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Issues - Refugees [2]

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Office of HIV/AIDS Policy

Office of Public Health and Science
Office of the Secretary
200 Independence Avenue, S.W., 736E
Washington, D.C. 20201

Deliver To: Todd

Fax: ( ) 456-2438

Phone: ( )

From: Deborah von Zinkernagel
Deputy Director for Policy
Phone: (202) 690-5560
Fax: (202) 690-6584
E-mail: (202) DvonZinkernagel@osophs.dhhs.gov

Date: _____/_____/_____

This fax contains _____ page(s) plus cover

If transmission problems occur, please call: Shellie Abramson @(202) 690-5560

Comments: _____

United States Department of Justice
Immigration and Naturalization Service
Office of the Executive Associate Commissioner
Policy and Planning
425 I Street, N.W.
Washington, D.C. 20536

Dear-----:

On behalf of the Secretary of Health and Human Services Donna Shalala, let me thank you for your attention to the health needs of refugees seeking entry to the United States. I understand that you are interested in obtaining information related to the programs that refugees who test positive for the human immunodeficiency virus (HIV), are eligible to receive including the Medicaid program, the Refugee Medical Assistance (RMA) program, and the Ryan White CARE Act (RWCA).

RMA provides for the health care of low-income refugees during their first eight months in the United States for those individuals not covered by Medicaid (primarily, single adults and couples without children). This coverage includes primary health care and some ancillary support services and is substantially equivalent to those services provided by Medicaid.

Medicaid coverage is extended to low-income and unemployed refugee families with children under the age of 18 eligible for Medicaid services with some limitations. All States extend Medicaid eligibility to pregnant women with incomes below 185 percent of the Federal poverty level; children less than age 6 in families with income below 133 percent of the Federal poverty level; children between ages 6 and 15 in families with income below 100 percent of the Federal poverty level; and, by 2002, children between ages 16 and 18 in families with income below 100 percent of the Federal poverty level.

There is a restriction on Medicaid coverage for non-citizens. However, that restriction is waived for all refugees for their first five years after arrival; for those that qualify for Medicaid because they are elderly or disabled, this restriction is waived for seven years (an additional two years). Additionally, States may, at their option, extend these waiver periods.

In addition to RMA and Medicaid, refugees may also be eligible for a variety of services supported through the Ryan White CARE Act (RWCA), which is administered by the Health Resources and Services Administration of the Department of Health and Human Services. These

services include primary care, prescription drug benefits, case management, and translation services. Though the range and availability of CARE Act funded services varies from area to area, we are confident that a basic level of HIV-related care is available in most communities. Ryan White CARE Act funds are not restricted from serving refugees or immigrants.

Our Office of Refugee Resettlement is working with your staff and those from other agencies of HHS to develop a pilot program for serving HIV-positive refugees. This prospective initiative may include training of private resettlement agency staff in HIV-related issues, support for accessing community-based HIV resources, and other components to improve awareness of and access to the broad array of publicly and privately supported programs for individuals living with HIV and AIDS. We look forward to developing this pilot and jointly assessing the benefits of an enhanced service program that will utilize service providers and materials that are linguistically and culturally appropriate for the refugee populations.

In our view, the country's commitment to providing services to HIV-positive individuals provides adequate support for refugees who are HIV-positive upon their admission to the United States and during their transition to full participation in our society.

Thank you again for your continuing efforts to provide for those individuals most in need. We stand ready and willing to continue our work together on their behalf.

Sincerely yours,

David Satcher, M.D., Ph.D.
Assistant Secretary for Health and
Surgeon General

Todd

To: Christy Quigley@IOS.ES,Elizabeth Summy@IOS.IO, INTERNET[DvonZinkernagel@OSOPHS.DHHS.GOV],Kristin Siebenaler@OAS@ACF.WDC
From: Shannon Rudisill@OAS@ACF.WDC
Cc: Emil Parker@OAS@ACF.WDC,Kristin Siebenaler@OAS@ACF.WDC,Lavinia Limon@ORR.OD@ACF.WDC,Nancy O Borders@ORR.OD@ACF.WDC
Bcc:
Subject: re: fwd: draft letter
Attachment:
Date: 5/7/99 1:24 PM

305-0134

I have received comments from John Monahan and Lavinia Limon on the draft letter. They are minor, but important. Here they are:

1) Lavinia just wants to be sure that someone is fully engaged with INS and that this letter is "what INS needs." It sounds from this email trail that is happening, but I don't know the context here, so I want to underline the importance of talking to INS.

2) On the second page of the letter, where it talks about the pilot program, please add language that says that the pilot program will use service providers and materials that are linguistically and culturally appropriate for the refugee populations.

Thank you for the opportunity to review. If you have any further questions or I can be of help, please call me at 401-6965.

Shannon

Original text
From: Kristin Siebenaler@OAS@ACF.WDC, on 5/6/99 12:42 PM:
There is a fax outside Lavinia's office that is up and running. I was just able to fax up the draft Satcher letter. We need to give her some time to review it given that she is extraordinarily busy right now. Since I will be out tomorrow, Shannon can follow up with John and Lavinia to get comments back to you all. Thanks so much.

From: Elizabeth Summy@IOS.IO@OS.DC, on 5/5/99 3:05 PM:
To: Kristin Siebenaler@OAS@ACF.WDC

this is the letter referred to in Deborah's e-mail.

Original Text
From: "Deborah Von Zinkernagel" <DvonZinkernagel@osophs.dhhs.gov>, on 5/5/99 10:44 AM:
To: Elizabeth Summy@IOS.IO@OS.DC
Cc: ISMTP@B11WDC-OV08B@Servers["Nicole Lurie" <NLurie@osophs.dhhs.gov>]

Liz,

I received a phone request from Todd in the White House AIDS Office yesterday asking for an HHS letter clarifying what federally supported services HIV+ refugees may receive. Because the ASH generally signs the blanket waiver requests for HIV+ travelers attending large conferences here, Todd drafted a letter for Dr. Satcher to consider. I've run both the letter and the nature of the request by Dick Riseberg of OGC -- who feels it would most appropriately be sent by the Secretary if the Dept. wanted to move on this.

Todd is on a very tight time line, Kosovo refugees are arriving at Ft. Dix now and INS is positively engaged. Please give me a call and I will give you more background and get some materials to you.

Thanks,

Deborah von Zinkernagel
Office of HIV/AIDS Policy
690-5566

Forward Header

Subject: draft letter
Author: Todd_A._Summers@opd.eop.gov at INTERNET
Date: 5/4/99 11:12 AM

Here's the draft - I had Gayle Smith from IRR/HHS do an informal review. I've also sent it to INS for them to informally review. Call me so that we can discuss. This needs to move ASAP -- preferably by the close of business tomorrow. We do not want this issue to be a problem at Ft. Dix -- we also want the current policy improved upon prior to the Cairo trip by the President. Hence the speed.

THIRD DRAFT - LETTER FROM DR. SATCHER TO INS
May 4, 1999 11:07 AM

On behalf of the Secretary of Health and Human Services Donna Shalala, let me thank you for your attention to the health needs of refugees seeking entry to the United States. I understand that you are interested in obtaining information related to the programs that refugees who test positive for the human immunodeficiency virus (HIV) are eligible to receive, including the Medicaid program, the Refugee Medical Assistance (RMA) program, and the Ryan White CARE Act.

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Thank you again for your continuing efforts to provide for those individuals most in need. We stand ready and willing to continue our work together on their behalf.

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Barbara Strack
FROM: Jodel

COMPANY: INS
DATE:

FAX NUMBER: 305-0134
TOTAL NO. OF PAGES INCLUDING COVER:

PHONE NUMBER:

RE:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

736 Jackson Place
Washington, DC 20503
(202) 456-2437
(202) 456-2438 (fax)

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Thank you again for your continuing efforts to provide for those individuals most in need. We stand ready and willing to continue our work together on their behalf.

Todd A. Summers
05/04/99 12:27:40 PM

Record Type: Record

To: DvonZinkernagel@osophs.dhhs.gov (Deborah Von Zinkernagel)

cc:
Subject: Re: draft letter

I will fax over some additional material. We have been working with INS and NSC to respond to a request by UNHCR and others to update our policy on admission of HIV-positive refugees. Currently, INS excludes HIV-positive refugees in accordance with statute. However, the AG has the discretion to waive that restriction and has done so through a non-codified policy that uses a three prong test (see attached description of the policy).

Concern was raised that the policy is unclear, inconsistent with current public health standards, and is implemented in a non-uniform fashion. Essentially, it has discouraged most HIV-positive refugees from applying for the waiver. In some cases, their identification as HIV-positive through the refugee application process puts them at increased risk of harm. This is contrary to the protective nature of the refugee resettlement efforts.

INS is prepared to update its waiver standards by collapsing the first two prongs into one, and revising the third prong to more accurately reflect fair public health standards. Essentially, the INS is prepared to revise the third prong test (which looks at cost) to reflect the responsibility of the USG to insure that adequate care is provided to HIV-positive refugees. The cost issue will remain, but INS is prepared to consider this test satisfied by virtue of their existing programs to provide for HIV-related care (in essence, arguing that the establishment of these programs reflects approval over the incurring of costs).

INS has asked for a letter from HHS that lays out in summary the availability of programs to provide for HIV-related care. Our discussions have focused on Medicaid, RMA, and Ryan White. The draft I have sent you is intended as a draft of that letter. It is not intended to be a complete expiation of qualification/eligibility standards but rather a general statement that a network of programs exists that would essentially cover all HIV-positive immigrants for at least the first eight months here. After that, they may access Medicaid if they are otherwise eligible. In addition, CARE provides for wrap-around services that might be useful and which are available to refugees and immigrants regardless of citizenship.

I would appreciate any help you can offer in moving this letter through the system at an expedited pace. I am enclosing a page from the HHS/CFDA web site that does a good job of outlining the RMA program.

Todd Summers

- c

July 10, 1998

HIV Infection: Inadmissibility and Waiver Policies

Section 212(a)(1)(A)(i) of the Immigration and Nationality Act renders inadmissible any applicant for a visa or admission who is found, according to the regulations published by the Secretary of Health and Human Services (HHS), to have a communicable disease of public health significance, which includes HIV infection. However, in view of humanitarian and family unity concerns, the law also provides waivers of inadmissibility, which are discretionary and granted on a case-by-case basis.

Two specific waiver policies have been implemented for applicants seeking admission as **nonimmigrants** (for a temporary period of time), who are inadmissible due to HIV infection:

Routine HIV Waiver Policy. Nonimmigrants may be granted a waiver for admission to the United States for 30 days or less to attend conferences, receive medical treatment, visit close family members, or conduct business. The applicant must demonstrate that he or she is not currently afflicted with symptoms of the disease; there are sufficient assets, such as insurance, that would cover any medical care that might be required in the event of illness while in the United States; the proposed visit to the United States is for 30 days or less; and that the visit will not pose a danger to public health in the United States.

The "Designated Event" Policy. This policy facilitates the admission of HIV-positive persons to attend certain "designated events," which are considered to be in the public interest, such as academic and educational conferences and international sports events. To initiate the process, HHS writes a letter to the Department of State (DOS) regarding a specific event. DOS recommends the event to the Attorney General, who "designates" the event and authorizes a blanket waiver. This blanket waiver allows HIV-positive applicants-seeking admission to the United States specifically to participate in the "designated event"-to be admitted for the duration of the event without being questioned about their HIV status.

Applicants seeking admission to the United States as **immigrants** (for a permanent stay) must establish the required family relationship. They must be the spouse or unmarried son or daughter, or the minor unmarried lawfully adopted child of a U.S. citizen or permanent resident; or have a son or daughter who is a U.S. citizen or permanent resident. The applicant also must satisfy three discretionary criteria that were developed by INS to ensure the public health, safety and welfare:

The danger to the public health created by the alien's admission is minimal;

The possibility of the spread of the infection created by the alien's admission is minimal; and

No expense will be incurred by any government agency, without that agency's prior consent.

