts would establish a consistent medical screening process to be carried out by trained personnel at all U.S. borders. To further improve medical screenings by U.S. Border Patrol, H.R. 3525 requires the Department to establish a pediatric medical presence along the border, research innovative solutions to address any capability gaps, and mandates the use of electronic health records for individuals in

DHS custody. These are critical steps to safeguard against further deaths at our borders.

#### BACKGROUND AND NEED FOR LEGISLATION

In December of 2018, the public learned about the deaths of Jakelin Caal Maquin and Felipe Alonzo-Gomez, two migrant children who passed away while in the custody of the U.S. Border Patrol. Following their deaths, CBP announced new medical screening procedures for children in its custody. Despite this added measure, there have been additional deaths in CBP custody, with a total of six children have passed away since 2018. In the decade proceeding 2018, not one child died while in CBP custody.<sup>1</sup>

The Committee received testimony in March 2019 from the American Academy of Pediatrics that detailed the challenges of providing medical care for children. Children’s vital signs have different normal parameters than adults and they vary by age. When children become ill, the symptoms are subtler, can be easily overlooked, and escalate quickly. A child can be happily playing even as their physical systems are shutting down. Conditions like the flu and sepsis can be particularly serious for children because symptoms are not easily recognizable to the untrained eye and with sepsis, each hour of delayed treatment dramatically increases morbidity. Significantly, the flu or sepsis played a role in the deaths of at least four of the six children who passed away in CBP custody.<sup>2</sup>

Medical professionals continue to find that the CBP medical screening process at the border is inadequate for children.<sup>3</sup> Directing DHS to explore new approaches or solutions for the medical screening process will help ensure that medical screenings conducted at the border improve. Additionally, the implementation of electronic health records for screened individuals is critical. Such a system should be able to be accessed by any DHS component at the border to reduce reliance on hard copy records, lessen the risk of lost health records, and ensure DHS personnel or contractors are not needlessly duplicating medical checks or procedures. This will not only ensure continuity of care but better facilitate custody transfers between DHS components.

#### HEARINGS

For the purposes of section 103(i) of H. Res. 6 of the 116th Congress, the following hearings were used to develop H.R. 3525:

- On March 6, 2019, the Committee held a hearing entitled “The Way Forward on Border Security.” The Committee received testimony from Kirstjen Nielsen, Secretary of Homeland Security.

<sup>1</sup> Commissioner Kevin McAleenan, CBS This Morning, December 26, 2018, “We need a different approach,” says border protection chief after 2nd migrant child dies in U.S. custody.” Available at: <https://www.cbsnews.com/news/customs-and-border-protection-chief-kevin-mcaleenan-on-migrant-child-death/>.

<sup>2</sup> Robert Moore, “Autopsy Offers Jarring New Details About the Death of a 16-year-old Guatemalan Boy,” Texas Monthly, July 24, 2019. See also, Molly Hennessy-Fiske, “Six migrant children have died in U.S. custody. Here’s what we know about them,” Los Angeles Times, May 24, 2019.

<sup>3</sup> Bob Ortega, “Doctor says Border Patrol often misses early signs of illness in migrant children,” CNN, July 1, 2019.

- On March 26, 2019 the Subcommittee on Border Security, Facilitation, and Operations held a hearing entitled “The Department of Homeland Security’s Family Separation Policy: Perspectives from the Border.” The Subcommittee received testimony from Jennifer Podkul, Director of Policy, Kids in Need of Defense; Michelle Brane, Director for Migrant Rights and Justice, Women’s Refugee Commission; Dr. Julie M. Linton, Co-Chair, Immigrant Health Special Interest Group, American Academy of Pediatrics; Tim Ballard, Founder and CEO, Operation Underground Railroad.

- On May 9, 2019, the Subcommittee on Border Security, Facilitation, and Operations held a hearing entitled “A Review of the FY 2020 Budget Request for U.S. Customs and Border Protection, U.S. Immigration and Customs Enforcement, and U.S. Citizenship and Immigration Services.” The Subcommittee received testimony from Robert E. Perez, Deputy Commissioner, U.S. Customs and Border Protection; Matthew T. Albence, Acting Director, U.S. Immigration and Customs Enforcement; Tracy Renaud, Acting Deputy Director, U.S. Citizenship and Immigration Services.

- On May 22, 2019, the Committee held a hearing entitled “A Review of the Fiscal Year 2020 Budget Request for the Department of Homeland Security.” The Committee received testimony from Kevin K. McAleenan, Acting Secretary of Homeland Security.

#### COMMITTEE CONSIDERATION

The Committee met on July 17, 2019, to consider H.R. 3525 and ordered the measure to be reported to the House with a favorable recommendation, with amendment, by voice vote.