--INS--

Table of Contents

We are recommending that DCF make a financial adjustment of $409,759 for the ineligible medical assistance payments. We are also recommending procedural changes to improve DCF's administration of the RRP.

In written comments to the draft report, DCF agreed with the amount of our overpayment. The DCF outlined changes to its computerized payment system that they believe will prevent payments after a refugee's period of eligibility has expired. In regard to our recommendation that DCF determine overpayments subsequent to our review, DCF said they would continue to rely on the State Auditor General's annual audits to determine eligibility accuracy. The DCF's comments are summarized after the Recommendations section of this report and are included in their entirety in the APPENDIX.

BACKGROUND

The Refugee Act of 1980 (Public Law 96-212) authorized Federal reimbursement to States for up to 100 percent of cash and medical assistance provided to refugees immediately following their date of entry (DOE) into the United States. The RRP reimbursed States the cost that they would normally incur to provide refugees cash and medical assistance under existing Federal and State assistance programs such as Aid to Families with Dependent Children (AFDC), Medicaid and the Supplemental Security Income State supplement, and for a special program of RCA and RMA.

For refugees eligible for Federal assistance programs, the RRP reimbursed the States their share of program costs while the Federal assistance programs, such as AFDC and Medicaid contributed their usual Federal financial participation. For refugees eligible for RCA and RMA, the RRP reimbursed States the full cost of assistance.

Funding for the RRP is subject to the availability of funds appropriated. Over the years, the Office of Refugee Resettlement (ORR) has found it necessary to change the period of eligibility for RCA and RMA from 36 months to 12 months due to limited funding.

Effective October 1, 1991, ORR notified the States to reduce the eligibility period for RCA and RMA for new arrivals from 12 months to 8 months. The 8-month eligibility period has remained in effect since that date.

At the Federal level, the RRP is administered by ORR, which is a part of the Administration for Children and Families. In Florida, the RRP is administered by DCF, formerly the Department of Health and Rehabilitative Services. The Florida Agency for Health Care Administration (AHCA) determines the duration and type of RMA services provided. The AHCA also contracts with the State's Medicaid fiscal agent to process RMA payments.

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Deborah

FROM: Jodel

COMPANY:

DATE:

FAX NUMBER:

TOTAL NO. OF PAGES INCLUDING COVER:

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RE:

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NOTES/COMMENTS:

736 Jackson Place
Washington, DC 20503
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Slight changes per HHS -

736 Jackson Place
Washington, DC 20503
(202) 456-2437
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For those individuals not covered by Medicaid (primarily, single adults and couples without children), RMA provides for a basic level of care for refugees during their first eight months in the United States. This coverage includes primary health care and some ancillary support services.

Low-income and unemployed refugee families with children under the age of 18 eligible for Medicaid services. All States extend Medicaid eligibility to pregnant women with incomes below 185 percent of the poverty level; children less than age 6 in families with income below 133 percent of poverty; children between ages 6 and 15 in families with income below 100 percent of poverty; and, by 2002, children between ages 16 and 18 in families with income below 100 percent of poverty. There is a restriction on Medicaid coverage for non-citizens. However, that restriction is waived for all refugees for their first five years after arrival; for those that qualify for Medicaid because they are elderly or disabled, this restriction is waived for seven years (an additional two years). Additionally, States may at their option extend these waiver periods.

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TO:	FROM:
Barbara Strack	Todd Summers
COMPANY:	DATE:
INS	May 4, 1999
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
305-0134	3
PHONE NUMBER:	
514-8860 /3242	
RE:	
Draft HHS letter	

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NOTES/COMMENTS:

Hi Barbara -

As per my voice memo, this is a draft that's gone through a little reworking and has more to go, but I wanted to get you in the loop earlier. Can you call me and let me know if you see any problems in this meeting your needs? Also, I need to know to whom this should be addressed.

Thanks,

Todd

736 Jackson Place
Washington, DC 20503
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For those individuals not covered by Medicaid (primarily, single adults and couples without children), ~~may receive~~ RMA during their first eight months in the United States. ~~This program~~ provides for a basic level of care for refugees ~~that are ineligible for other programs~~. This includes primary health care and some ancillary support services.

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The restriction on Medicaid eligibility to non-citizens is waived for all refugees for the first five years. Those that qualify because they are elderly or disabled have this restriction waived for their first seven years. States may, at their option, extend ~~either~~ these waiver periods.

Barbara Strack / INS
514-8860 direct
514-3242 general
305-0134

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Gayle Smith, Acting Director	Todd Summers, Deputy Director
COMPANY:	DATE:
IRR/HHS	May 4, 1999
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
401-5487	3
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205-3590	
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Second draft	

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NOTES/COMMENTS:

This reflects changes suggested by other staff here. It adds a level of detail. Give me a call at your earliest convenience.

Todd

736 Jackson Place
Washington, DC 20503
(202) 456-2437
(202) 456-2438 (fax)

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May 4, 1999

On behalf of the Secretary of Health and Human Services Donna Shalala, let me thank you for your attention to the health needs of refugees seeking entry to the United States. I understand that you are interested in obtaining information related to the programs that human immunodeficiency virus (HIV) positive refugees are eligible to receive, including the Medicaid program, the Refugee Medical Assistance (RMA) program, and the Ryan White CARE Act.

Low-income and unemployed refugee families with children under the age of 18 eligible for Medicaid services. All States extend Medicaid eligibility to pregnant women with incomes below 185 percent of the poverty level; children less than age 6 in families with income below 133 percent of poverty; children between ages 6 and 15 in families with income below 100 percent of poverty; and, by 2002, children between ages 16 and 18 in families with income below 100 percent of poverty. Refugees eligible for Medicaid may maintain their eligibility for longer than five years at state option. In addition, elderly and individuals with disabilities, including those who are infected with HIV, are eligible for SSI for their first seven years in the United States. Those individuals not covered by Medicaid (primarily, single adults and couples without children) may receive RMA during the first eight months in the United States. This program provides for a basic level of care for refugees that are ineligible for other programs.

In addition, refugees may also be eligible for a variety of services supported through the Ryan White CARE Act, which is administered by the Health Resources Services Administration of HHS. These services include primary care, prescription drug benefits, case management, and translation services. The range and availability of CARE Act funded services varies from area to area. We are confident that a basic level of HIV-related care is available in most communities. Ryan White CARE Act funds are not restricted from serving refugees or immigrants.

Our Office of Refugee Resettlement is working with your staff and those from other agencies of HHS to develop a pilot program for serving HIV-positive refugees. This prospective initiative may include cross-training of private resettlement agency staff in HIV-related issues, support for accessing community-based HIV resources, and other components to improve

awareness of and access to the broad array of publicly and privately supported programs for individuals living with HIV and AIDS. We look forward to developing this pilot and jointly assessing the benefits of an enhanced service program.

Thank you again for your continuing efforts to provide for those individuals most in need. We stand ready and willing to continue our work together on their behalf.

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Gayle Smith	Todd Summers, Deputy Director
COMPANY:	DATE:
IRR/HHS	May 3, 1999
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
401-5487	3
PHONE NUMBER:	
205-3590	
RE:	
Draft letter from Dr. Satcher to INS	

☒ URGENT ☒ FOR REVIEW ☒ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Gayle -

Can you look this over quickly before I send this to Dr. Satcher's office for review? You can call me at 456-2444 if you have any questions. Hopefully, Lavinia clued you in a little to this effort.

Thanks,

Todd

736 Jackson Place
Washington, DC 20503
(202) 456-2437
(202) 456-2438 (fax)

DRAFT MEMO FROM DR. SATCHER TO INS

On behalf of the Secretary of Health and Human Services Donna Shalala, let me thank you for your attention to the health needs of refugees seeking entry to the United States.

With respect to those that have tested positive for the human immunodeficiency virus (HIV), I would like to confirm that HIV-infected refugees are eligible for a variety of programs that provide for their primary medical care and related supportive services. These include the Medicaid program, the Refugee Medical Assistance (RMA) program, and the Ryan White CARE Act.

At a minimum, coverage is available to all refugees through RMA for at least the first eight months after resettlement in the United States. This provides for a basic level of care for all refugees that are ineligible for other programs.

Some, but not all refugees, may also eligible for Medicaid services (Medicaid coverage is used before RMA, which is the payer of last resort). This would include pregnant women, children, and those that are disabled, including those that are infected with HIV. Eligibility is also subject to means testing.

In addition, refugees are also eligible for a variety of services supported through the Ryan White CARE Act, which is administered by the Health Resources Services Administration of HHS. These services include primary care, prescription drug benefits, case management, and translation services. The range and availability of CARE Act funded services varies from area to area; however, we are confident that a basic level of HIV-related care is available in most communities. Ryan White CARE Act funds are not restricted from serving refugees or immigrants.

Our office of Refugee Resettlement is also working with your staff and those from other agencies of HHS to develop a pilot program to look at the benefit of an enhanced program for serving HIV-positive refugees. This may include cross-training of private resettlement agency

staff in HIV-related issues, support for accessing community-based HIV resources, and other components that might improve awareness of and access to the broad array of publicly and privately supported programs for those who are living with HIV and AIDS. We look forward to developing that pilot and jointly assessing the benefits of and continued need for some kind of enhanced service program.

Thank you again for your efforts to further our efforts to provide for the needs of those to whom this nation is providing shelter and protection. We stand ready and willing to continue our work together on their behalf.

Youth Intelligence -
Cassandra Report
Bch Res Panel
Chuck Blanchard
Bill Bartholomew

INS: - Legal basis for 3rd prong - not req'd, probably not legal
- Issuance of reg. 212
- Tweak - no, not easily - it's clearly laid out

Options
1) Drop 3rd
2) Drop 3rd, Beef up 1 + 2 - requirements of resettlement contracts
3) Retain 3rd, enhance coverage by HHS

Thursday @ 2:00 -

Nu

Youth
- Be good advocates but
Overcome barriers but let them stop you
Prevention, constantly reinvigorating
reaching new populations

301 4th St SW
@ C

Public Law 105–370
105th Congress

An Act

Nov. 12, 1998
[H.R. 2070]

To amend title 18, United States Code, to provide for the testing of certain persons who are incarcerated or ordered detained before trial, for the presence of the human immunodeficiency virus, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Correction Officers Health and Saftey Act of 1998.
18 USC 4001 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Correction Officers Health and Safety Act of 1998".

SEC. 2. TESTING FOR HUMAN IMMUNODEFICIENCY VIRUS.

(a) IN GENERAL.—Chapter 301 of title 18, United States Code, is amended by adding at the end the following:

"§ 4014. Testing for human immunodeficiency virus

"(a) The Attorney General shall cause each individual convicted of a Federal offense who is sentenced to incarceration for a period of 6 months or more to be tested for the presence of the human immunodeficiency virus, as appropriate, after the commencement of that incarceration, if such individual is determined to be at risk for infection with such virus in accordance with the guidelines issued by the Bureau of Prisons relating to infectious disease management.

"(b) If the Attorney General has a well-founded reason to believe that a person sentenced to a term of imprisonment for a Federal offense, or ordered detained before trial under section 3142(e), may have intentionally or unintentionally transmitted the human immunodeficiency virus to any officer or employee of the United States, or to any person lawfully present in a correctional facility who is not incarcerated there, the Attorney General shall—

"(1) cause the person who may have transmitted the virus to be tested promptly for the presence of such virus and communicate the test results to the person tested; and

"(2) consistent with the guidelines issued by the Bureau of Prisons relating to infectious disease management, inform any person (in, as appropriate, confidential consultation with the person's physician) who may have been exposed to such virus, of the potential risk involved and, if warranted by the circumstances, that prophylactic or other treatment should be considered.

"(c) If the results of a test under subsection (a) or (b) indicate the presence of the human immunodeficiency virus, the Attorney General shall provide appropriate access for counselling, health

care, and support services to the affected officer, employee, or other person, and to the person tested.

"(d) The results of a test under this section are inadmissible against the person tested in any Federal or State civil or criminal case or proceeding.

"(e) Not later than 1 year after the date of the enactment of this section, the Attorney General shall issue rules to implement this section. Such rules shall require that the results of any test are communicated only to the person tested, and, if the results of the test indicate the presence of the virus, to correctional facility personnel consistent with guidelines issued by the Bureau of Prisons. Such rules shall also provide for procedures designed to protect the privacy of a person requesting that the test be performed and the privacy of the person tested.". Deadline. Regulations.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 301 of title 18, United States Code, is amended by adding at the end the following new item:

"4014. Testing for human immunodeficiency virus.".

(c) GUIDELINES FOR STATES.—Not later than 1 year after the date of the enactment of this Act, the Attorney General, in consultation with the Secretary of Health and Human Services, shall provide to the several States proposed guidelines for the prevention, detection, and treatment of incarcerated persons and correctional employees who have, or may be exposed to, infectious diseases in correctional institutions. Deadline. 18 USC 4042 note.

Approved November 12, 1998.

LEGISLATIVE HISTORY—H.R. 2070:

HOUSE REPORTS: No. 105–665 (Comm. on the Judiciary).
CONGRESSIONAL RECORD, Vol. 144 (1998):
Aug. 3, considered and passed House.
Oct. 20, considered and passed Senate, amended.
Oct. 21, House concurred in Senate amendment.

○

Todd A. Summers
02/16/99 06:14:03 PM

Record Type: Record

To: Michael Deich/OMB/EOP

cc: Sandra Thurman/OPD/EOP
Subject: Justice/BoP Help

I'd like to spend about half an hour with you discussing some outstanding issues we have with the Bureau of Prisons on which we could truly use your help! I am particularly nervous that they have told us they expect no financial impact from HR2070 - Correctional Officer Health and Safety Act - which will mandate HIV testing (and counseling and treatment). The second big issue is care for those in pre-release status.

If your amenable, let me know and I'll have someone set up the appointment. Thanks - hope you're well.

Todd

DoJ

	TOC	FOR	INT	OVERVIEW MAIN
Top		ns_t_for.	ns_t_int	ns_t_ov
RIGHT		ns_r_for.	ns_r_int	ns_r_ov
LEFT		ns_l_for.		ns_l_ov
MAIN		ns_m_for	ns_m_int	ns_m_ov
tab-off	1a	2a	3a	4a
tab-on	1b	2b	3b	4b

Refugee Meeting

7/25/99

Protective Perspective

Pierino
Ty Accius

Factors for prioritization

Long-winded
chatty

Mike Meyers
~~224-5465~~
224-3961

Thursday

Refugee Mtg. 1/21/99

INS - Kathleen
- review legal issues

HHS - Sec. interested + supportive

Department of State

Bureau of Population, Refugees and Migration

HIV+ Cases in the U.S. Resettlement Program

Updated 2/25/99

	HIV+ Case Member		Unresolved*		% Unres.
Where:	Cases	Persons	Cases	Persons	Cases
Bangkok**	42	91	16	22	38%
Belgrade	1	2	0	0	0%
Cairo	4	4	2	2	50%
Frankfurt	3	3	1	1	33%
Havana	0	0	0	0	0%
Hong Kong	1	1	0	0	0%
Madrid					
Manila					
Moscow	29	102	29	102	100%
Nairobi	169	664	160	627	95%
Riyadh	1	9	0	0	0%
Vienna	0	0	0	0	
TOTAL	250	876	208	754	83%

* Unresolved means the HIV+ member is still stuck.
(Resolved means traveled to the U.S. or elsewhere or died.)

** Bangkok data does not yet include ODP numbers.

IMMIGRATION AND NATIONALITY ACT
TITLE II - IMMIGRATION
CHAPTER 2 - QUALIFICATIONS FOR ADMISSION OF ALIENS; TRAVEL CONTROL OF CITIZENS AND ALIENS
INA: ACT 212 - GENERAL CLASSES OF ALIENS INELIGIBLE TO RECEIVE VISAS AND INELIGIBLE FOR ADMISSION; WAIVERS OF INADMISSIBILLITY

(a) Classes of Aliens Ineligible for Visas or Admission.-Except as otherwise provided in this Act, aliens who are inadmissible under the following paragraphs are ineligible to receive visas and ineligible to be admitted to the United States:

(1) Health-related grounds.-

(A) In general.-Any alien-

(i) who is determined (in accordance with regulations prescribed by the Secretary of Health and Human Services) to have a communicable disease of public health significance, which shall include infection with the etiologic agent for acquired immune deficiency syndrome,

(ii) 1/ except as provided in subparagraph (C) 1a/ who seeks admission as an immigrant, or who seeks adjustment of status to the status of an alien lawfully admitted for permanent residence, and who has failed to present documentation of having received vaccination against vaccine-preventable diseases, which shall include at least the following diseases: mumps, measles, rubella, polio, tetanus and diphtheria toxoids, pertussis, influenza type B and hepatitis B, and any other vaccinations against vaccine-preventable diseases recommended by the Advisory Committee for Immunization Practices,

(iii) who is determined (in accordance with regulations prescribed by the Secretary of Health and Human Services in consultation with the Attorney General)-

(I) to have a physical or mental disorder and behavior associated with the disorder that may pose, or has posed, a threat to the property, safety, or welfare of the alien or others, or

(II) to have had a physical or mental disorder and a history of behavior associated with the disorder, which behavior has posed a threat to the property, safety, or welfare of the alien or others and which behavior is likely to recur or to lead to other harmful behavior, or

(iv) who is determined (in accordance with regulations prescribed by the Secretary of Health and Human Services) to be a drug abuser or addict, is inadmissible.

(B) Waiver authorized.-For provision authorizing waiver of certain clauses of subparagraph (A), see subsection (g).

(C) 1/ EXCEPTION FROM IMMUNIZATION REQUIREMENT FOR ADOPTED CHILDREN 10 YEARS OF AGE OR YOUNGER.--Clause (ii) of subparagraph (A) shall not apply to a child who--

(i) is 10 years of age or younger,

(ii) is described in section 101(b)(1)(F) , and

(iii) is seeking an immigrant visa as an immediate relative under section 201(b) ,

IMMIGRATION AND NATIONALITY ACT
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(II) The seizing or detaining, and threatening to kill, injure, or continue to detain, another individual in order to compel a third person (including a governmental organization) to do or abstain from doing any act as an explicit or implicit condition for the release of the individual seized or detained.

(III) A violent attack upon an internationally protected person (as defined in section 1116(b)(4) of title 18, United States Code) or upon the liberty of such a person.

(IV) An assassination.

(V) The use of any-

(a) biological agent, chemical agent, or nuclear weapon or device, or

(b) explosive or firearm (other than for mere personal monetary gain), with intent to endanger, directly or indirectly, the safety of one or more individuals or to cause substantial damage to property.

(VI) A threat, attempt, or conspiracy to do any of the foregoing.

(iii) Engage in terrorist activity defined.-As used in this Act, the term "engage in terrorist activity" means to commit, in an individual capacity or as a member of an organization, an act of terrorist activity or an act which the actor knows, or reasonably should know, affords material support to any individual, organization, or government in conducting a terrorist activity at any time, including any of the following acts:

(I) The preparation or planning of a terrorist activity.

(II) The gathering of information on potential targets for terrorist activity.

(III) The providing of any type of material support, including a safe house, transportation, communications, funds, false documentation or 5/ identification, weapons, explosives, or training, to any individual the actor knows or has reason to believe has committed or plans to commit a terrorist activity.

(IV) The soliciting of funds or other things of value for terrorist activity or for any terrorist organization.

(V) The solicitation of any individual for membership in a terrorist organization, terrorist government, or to engage in a terrorist activity.

(iv) Representative defined.-As used in this paragraph, the term 'representative' includes an officer, official, or spokesman of an organization, and any person who directs, counsels, commands, or induces an organization or its members to engage in terrorist activity.

(C) Foreign policy.-

(i) In general.-An alien whose entry or proposed activities in the United States the Secretary of State has

reasonable ground to believe would have potentially serious adverse foreign policy consequences for the United States is inadmissible.

(ii) Exception for officials.-An alien who is an official of a foreign government or a purported government, or who is a candidate for election to a foreign government office during the period immediately preceding the election for that office, shall not be excludable or subject to restrictions or conditions on entry into the United States under clause (i) solely because of the alien's past, current, or expected beliefs, statements, or associations, if such beliefs, statements, or associations would be lawful within the United States.

(iii) Exception for other aliens.-An alien, not described in clause (ii), shall not be excludable or subject to restrictions or conditions on entry into the United States under clause (i) because of the alien's past, current, or expected beliefs, statements, or associations, if such beliefs, statements, or associations would be lawful within the United States, unless the Secretary of State personally determines that the alien's admission would compromise a compelling United States foreign policy interest.

(iv) Notification of determinations.-If a determination is made under clause (iii) with respect to an alien, the Secretary of State must notify on a timely basis the chairmen of the Committees on the Judiciary and Foreign Affairs of the House of Representatives and of the Committees on the Judiciary and Foreign Relations of the Senate of the identity of the alien and the reasons for the determination.

(D) Immigrant membership in totalitarian party.-

(i) In general.-Any immigrant who is or has been a member of or affiliated with the Communist or any other totalitarian party (or subdivision or affiliate thereof), domestic or foreign, is inadmissible.

(ii) Exception for involuntary membership.- Clause (i) shall not apply to an alien because of membership or affiliation if the alien establishes to the satisfaction of the consular officer when applying for a visa (or to the satisfaction of the Attorney General when applying for admission) that the membership or affiliation is or was involuntary, or is or was solely when under 16 years of age, by operation of law, or for purposes of obtaining employment, food rations, or other essentials of living and whether necessary for such purposes.

(iii) Exception for past membership.-Clause (i) shall not apply to an alien because of membership or affiliation if the alien establishes to the satisfaction of the consular officer when applying for a visa (or to the satisfaction of the Attorney General when applying for admission) that-

(I) the membership or affiliation terminated at least-

(a) 2 years before the date of such application, or

(b) 5 years before the date of such application, in the case of an alien whose membership or affiliation was with the party controlling the government of a foreign state that is a totalitarian dictatorship as of such date, and

(II) the alien is not a threat to the security of the United States.

(iv) Exception for close family members.-The Attorney General may, in the Attorney General's discretion, waive the application of clause (i) in the case of an immigrant who is the parent, spouse, son, daughter, brother, or sister of a citizen of the United States or a spouse, son, or daughter of an alien lawfully admitted for permanent residence for humanitarian purposes, to assure family unity, or when it is otherwise in the public interest if the immigrant is not a threat to the security of the United States.

(E) Participants in nazi persecutions or genocide.-

(i) Participation in nazi persecutions.-Any alien who, during the period beginning on March 23, 1933, and ending on May 8, 1945, under the direction of, or in association with-

(I) the Nazi government of Germany,

(II) any government in any area occupied by the military forces of the Nazi government of Germany,

(III) any government established with the assistance or cooperation of the Nazi government of Germany, or

(IV) any government which was an ally of the Nazi government of Germany, ordered, incited, assisted, or otherwise participated in the persecution of any person because of race, religion, national origin, or political opinion is inadmissible.

(ii) Participation in genocide.-Any alien who has engaged in conduct that is defined as genocide for purposes of the International Convention on the Prevention and Punishment of Genocide is inadmissible.

(4) Public charge.-

(A) In general.-Any alien who, in the opinion of the consular officer at the time of application for a visa, or in the opinion of the Attorney General at the time of application for admission or adjustment of status, is likely at any time to become a public charge is inadmissible. 6/

(B) Factors to be taken into account.-(i) In determining whether an alien is excludable under this paragraph, the consular officer or the Attorney General shall at a minimum consider the alien's-

(I) age;

(II) health;

Department of State
Bureau of Population, Refugees and Migration

Refugee Resettlement -- HIV+ Case Incidence

- Data to date shows a total of 208 cases/754 people in unresolved cases involving an HIV+ member. (Unresolved means HIV+ case member is still stuck.)