The following Amendments were offered and accepted by voice vote:

An amendment in the Nature of a Substitute offered by Ms. Underwood (#1);

An amendment offered by Ms. Underwood:

Page 2, line 1, insert “, with priority given to children who have not yet attained the age of 18,” after “individuals”.

Page 2, line 3, strike “of such interdiction” and insert “after such interdiction, or six hours in the case of a high priority individual. Such screening should be conducted by a medical professional and should be developed in collaboration with non-governmental experts in the delivery of health care in humanitarian crises and in the delivery of health care to children.”.

Page 2, line 7, insert “in-person” after “initial”.

Page 2, line 13, insert “(including a list of confiscated medications and whether such have been replaced)” after “current medications”.

Page 2, line 16, insert the following: (D) A physical examination that includes the screening of vital signs such as body temperature, pulse rate, and blood pressure.”.

Page 2, line 23, insert the following:

“(4) Review by a medical professional of any prescribed medication that is in the detainee’s possession or that was confiscated upon arrival to

determine if such medication may be kept by such detainee for use during detention, properly stored with appropriate access for use during detention, or maintained with a detainee's personal property.

(5) Chaperones for the physical examination of minors, including, as appropriate, the parent, legal guardian, or the such minors' closest present adult relative, or a U.S. Border Patrol agent of the same gender.

(c) PEDIATRIC EXPERTISE.—A pediatric medical expert shall be on site in every U.S. Border Patrol sector, including at U.S. Border Patrol processing centers and at U.S. Border Patrol facilities at which 20 percent or more of detained individuals over the immediately preceding six month period are minors. The Chief of the U.S. Border Patrol shall prepare a plan to deploy in-person or technology-facilitated medical consultation with a licensed medical professional to U.S. Border Patrol facilities that experience an increase in apprehensions of children greater than 10 percent over the preceding 60 days.

(d) DEFINITION. In this section, the term 'high priority individual' means an individual who self-identifies as having a medical condition needing prompt attention, exhibits signs of acute illness, is pregnant, is a child, or is elderly."

Page 3, line 6, insert the following: "(b) RULE OF CONSTRUCTION.—Nothing in this section or the amendment made by this section may be construed as authorizing U.S. Customs and Border Protection to detain individuals for longer than 72 hours."

Page 4, line 7, insert "and non-governmental experts" after "expertise".

Page 4, line 8, strike "expertise in".

Page 4, strike line 18 to end, and insert new section 4,

**"SEC. 4. ELECTRONIC HEALTH RECORDS IMPLEMENTATION.**

(a) IN GENERAL.—Not later than 30 days after the date of the enactment of this Act, the Chief Information Officer of the Department of Homeland Security, in coordination with the Chief Medical Officer of the Department, shall establish within the Department an electronic health record system that can be accessed by all departmental components operating along the borders of the United States for individuals in the custody of such components.

(b) ASSESSMENT.—Not later than 120 days after the implementation of the electronic health records system, the Chief Information Officer, in coordination with the Chief Medical Officer, shall conduct an assessment of such system to determine system capacity for improvement and interoperability.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the recorded votes on the motion to report legislation and amendments thereto.

No recorded votes were requested during consideration of H.R. 3525.

## COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

CONGRESSIONAL BUDGET OFFICE ESTIMATE NEW BUDGET  
AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause (3)(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee adopts as its own the estimate of the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office.

*H.R. 3525—Enhanced Border Security and Visa Entry Reform Act  
of 2002*

CBO estimates that H.R. 3525 (enacted as Public Law 107–173) will result in no significant net cost to the federal government. The act will affect direct spending, but we estimate that any net effects will not be significant.

H.R. 3525 sets the amount of the machine-readable visa (MRV) fee at \$65 and establishes a surcharge of \$10 for issuing an MRV in a nonmachine-readable passport. Under prior law, the Secretary of State had the authority to raise MRV fees at his discretion, and on June 1, 2002, the department implemented a new schedule of consular fees, including an increase in the MRV fee from \$45 to \$65. According to the State Department, it would be nearly impossible to collect the \$10 surcharge under the existing application procedures because banks that collect various application fees would be unable to distinguish machine-readable passports from nonmachine-readable ones. Because the State Department currently does not have a specific plan for collecting the new surcharge, CBO cannot estimate the additional amounts that will be collected and spent, but the net effects will not be significant in any year.

H.R. 3525 also will increase the penalty from \$300 to \$1,000 for improper submission of passenger manifests by carriers entering United States ports. This provision will increase both collections and spending of such penalties by the Immigration and Naturalization Service (INS), but CBO estimates that the net effect will be less than \$500,000 annually.