- Overall, 83% of the cases reported remain unresolved. (Resolved cases include 17 that traveled to the U.S. with the HIV+ member and 5 resettled to 3rd countries.)

- The HIV+ caseload in Africa grew from 15 cases in FY 97 to 104 cases in FY 98. Already in FY 99 we have 50 cases on record.

10/29/98

U.S. Asylum and Refugee Policy

The United States offers asylum and refugee protection based on an inherent belief in human rights and in ending or preventing the persecution of individuals. Asylum is a precious and important protection granted by federal law to qualified applicants who are unable or unwilling to return to their country of nationality because of persecution or a well-founded fear of persecution. Claims of persecution must be based on at least one of five internationally recognized grounds: race, religion, nationality, membership in a particular social group, or political opinion. The Illegal Immigration Reform and Immigrant Responsibility Act of 1996 provided that some actions taken under coercive population control programs constitute persecution on account of political opinion. A maximum of 1,000 aliens per fiscal year may be granted asylum or admitted as a refugee under this provision.

In addition to asylum and refugee protection, withholding of removal is available to refugees in the United States who can show a likelihood their lives or freedom would be threatened if they were returned to the country in question. Withholding of removal is in some ways similar to asylum, but is governed by a higher standard, requiring applicants to establish that it is more likely than not that they would be persecuted. Unlike asylum, however, once this standard is met, there is no discretion to deny withholding and the applicant may not be returned to the country.

Asylum /Refugee Application Process

Asylum and refugee applicants are both adjudicated under the same legal standard, but differ in terms of where they are located. The potential asylee is in the United States or applying for admission at a port of entry, and the potential refugee is outside the United States. Aliens in the United States or at a port of entry can apply for asylum by filing an Application for Asylum, Form I-589, with either the Immigration and Naturalization Service (INS) or the Executive Office for Immigration Review (EOIR), the Department of Justice agency that comprises the immigration courts and Board of Immigration Appeals (BIA). Applicants can obtain a Form I-589 and filing instructions from an asylum office, an INS district office or by calling the INS toll-free request line at 1-800-870-3676. **A Form I-589 must be filed within one year after the alien's arrival in the United States, unless there exist changed circumstances affecting the applicant's eligibility for asylum, or extraordinary circumstances relating to the delay in filing.** People overseas who are eligible for consideration by the U.S. refugee program apply by filing a Registration for Classification as a Refugee, Form I-590.

"Affirmative" Asylum Applications With INS

An alien who is in the United States and who is not in immigration proceedings may apply for asylum by filing a Form I-589 with the appropriate INS regional Service Center by mail. The Service Center sends the applicant a receipt notice and refers the applicant to one of eight asylum offices around the country. The offices are staffed by approximately 300 specially trained members of the Asylum Officer Corps (AOC), which has been adjudicating asylum applications filed with INS since 1991. Asylum claims brought before the AOC are "affirmative" applications filed voluntarily by the alien. If an asylum officer denies the asylum application of an alien in lawful status, the applicant can reapply for asylum if he/she is later placed in removal proceedings before an immigration judge. Aliens who are in unlawful status and cannot be granted asylum

by the AOC are referred to an immigration judge, before whom they can again raise their asylum claim. **Affirmative asylum applicants are not placed in detention while their application is considered.**

Although the Form I-589 is an application for both asylum and withholding of removal, generally it is immigration judges, and not asylum officers, who adjudicate applications for withholding of removal during removal proceedings in which it has been determined that an alien is removable.

"Defensive" Asylum Applications With EOIR

The Executive Office for Immigration Review has exclusive jurisdiction over the cases of aliens who are placed in removal proceedings and then seek asylum. Asylum claims filed before EOIR are "defensive" applications raised in removal proceedings before immigration judges as a defense against removal. **Aliens who seek asylum as a defense against removal may be detained for being in the United States illegally until an immigration judge rules on their asylum claim. Their detention, however, is not due to their asylum claim.**

Asylum Process for Certain Arriving Aliens

The 1996 law mandates that aliens who arrive at a U.S. port of entry without travel documents or who engage in fraud or material misrepresentation be detained and placed in expedited removal. Aliens who express or indicate a fear of persecution during the expedited removal process receive a "credible fear" interview with an INS asylum officer. Aliens found to have a credible fear are referred for ordinary removal proceedings in which they may apply for asylum before an immigration judge. **Aliens determined to have a credible fear are detained because they remain in removal proceedings until an immigration judge rules on their asylum claim. Their detention also is not due to their asylum claim.**

Parole

INS district directors have discretionary authority to parole, or release, an alien in proceedings from detention. In determining whether release is appropriate on a case-by-case basis, district directors must decide whether the alien's release would serve an urgent humanitarian need or significant public benefit and whether the alien has established his/her identity, poses a threat to the community, demonstrates family ties in the community, presents evidence of a credible asylum claim, or poses a risk of flight. Different, more restrictive criteria govern the custody of certain criminal aliens.

Overseas Refugee Processing

Each year the President, in consultation with Congress, determines the number of refugees who may be admitted to the United States during the coming fiscal year. This annual ceiling is divided among five regional sub-ceilings -- Africa, East Asia, Europe, Latin America/Caribbean and the Near East/South Asia. For fiscal 1999, the President and Congress have determined that up to 78,000 refugees may be admitted to the United States, with those admissions allocated among the five regions as follows:

- Africa.....12,000
- East Asia..... 9,000
- Europe (includes 3,000 unfunded).....48,000
- Latin America/Caribbean.....3,000
- Near East/South Asia.....4,000
- Unallocated.....2,000

The Europe, Bosnia and former Soviet Union ceiling includes 3,000 unfunded numbers allocated to the former Soviet Union for use as needed, provided that resources within existing appropriations are available to fund the cost of their admission. The 2,000 unallocated numbers will be allocated as needed to meet regional shortfalls. Unused admissions numbers from one region may be transferred to another region where the need for admissions numbers exceeds the sub-ceiling.

Access to the U.S. refugee program is not open-ended. To file a Form I-590, a refugee applicant must first be found to be eligible for a refugee interview. The question of whether applicants are eligible for a refugee interview is governed by their nationality and whether they come under one of the processing priorities used to manage the U.S. refugee program. Like the setting of the admissions' ceiling, the designation of eligible nationalities and processing priorities is decided annually as part of the consultations process.

Traditionally, refugee applicants are interviewed in third countries after having fled their country of persecution. Individuals who have fled their country and believe themselves to be at risk if returned should contact the nearest office of the United Nations High Commissioner for Refugees (UNHCR). That office will make a decision as to whether the individuals require protection and where that protection may be provided. The U.S. legal definition of refugee also allows for in-country refugee processing in countries so designated by the President. For fiscal 1999, the U.S. refugee program will operate in-country programs in Havana, Ho Chi Minh City and Moscow. Those eligible for Moscow processing are nationals or habitual residents of the former Soviet Union as it existed on September 2, 1991.

--INS--

Table of Contents

Home Page

December 18, 1998

MEMORANDUM

Waiver of Exclusion for HIV-positive Refugees

The InterAction Committee on Migration and Refugee Affairs ("CMRA") is a coalition of national non-governmental organizations that work in partnership with the United States Government to rescue and resettle refugees. CMRA presents this memorandum of law with the conviction that the Immigration and Naturalization Service ("INS") should omit from any proposed rule on admission of HIV-positive refugees considerations of ability to pay medical costs, because such a criterion would be: a "public charge" exclusion that is contrary to the plain language, legislative intent, and legislative purpose of the Refugee Act of 1980; arbitrary and capricious; and contrary to U.S. obligations under international refugee protection agreements. The HIV waiver policy would undermine refugee protection by resulting in refoulement of persons already adjudicated by the U.S. to have a "well-founded fear of persecution."

Since the mid-1980s, the United States has maintained, in one form or another, an exclusion for reasons of public health on admission of aliens infected with HIV ("HIV-positive aliens"), the precursor to Acquired Immune Deficiency Syndrome ("AIDS").[1] While this bar applies to all categories of aliens under the Immigration and Nationality Act ("INA"), the Attorney General is authorized to waive the INA's public health exclusions for refugees, including the HIV bar, because of "humanitarian purposes, to assure family unity, or when it is

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[1] Section 212(a)(1)(A)(i) of the INA, 8 U.S.C. § 1182(a)(1)(A)(i), classifies any alien who is infected "with the etiologic agent for acquired immune deficiency syndrome" to be inadmissible.

otherwise in the public interest."[2] As the Attorney General's delegate for the exercise of this waiver authority, since 1988 the INS has required an HIV-positive refugee applying for a waiver of the HIV exclusion to establish that:

> "(1) the danger to the public health of the United States created by his or her admission is minimal; (2) the possibility of the spread of the infection created by his or her admission to the United States is minimal; and (3) there will be no cost incurred by any level of government agency of the United States without the prior consent of that agency."[3]

As recently as 1995, the INS reaffirmed these conditions for exercise of the waiver of the HIV ban for refugees ("the INS HIV Waiver Policy").[4] CMRA has learned that INS is considering incorporating these three criteria into a proposed regulation, the details of which are still under consideration.

Congress did not authorize the Attorney General to consider ability to pay medical costs in the exercise of her discretion to waive the HIV exclusion for refugees, and indeed specifically excluded refugees from application of the "public charge" ground of exclusion.[5] Consideration of ability to pay medical costs has long been a "public charge" issue, from which Congress intended refugees to be exempt. Estimates from the United Nations High Commissioner for Refugees ("UNHCR") suggest that the third or "no governmental cost" prong of the INS HIV Waiver Policy operates to bar entry of persons adjudicated by the United States

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2 INA § 207(c)(3); 8 U.S.C. § 1157(c)(3).

3 *See* Cable from James A. Puleo, INS Assistant Commissioner for Examinations, to INS Field Offices (Mar. 2, 1988), *reprinted in* 65 Interpreter Releases 239 (Fed. Publications 1988) ("Puleo Cable").

4 Memorandum from T. Alexander Aleinikoff, Executive Associate Commissioner of the INS, Regarding Immigrant Waivers for Aliens Found Excludable Under Section 212(a)(1)(A)(i) of the Immigration and Nationality Act Due to HIV Infection (Sept. 6, 1995), *reprinted in* 72 Interpreter Releases 1347 (Fed. Publications 1995) ("Aleinikoff Memo").

5 INA § 207(c)(3); 8 U.S.C. § 1157(c)(3).

to have a "well-founded fear of persecution," notwithstanding the statutory ban on application of the "public charge" exclusion to refugees.[6] CMRA thus respectfully requests that INS reconsider the legality and propriety of including such "public charge" considerations in determinations of whether the Attorney General should exercise her discretion to waive the HIV ground of exclusion for refugees. INS should omit the "no governmental cost" prong of its HIV Waiver Policy from any formal agency rule it promulgates because this criterion is: (1) a "public charge" exclusion that is contrary to the plain language, legislative intent, and legislative purpose of the Refugee Act of 1980; (2) arbitrary and capricious; and, (3) contrary to U.S. obligations under international agreements dealing with refugee protection.[7]

BACKGROUND

The history of the exclusion of HIV-positive aliens dates to the mid-1980s and provides some useful insight into what authority the INS was granted to add to the language of INA § 212(a)(1)(A)(i). Section 212(a)(1)(A)(i) provides for the exclusion of any alien who has

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[6] Under § 101(a) of the INA, 8 U.S.C. § 1101(a), Congress defined a refugee in terms almost identical to those used in international treaties on refugee protection. That definition of a refugee includes:

> "(A) any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitaully resided, and who is unable or unwilling to return to, and unable or unwilling to avail himself or herself of the protection of that country because of persection or a *well-founded fear of persecution* on account of race, religion, nationality, membership in a particular social group, or political opinion * * *." (Emphasis added).

[7] CMRA assumes that criteria 1 and 2 of the INS HIV Waiver Policy may be addressed through education of HIV-positive refugees on the modes of transmission of HIV, and thus does not take issue with either at this time.

been determined to carry a "communicable disease of public health significance."[8] While the exact language of this exclusion has changed over the years, the immigration laws have provided for the exclusion of carriers of contagious diseases that threaten the public health of the United States for over a century. For most of that time, and for most diseases, the U.S. Public Health Service ("PHS") has been charged with determining which diseases fall into the category of "communicable disease[s] of public health significance."[9]

The first proposal to add AIDS to the list of contagious diseases for which an alien may be excluded under the INA was made by the Department of Health and Human Services ("HHS") in April 1986.[10] While that proposal was pending, in June of 1987, Senator Jesse Helms succeeded in obtaining unanimous Senate approval for an initiative to statutorily mandate addition of HIV to the list of "dangerous contagious diseases."[11] Senator Helms

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[8] 8 U.S.C. § 1182(a)(1)(A)(i). Prior to revision of this ground of exclusion in 1990, aliens infected with a "dangerous contagious disease" were excludable. *See supra* for a discussion of the 1990 amendments to Section 212(a).

[9] *See generally* "Grounds for Exclusion of Aliens Under the Immigration and Nationality Act: Historical Background and Analysis," H.R. Doc. 89-263, 100th Cong., 2d Sess. 73-78 (Sept. 1988).

[10] "Medical Examination of Aliens (AIDS)," 51 Fed. Reg. 15354 (1986).

[11] In a comprehensive review of grounds for exclusion of aliens under U.S. immigration law, the House of Representatives Committee on the Judiciary described the history of the statutory listing of HIV as an excludable disease:

> "On May 31, 1987, according to Senator Jesse Helms, President Reagan 'directed the Secretary of Health and Human Services to finalize an April 23, 1986 proposed rule adding AIDS to the list of dangerous contagious diseases.' Senator Helms noted this as an argument for his amendment to H.R. 1827, the fiscal year 1987 Supplemental Appropriations bill, requiring the President to add HIV infection to the list of dangerous contagious diseases on or before August 31, 1987. While the need for the amendment was questioned during the floor debate, it passed the Senate on June 2 by a unanimous vote of 96 yeas and was accepted in a modified form in the legislation enacted on July 11, 1987 as Public Law 100-71." *Grounds for Exclusion, supra*, at 85-86.

accomplished this by offering a modified Senate floor amendment to the 1987 Supplemental Appropriations Act to direct the Secretary of HHS to list HIV as an excludable disease.[12] Under this pressure, HHS finalized its proposed regulations in June 1987.[13] According to the Secretary of HHS: "[w]ith our current state of knowledge about HIV infection, * * * the exclusion of applicants with HIV infection is justified."[14] The status of HIV as an excludable "dangerous contagious disease" remained unchanged from 1987 until the passage of the Immigration Act of 1990.

In the Immigration Act of 1990, Congress extensively revised the health-related grounds for exclusion of aliens. The revised public health ground excluded any alien "who is determined (in accordance with regulations prescribed by the Secretary of Health and Human Services) to have a communicable disease of public health significance * * *."[15] Congress's intent in revising the public health ground of exclusion was to "insure that this exclusion will apply *only* to those diseases for which admission of aliens with such diseases would pose a public health risk to the United States."[16] The HHS Secretary was instructed to determine the list

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[12] *See* 133 Cong. Rec. S7415 (daily ed. June 2, 1987). Section 518 of the Supplemental Appropriations Act, Pub. L. 100-71, 101 Stat. 391, 475 (July 11, 1987) provides that "[o]n or before August 31, 1987, the President, pursuant to his existing power under section 212(a)(6) of the Immigration and Nationality Act, shall add human immunodeficiency virus infection to the list of dangerous contagious diseases contained in title 42 of the Code of Federal Regulations."

[13] "Medical Examination of Aliens (AIDS), 52 Fed. Reg. 21532 (1987) (to be codified at 42 C.F.R. § 34).

[14] "Medical Examination of Aliens," 52 Fed. Reg. 32540, 32543 (Aug. 28, 1987) (final rule).

[15] Pub. L. 101-649, § 601, 104 Stat. 4978, 5067 (Nov. 29, 1990) *amending* INA § 212(a)(1)(A)(i); 8 U.S.C. § 1182(a)(1)(A)(i).

[16] H.R. Conf. Rep. No. 955, 101st Cong., 2d Sess. 119 (1990), *reprinted in* 1990 U.S.C.C.A.N. 6784, 6793 (emphasis added).

of "communicable diseases of public health significance" on the basis of "current epidemiological principles and medical standards."[17]

The HHS Secretary in the Bush Administration, Dr. Louis Sullivan, published his recommendations in the Federal Register in early 1991, proposing to remove all diseases from the exclusion list except infectious tuberculosis.[18] In May 1991, one week prior to taking effect, the Bush Administration pulled back the proposal citing hostile public reaction, and adopted an interim rule retaining HIV infection as a ground for exclusion.[19] The status of HIV as an excludable disease under INA § 212(a)(1)(A)(i) remained unchanged until President Clinton took office.

Campaigning on a promise to lift the HIV exclusion, President Clinton indicated that he would remove HIV administratively from the list of excludable diseases. Shortly after President Clinton assumed office in early 1993, the PHS prepared a final rule to remove HIV from the list of excludable diseases.[20] Opponents of removing HIV from the list of exclusions quickly moved to amend the National Institutes of Health Revitalization Act of 1993 to codify the existing interim ban on admission of HIV-positive aliens into the United States.[21] After a frequently bitter debate, the National Institutes of Health Revitalization Act of 1993 was passed

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17 *Id.*

18 56 Fed. Reg. 15258 (Jan. 23, 1991).

19 56 Fed. Reg. 25000 (May 31, 1991).

20 "Debate Again Erupts Over Excluding Aliens Infected With AIDS Virus," 70 Interpreter Releases 210 (Fed. Publications Feb. 22, 1993).

21 *See* 139 Cong. Rec. S 1762 (daily ed. Feb. 18, 1993).

by the Congress and signed into law by the President.[22] While the NIH Revitalization Act statutorily required that HIV be listed on the excludable disease list, there is no indication in the record that Congress intended to do anything other than prevent the Clinton Administration from administratively removing HIV from the exclusion list.[23]

Thus, despite the changing statutory basis for listing HIV as an excludable disease, administrative guidelines issued by INS headquarters in 1988, and reaffirmed in 1995, on criteria for the grant of waivers of the HIV exclusion, remain in effect to this day. Those guidelines provide that the Attorney General's waiver authority under INA § 207(c)(3) will be exercised for HIV-positive refugees only where the refugee can establish that:

> "(1) the danger to the public health of the United States created by his or her admission is minimal; (2) the possibility of the spread of the infection created by his or her admission to the United States is minimal; and (3) there will be no cost incurred by any level of government agency of the United States without the prior consent of that agency." [24]

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[22] National Institutes of Health Revitalization Act of 1993, Pub. L. No. 103-43, 107 Stat. 122 (Jun 10, 1993).

[23] *See, e.g.,* 139 Cong. Rec. H2739 (daily ed. May 25, 1993) (Statement of Rep. Mazzoli):

> "Regulations, policies, and practices have developed with regard to waivers of exclusion, testing requirements, and health-related questioning. The conferees, by requiring that HIV be included among the list of excludable diseases until such time as Congress shall remove it, have taken the position that waiver, questioning, and testing decisions should continue to be left to the discretion of the Attorney General. Thus the conference report does not codify any current policies or practices concerning those authorities." *See also id.* at H2736 ("[w]aiver authority under the current law remains unchanged.") (Statement of Rep. Bliley).

[24] *See supra* Puleo Cable, 65 Interpreter Releases at 239; Aleinikoff Memo, *supra*, 72 Interpreter Releases at1347.

These guidelines were developed in the context of the "legalization" program pursuant to the Immigration Reform and Control Act of 1986 ("IRCA").[25] They were intended primarily for undocumented immigrants applying for amnesty under IRCA, not for refugees fleeing persecution. Indeed, these guidelines are contrary not only to the spirit but also the letter of U.S. refugee law, and thus should be amended before including them in any formal agency rule the INS may contemplate promulgating.

DISCUSSION

I. THE INS HIV WAIVER POLICY IMPERMISSIBLY ADDS A PUBLIC CHARGE CRITERION TO THE WAIVER DETERMINATION FOR REFUGEES.

A. The Plain Language of the Refugee Act of 1980 Exempted Refugees from the "Public Charge" Ground of Exclusion.

When Congress enacted the Refugee Act of 1980, it established a "permanent and systematic procedure for the admission to this country of refugees of special humanitarian concern to the United States, and * * * provide[d] comprehensive and uniform provisions for the effective resettlement and absorption of those refugees who are admitted."[26] Congress reiterated in the Refugee Act:

> "the historic policy of the United States to respond to the urgent needs of persons subject to persecution in their homelands, including, where appropriate, humanitarian assistance for their care and maintenance in asylum areas, efforts to promote opportunities for resettlement or voluntary repatriation, aid for necessary transportation and processing admission to this country of refugees of special humanitarian concern to the United States, and transitional assistance to refugees in the United States."[27]

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25 Pub. L. 99-603, 100 Stat. 3359 (Nov. 6, 1986).

26 Pub. L. No. 96-212, § 101(b), 94 Stat. 102 (1980) (codified in scattered parts of 8 U.S.C.).

27 *Id.* § 101(a).

To implement this policy, Congress, *inter alia*, delegated discretion to the Attorney General to waive for refugees some exclusions in the INA that operate to keep certain classes of aliens out of the United States.[28]

In INA § 207(c)(3), Congress also *statutorily precluded* application to refugees of the INA's provisions excluding aliens on the basis that they are: (1) "likely at any time to become a public charge," (8 U.S.C. § 1182(a)(4)); (2) lack a labor certification (8 U.S.C. § 1182(a)(5)); or (3) lacked at the time of application a valid, unexpired visa and/or passport (8 U.S.C. § 1182(a)(7)(A)). Not only is it unnecessary for the Attorney General to waive the public charge, labor certification, and lack of visa or passport exclusions for refugees, Congress has *mandated* that such grounds "not be applicable to any alien seeking admission to the United States under this subsection * * *."[29] Those grounds of exclusion cannot be applied to refugees even if the Attorney General so desired. Ironically, the INS has recognized as much in the policy memorandum concerning its HIV Waiver Policy: "the public charge provisions do not apply to refugees" and "[r]efugees and individuals granted asylum who are applying for adjustment of status under section 209 of the Act are not subject to the public ground charge of excludability."[30] Thus, to the extent that the "no governmental cost" criterion of the INS HIV Waiver Policy is a "public charge," it conflicts with § 207(c)(3) of the INA and is thus unlawful.

B. Congress Clearly Considered Medical Costs To Be A Public Charge.

The plain language of the Refugee Act indisputably expresses Congress's intention that the "public charge" exclusion not be applied to refugees. While Congress did not

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28 *See id.* at § 201(b) (adding INA § 207(c)(3); 8 U.S.C. § 1157(c)(3)).

29 INA § 207(c)(3); 8 U.S.C. § 1157(c)(3).

30 Aleinikoff Memo, *supra*, 72 Interpreter Releases at 1353

expressly define what a "public charge" is for purposes of the INA or Refugee Act, its intent and purpose in enacting the Refugee Act (and making corresponding amendments to the INA) clearly demonstrates that Congress considered refugee medical costs to be subsumed in the "public charge" exclusion. Moreover, because Congress intentionally left the definition of a "public charge" to administrative regulation and practice, and ultimately the courts, to develop, the administrative and judicial definition of the term in the INA is presumed to have been endorsed by Congress at the time of enactment of the Refugee Act absent some affirmative indication to the contrary.[31] Under those judicial and administrative interpretations, medical costs have long been considered a "public charge" issue.