The CBO staff contacts for this estimate are Mark Grabowicz (for INS costs) and Sunita D'Monte (for State Department costs). This estimate was approved by Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

#### DUPLICATIVE FEDERAL PROGRAMS

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

#### PERFORMANCE GOALS AND OBJECTIVES

The Committee states that pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, H.R. 3525 would require the Department of Homeland Security to make certain improvements to medical screening of individuals apprehended at the border.

#### ADVISORY ON EARMARKS

In compliance with rule XXI of the Rules of the House of Representatives, this bill, as reported, contains no congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(c), or 9(f) of the rule XXI.

#### SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

##### *Section 1. Short title*

This section provides that this bill may be cited as the “U.S. Border Patrol Medical Screening Standards Act”.

##### *Sec. 2. Uniform medical screening process for apprehensions*

This section amends the Homeland Security Act to require the Commissioner of U.S. Customs and Border Protection (CBP), in coordination with the Department’s Chief Medical Officer (CMO), to establish uniform medical screening processes and training not later than 30 days after enactment. The U.S. Border Patrol, in turn, will be required to use these processes to conduct consistent and efficient medical screening of all apprehended individuals with priority given to children under the age of 18. Such screening is to occur before the individual is transferred from CBP custody or within 12 hours of apprehension, whichever is shortest. An individual who self-identifies as having a medical condition needing prompt attention, exhibits signs of acute illness, is pregnant, is a child, or is elderly, is to be considered a high-priority individual and should be screened within six hours of apprehension. This section lists the minimum requirements that must be a part of the screening process and requires pediatric medical expert presence on site in every U.S. Border Patrol sector, processing center, and facility with a significant presence of children.

This section also requires that not later than 60 days after the establishment of uniform processes and training, the CBP Commissioner ensure that the individuals conducting such screening shall be trained on the process to ensure consistent assessments and operations along the borders of the United States.

##### *Sec. 3. Research improvements to medical screening*

Not later than one year after enactment, the Secretary of Homeland Security, acting through the Under Secretary for Science and Technology, in coordination with the CBP Commissioner and CMO, are required to research innovative solutions to address any capa-

bility gaps in the screening of individuals apprehended by U.S. Border Patrol. In carrying out this research, national professional associations and non-governmental experts in relevant medical fields are to be consulted. Any recommendations resulting from such research are to be submitted by the Secretary to the House Committee on Homeland Security and the Senate Committee on Homeland Security and Governmental Affairs along with information on what actions the Secretary plans in response to the recommendations.

*Sec. 4. Electronic health records implementation*

This section requires the Department's Chief Information Officer (CIO) and CMO to establish an electronic health record system for individuals in DHS custody along the borders of the United States not later than 30 days after enactment. All the DHS components who operate along the borders should be able to access the records in the system. Not later than 120 days after implementation of the system, the CIO and CMO will assess the system to determine its interoperability and identify needed improvements. Presently, DHS does not have a fully-integrated electronic records system to ensure that each component involved in the care of an apprehended individual has access to any records from an initial health screening and information on any health conditions warranting certain care.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

**HOMELAND SECURITY ACT OF 2002**

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) **SHORT TITLE.**—This Act may be cited as the “Homeland Security Act of 2002”.

(b) **TABLE OF CONTENTS.**—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

\* \* \* \* \*

Subtitle C—Miscellaneous Provisions

*Sec. 437. Medical screening of individuals interdicted between ports of entry.*

\* \* \* \* \*

**TITLE IV—BORDER, MARITIME, AND  
TRANSPORTATION SECURITY**

\* \* \* \* \*

**Subtitle C—Miscellaneous Provisions**

\* \* \* \* \*

**SEC. 437. MEDICAL SCREENING OF INDIVIDUALS INTERDICTED BETWEEN PORTS OF ENTRY.**

(a) *IN GENERAL.*—To improve border security and the processing of individuals and families interdicted by the U.S. Border Patrol between ports of entry, the Commissioner of U.S. Customs and Border Protection, in coordination with the Chief Medical Officer of the Department, shall, not later than 30 days after the date of the enactment of this section, establish uniform processes and training to ensure consistent and efficient medical screening of all individuals, with priority given to children who have not yet attained the age of 18, so interdicted before transfer from U.S. Customs and Border Protection custody, but in no case longer than 12 hours after such interdiction, or 6 hours in the case of a high priority individual. Such screening should be conducted by a medical professional and should be developed in collaboration with non-governmental experts in the delivery of health care in humanitarian crises and in the delivery of health care to children.