Employing traditional tools of statutory construction, it is clear that Congress intended to preclude consideration of ability to pay potential medical costs as a ground for exclusion of refugees. Under those circumstances, where Congress has expressed a clear intent on an issue, the INS's HIV Waiver Policy, even if promulgated as a formal agency rule, is not entitled to the deference traditionally afforded reasonable interpretations of a statute entrusted to an agency to administer. Although the Supreme Court has held in *Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc.*[32] and its progeny, that an agency's interpretation of the statute entrusted by Congress to it to administer is entitled to significant deference, that deference is not unbounded. Before an agency interpretation of a statute is afforded *Chevron* deference, it must be determined whether Congress has spoken to the particular issue in the statute the agency is purporting to interpret. As the Court noted in *Chevron*:

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[31] *See, e.g., Conroy v. Aniskoff*, 507 U.S. 511, 516-518 (1993) (applying well-established presumption that Congress is familiar with, and accepts, judicial construction of an act when it subsequently legislates in that area without affirmatively reversing judicial interpretations).

[32] 467 U.S. 837 (1984).

> "The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent [citing cases]. If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect."[33]

It cannot be disputed that Congress exempted refugees from exclusion as "public charges." It is also clear that Congress understood and intended that medical costs be included within the sweep of the "public charge" exclusion.

1. The Statutory Factors To Be Used To Identify Likely Public Charges Include Medical Costs And Ability To Pay.

INS has phrased criterion 3 of its HIV Waiver Policy without reference to the term "public charge," but that cannot obscure the "public charge" nature of the test. Criterion 3 states that an HIV-positive refugee applicant must establish that "there will be no cost incurred by any level of government agency of the United States without the prior consent of that agency" in order for the Attorney General to exercise her discretion to waive the exclusion of HIV-positive aliens. According to INS guidance to Field Officers, HIV-positive refugees may satisfy criteria 3 by any of the following: proof that a hospital, research organization or other type of facility will provide care at no cost to the U.S. Government; proof of private insurance; formal consent by a U.S. government agency to provide medical treatment to the applicant; or proof of personal assets of the applicant sufficient to cover medical costs.[34]

While Congress intentionally left the term "public charge" undefined in the INA,[35] section 212(a)(4) of the INA, (8 U.S.C. § 1182(a)(4)) lists the factors that a consular

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33 *Id.* at 843 n.9.

34 Aleinikoff Memo, *supra*, 72 Interpreter Releases at 1351.

35 *See* Grounds for Exclusion, *supra*, at 121 ("As [a] 1950 Senate Judiciary report recommended, the term `public charge' has not been defined by statute. However, there has been

officer should take into account in determining whether an alien is "likely at any time to become a public charge." Those factors include age; health; family status; assets, resources and financial status; and education and skills.[36] The similarity between the factors to be taken into account under the "no governmental cost" criterion and the "public charge" determination indicates that they are in fact the same test.

2. Judicial and Board of Immigration Appeals Opinions Confirm that Ability to Pay Medical Costs Is a "Public Charge" Issue.

Because Congress intentionally left the term "public charge" undefined in the INA, it has fallen to the Board of Immigration Appeals ("BIA") and the courts to give content to the exclusion. A review of BIA and judicial decisions that have considered the definition of "public charge," demonstrates that the ability of an alien to pay his or her medical costs long has been a public charge issue. In keeping with administrative practice, the courts and BIA have kept issues of excludability on public health grounds separate from considerations of whether an alien could meet his or her health-related expenses. The latter traditionally has been part of the "public charge" analysis of admissibility.

The definition of a "public charge" has remained largely unchanged in both the INA and the administrative and judicial opinions that have considered the term. One of the leading cases to consider the term is *Wallis v. United States ex rel. Mannara*, in which the Second Circuit upheld a determination that an alien suffering from a cardiac problem and senility was likely to become a public charge.[37] The court reasoned that:

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a sizeable body of case law interpreting what it does and does not mean in varying circumstances.").

[36] INA § 212(a)(4)(B); 8 U.S.C. § 1182(a)(4)(B).

[37] 273 F. 509 (2d Cir. 1921).

> "[a] person likely to become a public charge is one whom it may be necessary to support at public expense by reason of poverty, insanity and poverty, *disease and poverty*, idiocy and poverty."[38]

Similarly, the District Court in *Ex parte Orzechowska* found that a girl who was institutionalized in a state hospital was not a public charge, but *only* because her family had paid part of the cost of hospitalization and assured the court that it would reimburse the state for the balance.[39] Thus, the fact that she was being treated for a medical condition at public expense would have made her excludable as a public charge if the state were not adequately reimbursed for its expenses in treating her by her family. Other early cases also understood the costs of hospitalization or institutionalization to be a "public charge" issue.[40]

While there have been few recent judicial cases considering the issue of excludability as a "public charge" on the basis of potential medical costs, more recent opinions of the Board of Immigration Appeals are consistent with these judicial precedents in defining medical costs as a public charge, not a public health, issue. For example, in *Matter of B*, the BIA held that an alien admitted to an Illinois mental institution at public expense was not deportable as a public charge because the state provided free mental care to all of its residents.[41] Implicit in its holding was the BIA's view that hospitalization at public expense was a public charge issue in

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38 *Id.* at 511 (emphasis added) (*quoting Ex parte Mitchell*, 256 F. 229 (N.D.N.Y. 1919)).

39 23 F.Supp. 428, 429 (D. Oregon 1938).

40 *See, e.g., Canciamilla v. Haff*, 64 F.2d 875 (9th Cir. 1933) (excluding epileptic alien as public charge because committed to state hospital at public expense); *Fernandez v. Nagle*, 58 F.2d 950 (9th Cir. 1932) (alien who was committed to home for the aged and infirm because too weak and sick to work was a public charge); *United States ex rel. Markin v. Curran, 9 F.2d 900 (2d Cir. 1925)* (excluding alien suffering from syphilis as likely to become a public charge); *United States ex rel. La Fata v. Williams*, 204 F. 848 (S.D.N.Y. 1913) (excluding alien as likely to become a public charge due to valvular heart condition).

41 3 I & N. Dec. 323 (Sept. 10, 1948) (Approved by Atty. Gen).

general. And in *Matter of Harutunian*, a decision that extended the analysis of *Matter of B*, the BIA stated that in the public charge analysis, an alien's physical and mental condition as it affects his or her ability to earn a living is of major significance.[42] Finally, in a more recent BIA opinion, the Board stated that:

> "The traditional test applied by the Service to determining whether an alien is likely to become a public charge is a `prediction based on the totality of the alien's circumstances' as presented in the individual case." [Citation omitted].
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> * * * *
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> "[F]actors that have been considered are the alien's age, capacity to earn a living, *health*, family situation, work history, *affidavits of support*, and other relevant factors."[43]

Thus, a longstanding and unbroken chain of judicial and administrative interpretations of the scope of the "public charge" exclusion confirms that ability to pay potential medical costs is a "public charge" issue. And, as noted above, barring an affirmative expression of a contrary intent, Congress is presumed to have been aware of and endorsed these longstanding constructions of the scope of the "public charge" exclusion in subsequent legislation amending the INA, such as the Refugee Act.

3. *The History of the 1990 Immigration Act and Implementing Regulations Also Confirm that Medical Costs Are A Public Charge Issue.*

Further evidence of the public charge nature of ability to pay medical costs is found in the legislative history of the Immigration Act of 1990 and the PHS regulations promulgated to implement the statute.[44] The 1990 Immigration Act extensively revised 8 U.S.C. § 1182(a), the health-related exclusion of aliens, to remove specific disorders in favor of a focus on the dangers that may be posed by physical and mental disorders. In the change most pertinent

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42 14 I. & N. Dec. 583, 588 (Feb. 28, 1974).

43 *Matter of A*, 19 I. & N. Dec. 867, 869 (Dec. 29, 1988) (emphases added).

44 Pub. L. 101-649, 104 Stat. 4978 (Nov. 29, 1990).

to the issue of the ban on HIV-positive aliens, the public health exclusion was rewritten to focus on "communicable disease[s] of public health significance." Although the nomenclature of this ground for exclusion was changed, the House Judiciary Committee Report accompanying the Act noted with respect to the Attorney General's authority to waive the contagious disease exclusion in 8 U.S.C. § 1182(a):

> "The bill does not repeal the Attorney General's discretionary authority to admit or exclude aliens or exercise waiver authority for certain health conditions. In this regard, the Committee recognizes that the Attorney General may be required to impose certain requirements in order to address possible health threats *or public charge situations*, including follow-up treatments and institutional care. It is expected that HHS and the Attorney General will work closely together in setting guidelines for the imposition of such conditions. Although the Attorney General may impose bonds and other conditions as prerequisites to admissions, such requirements are not to be interpreted so strictly as to undermine the purpose of the bill in this area, namely to make it possible for aliens who do not pose a danger to enter this country."[45]

As the Committee Report makes clear, in the exercise of her waiver authority for certain health conditions, the Attorney General is authorized to impose requirements to address public health threats *or* public charge situations. While criteria 1 and 2 of the INS HIV Waiver Policy are arguably requirements imposed to address the public health threat posed by HIV-positive refugees, criterion 3, the "no governmental cost" requirement, cannot be characterized as anything but a measure to address a "public charge" situation.

The PHS regulations to implement the 1990 Immigration Act's mandate for revision of the exclusions of aliens on health grounds confirm this interpretation. Those regulations recognize two separate categories of public health-related exclusions.[46] In the first category, a Class A Medical Certificate is issued by a doctor in cases where the alien poses a

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[45] H. R. Rep. No. 723(I), 101st Cong., 2d Sess. 53, *reprinted in* 1990 U.S.C.C.A.N. 6710, 6733 (emphasis added).

[46] 56 Fed. Reg. 25000 (May 31, 1991).

threat to herself or the community.[47] An alien issued a Class A Medical Certificate is presumptively excludable as a threat to the public health and can only be admitted if the immigration officer invokes a discretionary waiver. In contrast, in the second category, a Class B Medical Certificate is used to exclude aliens on the basis not of the threat they pose to themselves or the public health, but because of the possibility that the alien might become a public charge due to a medical condition.[48] Indeed, under the heading "Public Charge Exclusion on Health Grounds" in the Federal Register notice implementing Section 601 of the 1990 Immigration Act, which required amendment of the Class B Medical Certificate to its current form, the PHS stated that a physician is to issue a Class B Medical Certificate if the alien has "physical and mental abnormalities which bear on the likelihood of an alien becoming a public charge."[49] In a Class B Medical Certificate case, the examining physician is:

> "required to identify, in addition to any specifically excludable conditions they find in an alien, any physical or mental abnormality, disease, or disability serious in degree or permanent in nature amounting to a departure from normal well-being. Their reports must describe the nature and extent of the abnormality, the degree to which the alien is incapable of normal physical activity, and the extent to which the condition is remediable. They *must also indicate the likelihood, that because of the condition, the applicant will require extensive medical care or institutionalization and state total projected costs of medical care or institutionalization.*"[50]

Thus, even the PHS regulations relating to exclusion as a public charge recognize that consideration of the medical costs associated with care of an alien suffering from a disease or disability is a public charge issue, not a public health factor.

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47 *See* 42 CFR § 34.4(b) (1997).

48 *Id.* § 34.4(c).

49 56 Fed. Reg. at 25001.

50 *Id.* (Emphasis added).

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Congress left the definition of a "public charge" in the INA to administrative, and ultimately judicial, interpretation. In interpreting that term, the courts and BIA have long held that ability to pay medical costs, as opposed to the underlying medical condition that generates those costs, is a public charge issue. Legislating against that longstanding administrative and judicial construction of a "public charge," Congress's exemption of refugees from the "public charge" ground of exclusion in the Refugee Act of 1980 can only be interpreted as exempting refugees from exclusion on the basis of ability to pay medical costs, the very purpose and effect of the INS HIV Waiver Policy's "no governmental cost" criterion.

It is also clear that, notwithstanding the fact that Congress has not defined a "public charge" either generally in the INA or for purposes of the exemption for refugees in the Refugee Act, Congress clearly understood that term to include a refugee's ability to pay the medical costs of a chronic medical condition or disease. The legislative language, history and purpose of the Refugee Act and subsequent legislation all are premised on admission of refugees without regard to the costs of treating their medical conditions. Indeed, even the PHS's regulations for medical examination of aliens recognize that ability to pay medical costs is a "public charge" issue.

II. THE INS HIV WAIVER POLICY IS ARBITRARY AND CAPRICIOUS AND THUS SHOULD NOT BE PROMULGATED AS A REGULATION.

A. Regulations Based on Factors That Congress Expressly Precluded An Agency From Considering Are Arbitrary and Capricious.

Agency rules or regulations that are "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law" are an invalid exercise of the agency's rulemaking

authority.[51] In giving meaning to "arbitrary" and "capricious" for purposes of determining the validity of agency regulations, the Supreme Court has stated that: "an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider * * *."[52] Indeed, an agency rule that relies on factors Congress did not intend the agency to consider is unlawful not only because arbitrary and capricious, but also because it is contrary to law.[53] As the U.S. Court of Appeals for the District of Columbia Circuit has noted, whether classified as contrary to law or arbitrary and capricious:

> "an agency cannot justify a decision by reference to its discretionary authority, if the decision lies beyond the scope of the agency's discretion. * * * * A statute may define as off-limits to an agency a particular basis for a decision, just as it may foreclose a particular result altogether. * * * * Thus, *if an agency rests a decision on statutorily impermissible considerations, a reviewing court must set aside the decision as beyond the scope of the agency's discretion.*"[54]

By incorporating criterion 3 of the INS HIV Waiver Policy into a regulation, the INS would be basing its regulation on a factor Congress expressly has made an impermissible consideration in the exercise of the Attorney General's discretion to grant waivers of the HIV exclusion for refugees.

The Service has conceded in its various guidelines on HIV that the public charge ground of exclusion is inapplicable to refugees.[55] It could not do otherwise given the clear

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51 Administrative Procedures Act § 10, 5 U.S.C. § 706(2)(A).

52 *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (holding that National Highway Traffic Safety Administration's rescission of a passive restraint requirement for automobiles was arbitrary and capricious). *See also Arent v. Shalala*, 70 F.3d 610, 616 (D.C. Cir. 1995).

53 *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402 (1971).

54 *Farmworker Justice Fund, Inc. v. Brock*, 811 F.2d 613, 620 (D.C. Cir. 1987) (emphasis added), *vacated as moot*, 817 F.2d 890 (D.C. Cir. 1987).

55 *See* Aleinikoff Memo, *supra*, 72 Interpreter Releases at 1353.

statement of Congress in section 201(b) of the Refugee Act of 1980 that "public charge" considerations were not to be applied against refugees. By specifically exempting refugees from the public charge ground of excludability, Congress manifested its unambiguous intention that issues of cost to government agencies not serve as a bar to entry for refugees. It would be strange indeed if Congress had enacted the Refugee Act to bring the United States into compliance with its obligations under international agreements to provide protection to refugees, who by definition have fled their homes and property, yet included provisions that would require those same refugees to be self-sufficient upon arrival in the United States. Indeed, Congress expressly recognized that many refugees would require public assistance to meet their medical needs by creating and funding programs to provide refugees with medical care. For the INS and Attorney General to incorporate into regulations the current criterion in the INS HIV Waiver Policy requiring refugees to establish that they will not impose HIV-related medical costs on any governmental agency without the prior consent of an agency, would be to circumvent by regulation the express statutory bar Congress erected. INS should remove the "no governmental cost" criterion from its guidelines and any proposed regulations on waiver determinations for HIV-positive refugees, else it "rel[y] on factors which Congress has not intended it to consider" in promulgating regulations.

CMRA understands that "federalism" concerns have been offered as a rationale for the "no governmental cost" prong of the INS HIV Waiver policy. Clearly, Congress intended the federal government to work in close coordination with state and local governments, as well as private refugee assistance organizations, in assisting refugees to adjust to life in the United States. That said, Congress just as clearly has expressed its intention that refugees, even those who may require public medical assistance, be admitted to the United States without regard to

their ability to pay for their medical costs.[56] By specifically exempting refugees from the public charge ground of exclusion, Congress manifested its intent that refugees be admitted without regard to the potential medical costs HIV-positive or otherwise ill refugees may impose on public health agencies at the local, state or federal level. It is for Congress to balance "federalism" concerns with other interests, including the national refugee assistance policy of the U.S.[57] Having spoken clearly on its desire for refugees to be admitted without regard to their ability to pay medical costs, INS and other Executive branch agencies are not free to circumvent the will of Congress through the introduction of "federalism" or other concerns.

B. The INS HIV Waiver Public Charge Criterion Is Also Arbitrary and Capricious Because It Is Not Applied to Other Medical Conditions That Cost Governmental Agencies As Much or More Than HIV.

Despite repeating the congressional mandate that the public charge exclusion does not apply to refugees, the INS justifies its "no governmental cost" criterion for waiver of the HIV exclusion on the basis of the purported costs of treating HIV-positive refugees over the course of the disease.[58] In addition to the facial contradiction in the INS HIV Waiver Policy, the

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[56] INA § 207(c)(3); 8 U.S.C. § 1157(c)(3).

[57] *See American Textile Manufacturers Institute v. Donovan*, 452 U.S. 490, 509 (1981) (holding that provision of the Occupational Safety and Health Act directing Secretary of Labor to regulate toxic materials "to the extent feasible" precludes the Secretary from using cost-benefit analysis in deciding how to exercise his statutory standard-setting authority because "[a]ny standard based on a balancing of costs and benefits by the Secretary that strikes a different balance than that struck by Congress would be inconsistent with the command set forth in [the OSH Act].)"

[58] *See* Aleinikoff Memo, *supra*, 72 Interpreter Releases at 1349. The Aleinikoff Memo notes that:

> "[The Public Health Service] has determined that HIV infection gives rise to the possibility that the applicant will develop AIDS and that he or she will eventually require hospitalization or other type of medical care at some point in the future. Consequently, those who qualify for a discretionary waiver of excludability for

governmental cost criterion also is arbitrary and capricious because it selectively requires refugees infected with HIV to establish their ability to pay medical costs, while imposing no such condition on other refugees with chronic diseases that potentially cost as much or more than HIV/AIDS to treat over the course of the disease. Such a selective exercise of the Attorney General's discretion to grant waivers for refugees under INA § 207(c)(3) is irrational, and if incorporated into a formal agency rule, would be invalid as an arbitrary and capricious exercise of agency rulemaking authority.

As noted *supra*, Section 10 of the Administrative Procedures Act prohibits agency actions that are "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law."[59] While the scope of review by a court of agency action under the arbitrary and capricious standard is narrow, an agency must "examine the relevant data and articulate a satisfactory explanation for its action."[60] Under this standard, an agency action or regulation that treats similarly situated parties differently must be adequately explained or it will be set aside as arbitrary and capricious.[61] The purpose of the rule against disparate treatment of similarly

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> HIV infection must also establish that the burden of supporting them during the course of their illness will not rest on the public. According to PHS, the average cost of medical treatment for an HIV-infected person through the course of the illness is approximately U.S. $85,000. Examiners should note that HIV infection does not automatically result in a finding that an applicant is likely to become a public charge; however, in reviewing each case, a reasonable calculation of the applicant's future ability to pay the expected costs of the illness should be made. In addition to the medical expenses, a reasonable calculation of the applicant's ability to meet basic living expenses should also be made."

[59] 5 U.S.C. § 706(A)(2).

[60] *State Farm, supra,* 463 U.S. at 43.

[61] *See Petroleum Communications, Inc. v. Federal Communications Comm'n,* 22 F.3d 1164, 1172 (D.C. Cir. 1994); *Chadmoore Communications, Inc. v. Federal Communications Comm'n,* 113 F.3d 235, 242 (D.C. Cir. 1997).

situated parties is "to prevent an agency from, inter alia, `vacillat[ing] without reason in its application of a statute or the implementing regulations.'"[62] Absent an adequate explanation by the agency for its disparate treatment of similarly situated parties, agency action will be set aside as arbitrary and capricious.[63]

Despite the fact that the INS HIV Waiver Policy has been in effect for over a decade, the Service has not provided any basis for concluding that HIV-positive refugees are distinct from refugees suffering from other chronic medical conditions in their inability to pay for the costs of their medical treatment. Asymptomatic HIV-positive refugees are likely to be able to work, and thus to contribute to their medical costs and upkeep, for many years.[64] Moreover, empirical evidence in fact demonstrates that other diseases cost more to treat and have a greater incidence in the refugee population.[65] Without some reasoned explanation for imposing an ability to pay health care cost condition on HIV-positive refugees, when refugees suffering from other chronic medical conditions face no such obstacle, the INS HIV Waiver Policy is arbitrary and capricious and should not be promulgated as an agency rule.

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62 *Chadmoore Communications*, 113 F.3d at 242 (citation omitted).

63 *Id.*

64 *See* Sarah N. Qureshi, *Global Ostracism of HIV-Positive Aliens: International Restrictions Barring HIV-Positive Aliens*, 19 Md. J. Int'l L. & Trade 81, 84 (1995) (noting that the long incubation period of HIV results in most HIV-positive persons remaining asymptomatic for five to eight years).

65 *See, e.g.*, Christine N. Cimini, Note, *The United States Policy on HIV Infected Aliens: Is Exclusion an Effective Solution?*, 7 Conn. J. Int'l L. 367, 384 (1992); Website of the American Liver Foundation, http://gi.ucsf.edu/ALF/pubs/progtxcost.html, visited Oct. 27, 1998; *see also* "The Cost of Treating HIV/AIDS," Website of Milliman & Robertson: Actuaries & Consultants, http://www.blueworld.com/milliman/publications/reports/HRR26/CoT_AIDS.htm, visited Nov. 10, 1998.

III. THE INS HIV WAIVER POLICY IS UNLAWFUL BECAUSE IT IS IN DEROGATION OF UNITED STATES' INTERNATIONAL OBLIGATIONS.

As a signatory to the Protocol Relating to the Status of Refugees, the United States agreed to be bound by the substantive provisions of the Convention Relating to the Status of Refugees without respect to the country of origin of the refugee.[66] The Protocol defines a refugee by reference to the Convention as:

> "any person who * * * owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return it." [67]

This definition tracks almost verbatim the definition of a refugee added to INA § 101(a)(42), by the Refugee Act of 1980. Indeed, as the Supreme Court has observed, enactment of the Refugee Act was intended primarily to bring U.S. refugee law into compliance with U.S. international obligations under the Protocol and Convention.[68]

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[66] 19 U.S.T. 6224, T.I.A.S. 6577, *done* Jan. 31, 1967, *entered into force* Nov. 1, 1968. The Convention Relating to the Status of Refugees, T.I.A.S. 6577, 189 U.N.T.S. 150 (July 28, 1951), to which the U.S. never formally acceded, was limited by its definition of a "refugee" as a person who had a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion" because "of *events occurring before 1 January 1951*" either "*in Europe*" or "in Europe and elsewhere." Convention Art. I(A) & (B) (emphases added). The Protocol essentially amended the Convention to remove any geographic or temporal limitation in the Convention, but expressly incorporated articles 2 to 34 of the Convention into the Protocol. Thus, although the United States was never a State Party to the Convention, its ratification of the Protocol bound it to observe articles 2 through 34 of the Convention with respect to any refugee who qualifies under the Convention's definition, as modified by the Protocol.

[67] Convention, art. I, as modified by Protocol, art. I(2).