(b) *SCREENING PROCESS COMPONENTS.*—At a minimum, the uniform processes and training established under subsection (a) shall include the following:

(1) Requirements for initial in-person screening that includes documentation of the following:

(A) Visual assessment of overall physical and behavioral state, including any possible disability.

(B) A brief medical history, including demographic information, current medications (including a list of confiscated medications and whether such have been replaced), and any chronic or past illnesses.

(C) Any current medical complaints.

(D) A physical examination that includes the screening of vital signs such as body temperature, pulse rate, and blood pressure.

(2) Criteria for determining when to make a referral to higher medical care and a process to execute such referral.

(3) Recordkeeping requirements regarding how information is to be recorded for each initial screening under paragraph (1), including information on the use of interpretation services.

(4) Review by a medical professional of any prescribed medication that is in the detainee's possession or that was confiscated upon arrival to determine if such medication may be kept by such detainee for use during detention, properly stored with appropriate access for use during detention, or maintained with a detainee's personal property.

(5) Chaperones for the physical examination of minors, including, as appropriate, the parent, legal guardian, or the such minors' closest present adult relative, or a U.S. Border Patrol agent of the same gender.

(c) *PEDIATRIC EXPERTISE.*—A pediatric medical expert shall be on site in every U.S. Border Patrol sector, including at U.S. Border Patrol processing centers and at U.S. Border Patrol facilities at which 20 percent or more of detained individuals over the immediately preceding six month period are minors. The Chief of the U.S. Border Patrol shall prepare a plan to deploy in-person or technology-facilitated medical consultation with a licensed medical professional to U.S. Border Patrol facilities that experience an increase in appre-

*hensions of children greater than 10 percent over the preceding 60 days.*

*(d) DEFINITION.—In this section, the term “high priority individual” means an individual who self-identifies as having a medical condition needing prompt attention, exhibits signs of acute illness, is pregnant, is a child, or is elderly.*

*(e) TRAINING.—Not later than 60 days after the issuance of the uniform processes and training established under subsection (a), the Commissioner of U.S. Customs and Border Protection shall ensure that any individual carrying out medical screening under this section at a U.S. Customs and Border Protection facility of individuals interdicted by the U.S. Border Patrol between ports of entry shall complete training on such uniform processes.*

\* \* \* \* \*

## MINORITY VIEWS

H.R. 3525 directs the Border Patrol to conduct comprehensive medical screenings of the thousands of people they encounter every day within 12 hours of interdiction. Border Patrol simply does not have the resources, medical contract support, or physical space to meet the requirements of H.R. 3525, especially with the record numbers of migrants it is encountering on a daily basis. No funding is provided in this bill to enable Customs and Border Protection (CBP) to achieve this mandate.

The Border Patrol is responsible for short-term detention and for expeditiously processing and coordinating the transfer of illegal immigrants into the custody of agencies with the capacity to hold them for longer terms of stay. The majority's policy decision to deny funding for Immigration and Customs Enforcement (ICE) bed space has severely degraded the U.S. government's ability to safely hold illegal immigrants in long-term facilities. As a result, illegal immigrants are being held in Border Patrol custody much longer than was ever envisioned. ICE provides comprehensive medical screenings for illegal immigrants when they are transferred into their care, which prior to the crisis took on average no more than 72 hours. Instead of conflating which government agencies are responsible for the comprehensive medical screening of illegal immigrants, Congress should provide ICE the resources it needs to provide proper care to the record number of illegal immigrants in government custody.

H.R. 3525 also forces huge unfunded and unachievable mandates on the Department of Homeland Security (DHS). The bill requires DHS research innovative ways to conduct medical screenings at the border. This new research and development mandate would force the DHS to redirect its limited funding away from homeland security research priorities that are focused on preventing drugs, criminals, and terrorists from entering the country, to instead research technology that is not directly related to the mission of the Department.

This bill also forces DHS to establish within 30 days of passage, an electronic health record system to track illegal immigrant health records that is fully interoperable with all components that operate along the border. That is a completely unrealistic time-frame designed to result in failure. No funding is provided in the bill to cover such major acquisition, forcing the DHS to reprogram funding used for combating terrorists and criminal organizations, and for responding to man-made and natural disasters, to an IT system to track illegal immigrant health records.

Health screenings for migrants are necessary to protect public health. Congress should work with DHS and the Department of Health and Human Services on ways to improve the delivery of these screenings. Unfortunately, the unrealistic mandates included

H.R. 3525 are simply unachievable. As a result, H.R. 3525 will not improve the health screening process or protect the health of migrants, Border Patrol, or the general public.

MIKE ROGERS.