[68] *INS v. Cardoza-Fonseca*, 480 U.S. 421, 436-37 (1986) ("If one thing is clear from the legislative history of the * * * entire 1980 [Refugee] Act, it is that one of Congress' primary purposes was to bring United States refugee law into conformance with the 1967 United Nations

The central element of the Protocol is the principle of "non-refoulement," meaning that no Party "shall expel or return ('refouler') a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened * * *."[69] In the case of persons affected by criterion 3 of the INS HIV Waiver Policy, these people have already been adjudicated to have a "well-founded fear of persecution" and thus to be refugees deserving of protection under the Protocol and Convention. The only ground on which the United States denies them protection is that they may impose costs upon a local, state or federal agency by virtue of a disease. By imposing this condition upon persons who fully qualify as refugees under the Protocol's definition, the United States puts those refugees in danger of forced repatriation ("refoulement") because many countries of first asylum will not permit HIV-positive refugees to reside within their borders. Thus, when a refugee flees his or her country of nationality into a country of first asylum that prohibits HIV-positive aliens from residing therein, the INS HIV Waiver Policy operates to preclude resettlement in what may be the refugee's only viable option - the United States.

The United Nations High Commissioner for Refugees, who has been delegated primary responsibility for implementation of the Protocol and Convention, has criticized national HIV-exclusion policies on these very grounds.[70] In a 1988 Policy Statement, the High

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Protocol Relating to the Status of Refugees, 19 U.S.T. 6223, T.I.A.S. No. 6577, to which the United States acceded in 1968." (footnote omitted).

[69] Convention, art. 33, 19 U.S.T. at 6276.

[70] The U.N. General Assembly passed the Statute of the Office of the United Nations High Commissioner for Refugees on December 14, 1950, charging the UNHCR with, *inter alia*, "[p]romoting the conclusion and ratification of international conventions for the protection of refugees, supervising their application and proposing amendments thereto;" and "[p]romoting the admission of refugees, not excluding those in the most destitute categories, to the territories of States." ¶¶ 8(a) & (d). Indeed, for purposes of U.S. law, the Supreme Court has accorded the

Commissioner spelled out the legal and policy grounds against screening and exclusion of refugees for HIV and/or AIDS.[71] The High Commissioner noted that:

> "[e]ven if express provisions [on the chronically sick or disabled] are absent from the Convention and the Statute, these instruments provide the framework within which the problems of sick and disabled refugees must be resolved; namely, international protection predicated upon the basic principle of non-refoulement and durable solutions premised upon international co-operation and solidarity.
>
> "Fundamental principles of human rights provide further, and occasionally more specific, guidance as to the policies and practices appropriate to the resolution of the problems of refugees who are chronically sick, or who suffer from infectious diseases."[72]

Drawing on this framework and principles, the High Commissioner concluded that:

> "In so far as they have an impact on refugees and asylum-seekers, national and other measures taken to combat AIDS and to prevent the spread of HIV infection must be related to the overall objectives of the international system, namely, protection and solutions. Every aspect of the refugee's life, from the moment of flight to return home or assimilation in a new national community, may be affected. Screening for example may result in refoulement, refusal to grant protection or denial of refugees' right to return voluntarily to their country of origin."

UNHCR's interpretation of the Convention and Protocol significant deference when construing U.S. obligations under the Protocol and implementing legislation. *See INS v. Cardoza-Fonseca*, 480 U.S. 421, 439 n.22 (1987) ("the [UNHCR's] Handbook provides significant guidance in construing the Protocol, to which Congress sought to conform. It has been widely considered useful in giving content to the obligations that the Protocol establishes."). Thus, when the UNHCR criticizes the INS HIV Waiver Policy as applied to refugees, it is more than just an expression of the viewpoint of a disinterested international agency; it is an interpretation of the obligations the U.S. has assumed under the Refugee Protocol and Convention that is entitled to significant deference.

[71] *UNHCR Policy and Guidelines regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS)*, UNHCR/IOM/70/88; UNHCR/FOM/63/88, (May 6, 1988).

[72] *Id.*

The High Commissioner explained how discrimination against HIV-positive refugees either on the basis of fear of their disease or of the costs of treating the disease undermines the framework established under the Convention and Protocol for protection of refugees:

> "It may be assumed that the ordinary non-national, denied admission because of testing HIV seropositive, can return to the support system of his or her own community. That possibility is denied to the refugee, for whom a waiver is the only alternative to indefinite orbit or return to persecution. In the resettlement context, waivers will be required as a matter of policy, often for specific groups of refugees. Without systematic waivers, established first asylum and transit practices will be subverted by the apprehensions of receiving countries. Lives will also be lost, for example, through failure to rescue at sea when disembarkation schemes premised on resettlement guarantees collapse, because of third country unwillingness to accept those with HIV infection.
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> * * * * The economic costs of admission and care must be seen as essential to overall international efforts as has long been the case for physically and mentally disabled refugees. [73]

In commenting more recently on the effect of national policies that serve to exclude HIV-positive refugees, the Executive Committee of the High Commissioner's Programme has reaffirmed the contradiction between international refugee protection obligations and national bans on admission of HIV-positive refugees: "UNHCR is concerned about refugees who are rejected by resettlement countries on the basis of their HIV status, especially when rejections lead to risk of *refoulement*, detention or persecution in the country of first asylum or refuge."[74]

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[73] *Id.*

[74] "Resettlement: An Instrument of Protection and a Durable Solution," 3rd Meeting, Standing Committee, Executive Committee of the High Commissioner's Programme, ¶ 12, 28 May 1996, EC/46/SC/CRP.32, *available at* www.unhcr.ch/refworld/unhcr/excom/standcom/1996/32.htm. The UNHCR made the same point in its comments submitted to HHS on its ultimately unsuccessful January 23, 1991 proposal to remove HIV from the list of excludable diseases:

> "This principle [of nonrefoulement] is jeopardized by medical screening programs that contribute to the creation of an international impasse: the refugee cannot remain indefinitely incarcerated in a refugee camp in the country of first asylum, (s)he is denied resettlement solely on the grounds of a chronic health condition, and (s)he cannot return home where his or her life or freedom would be

According to UNHCR officials, a number of countries have policies requiring reporting of HIV-positive refugees, which result in detention and deportation of such refugees.[75]

Indeed, in specifically considering the U.S. exclusion of HIV-positive aliens as applied to refugees, the U.N High Commissioner for Refugees has gone so far as to urge the U.S. to abrogate its exclusion of HIV-positive refugees. In 1990, then-U.N. High Commissioner for Refugees Thorvald Stoltenberg asked the U.S. to end its policy of screening refugees seeking resettlement in the U.S. for the HIV virus because:

> "[w]ith respect to legal protection concerns, the special situation of refugees must be given due consideration. Refugees constitute a particularly vulnerable category of persons given the fact that their very status as refugees means that they are denied the protection of their countries of origin. In concrete terms, they cannot return to these countries of origin. If adopted by all receiving countries, mandatory screening of refugees prior to resettlement would deny a durable solution, resettlement, and would threaten a temporary solution, first asylum. By doing this, screening puts in danger the most basic and inalienable right of refugees: the right to non-refoulement or safety from persecution."[76]

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threatened." Comments of the Office of the U.N. High Commissioner for Refugees, Feb. 21, 1991, on "Medical Examination of Aliens," 56 Fed. Reg. 2482 (Jan. 23, 1991).

[75] While UNHCR would not specify which countries have policies that result in deportation of HIV-positive refugees, a number of countries have policies or regulations prohibiting admission of HIV-positive aliens in general. *See, e.g.*, Peri H. Alkas & Wayne X. Shandera, "HIV and AIDS in Africa: African Policies in Response to AIDS In Relation to Various National Legal Traditions," 17 *J. Leg. Med.* 527, 541-542 (1996) (listing Libya and Mauritius as countries that exclude HIV-infected persons "outright" for purposes of tourism, employment and permanent residence); Sarah N. Qureshi, Note and Comment, "Global Ostracism of HIV-Positive Aliens: International Restrictions Barring HIV-Positive Aliens," 19 *Md. J. Int'l L. & Trade* 81, 93 (1995) (noting that "China, * * * Japan and Vietnam routinely denied entry to carriers of the AIDS virus.").

[76] Letter from Thorvald Stoltenberg, United Nations High Commissioner for Refugees, to James A. Baker, III, Secretary of State, Aug. 24, 1990, at 2. Identical letters were sent to, *inter alia*, HHS Secretary Louis Sullivan and Attorney General Richard Thornburgh.

As the High Commissioner subsequently made clear in his letter, his office would continue attempts "to convince other Nations [including the United States] *to follow internationally acceptable guidelines* in their legislation and practices with regard to HIV-infected refugees." [77] The clear implication of the High Commissioner's diplomatic language is that the U.S. HIV-positive refugee policy is *not* internationally acceptable. The INS should drop the "no governmental cost" criterion from any rule it proposes on exercise of the Attorney General's waiver authority for HIV-positive refugees. To do otherwise would be to risk undermining the international obligations the U.S. assumed in acceding to the Refugee Protocol.

CONCLUSION

Congress enacted the Refugee Act of 1980 to provide a systematic and regular procedure to give effect to the historic commitment of the United States to refugees. As victims of persecution on the basis of race, religion, nationality, political opinion, or membership in a particular social group, refugees of necessity often flee their country leaving behind all of their possessions and property. Congress recognized this fact when it enacted the Refugee Act, providing for a variety of social services for refugees resettled in the United States, including funding for medical care. Most significantly, Congress specifically prohibited the consideration of "public charge" issues with respect to the admission of refugees, again in recognition of the fact that refugees leave their homelands not of choice but of necessity.

The INS HIV Waiver Policy operates to exclude most HIV-positive refugees who cannot meet that policy's "no governmental cost" criterion. In enacting the exemption from the public charge ground of exclusion in the Refugee Act of 1980, Congress was aware of the significant number of refugees who would require resettlement in the U.S., but would not have

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[77] *Id.* (Emphasis added).

the financial resources to pay for care of chronic medical conditions or disease. Congress made clear, however, that the only refugees to be denied admission on public health grounds were those that posed a risk to the public health of the U.S. because of the communicable nature of their disease. Longstanding judicial construction of the "public charge" exclusion, and the legislative language, history and purpose of the Refugee Act and subsequent legislation, all confirm that Congress intended refugees to be admitted to the U.S. *without* regard for their ability to pay for their medical costs.

In addition to the fact that Congress intended for refugees to be admitted without regard to their ability pay medical costs, it would be arbitrary and capricious for the INS to exclude HIV-positive refugees on the basis of their ability to pay the costs of treating their disease. Consideration of a factor in the Attorney General's waiver determination that Congress expressly precluded from entering into the refugee admission decision would be arbitrary and capricious, as well as contrary to law. Thus, any agency rule incorporating such public charge considerations would be unlawful. Moreover, application of a condition for exercise of the Attorney General's waiver authority only to HIV-positive refugees also would be arbitrary and capricious because selectively applied. Notwithstanding the deference traditionally paid to agency rulemaking authority, an agency rule that treats similarly situated parties differently without some reasoned explanation is clearly arbitrary and capricious.

Finally, the INS HIV Waiver Policy contradicts the international obligations the U.S. has assumed as a party to the Protocol Relating to the Status of Refugees. As the U.N. High Commissioner has made clear in several different forums, exclusion of HIV-positive refugees threatens the ability of the international refugee system to effectively resettle refugees, ultimately risking the refoulement of those refugees to their countries of persecution. Indeed, as the U.N.

agency charged with primary responsibility for interpretation and enforcement of refugee protection agreements, the High Commissioner has gone so far as to criticize the U.S. HIV Waiver policy directly as internationally unacceptable.

Because the "no governmental cost" criterion of the INS HIV Waiver Policy is contrary to congressional intent, arbitrary and capricious, and in derogation of U.S. international obligations, CMRA respectfully requests that INS omit this criterion from any rule it promulgates.

Ryan White reauth

1) tx protocols
2) children

SLT - Refugee camp visit?