Lavender Law 2017
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Overview of Immigrant Eligibility for Federal Programs

By Tanya Broder, Avideh Moussavian, *and* Jonathan Blazer *DECEMBER 2015*

The major federal public benefits programs have always left some non–U.S. citizens out of eligibility for assistance from the programs. Since their inception, programs such as the Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamp Program), nonemergency Medicaid, Supplemental Security Income (SSI), and Temporary Assistance for Needy Families (TANF) and its precursor, Aid to Families with Dependent Children (AFDC), have been inaccessible to undocumented immigrants and people in the United States on temporary visas.

However, the 1996 federal welfare and immigration laws introduced an unprecedented new era of restrictionism.[1] Prior to these laws' enactment, lawful permanent residents of the U.S. generally were eligible for assistance in a manner similar to U.S. citizens. After these laws' enactment, most lawfully residing immigrants were barred from receiving assistance under the major federal benefits programs for five years or longer. Even where eligibility for immigrants was preserved by the 1996 laws or restored by subsequent legislation, many immigrant families hesitate to enroll in critical health-care, job-training, nutrition, and cash-assistance programs due to fear and confusion caused by the laws' chilling effects. As a result, the participation of immigrants in public benefits programs decreased sharply after passage of the 1996 laws, causing severe hardship for many low-income families who lacked the support available to other low-income families.[2]

This article focuses on eligibility and other rules governing immigrants' access to federal public benefits programs. Many states have attempted to fill some of the gaps in noncitizen coverage resulting from the 1996 laws, either by electing federal options to cover more eligible noncitizens or by spending state funds to cover at least some of the immigrants who are ineligible for federally funded services. Many state-funded programs, however, have been reduced or eliminated in state budget battles. Some of these cuts have been challenged in court.[3]

[1] Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (hereinafter "welfare law"), Pub. L. No. 104– 193, 110 Stat. 2105 (Aug. 22, 1996); and Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (hereinafter "IIRIRA"), enacted as Division C of the Defense Department Appropriations Act, 1997, Pub. L. No. 104–208, 110 Stat. 3008 (Sept. 30, 1996).

[2] Michael Fix and Jeffrey Passel, *The Scope and Impact of Welfare Reform's Immigrant Provisions* (Discussion Paper No. 02-03) (The Urban Institute, Jan. 2002), www.urban.org/publications/410412.html.

[3] A state's denial of benefits to lawfully present immigrants may be unconstitutional, even if apparently authorized by the 1996 welfare law. See, e.g., *Aliessa v. Novello*, 96 N.Y.2d 418 (N.Y. 2001) (New York's denial of health coverage to lawfully residing immigrants violated federal and state Equal Protection clauses, as well as state constitutional obligation to care for the needy); *Ehrlich v. Perez*, 394 MD. 691 (Md. 2006) (enjoining Maryland's termination of health coverage to lawfully residing children and pregnant women); *Finch v. Commonwealth Health Ins. Connector Auth.*, 461 Mass. 232 (Mass. 2012) (striking Massachusetts law that denied state health care coverage to certain lawfully present immigrants). But see *Pham v. Starkowsky*, 300 Conn. 412 (Conn. 2011) (Connecticut's termination of health coverage to lawfully residing immigrants did not constitute discrimination on the basis of alienage); *Soskin v. Reinertson*, 353 F.3d 1242 (10th Cir. 2004); *Pimentel v. Dreyfus*, 670 F.3d 1096 (9th Cir. 2012) (upholding Washington's denial of state SNAP benefits to certain lawful immigrants); *Bruns v. Mayhew*, 750 F.3d 61 (1st Cir. 2014) (Maine's termination of state medical assistance for those not eligible for Medicaid did not violate Equal Protection).

Even where the courts failed to find an Equal Protection violation, however, some states decided to preserve or restore access to benefits. For example, the Colorado legislature chose to

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In determining an immigrant's eligibility for benefits, it is necessary to understand the federal rules as well as the rules of the state in which an immigrant resides. Updates on federal and state rules are available on NILC's website.[4]

Immigrant Eligibility Restrictions

Categories of Immigrants: "Qualified" and "Not Qualified"

The 1996 welfare law created two categories of immigrants for benefits eligibility purposes: "qualified" and "not qualified." Contrary to what these names suggest, the law excluded most people in *both* groups from eligibility for many benefits, with a few exceptions. The "qualified" immigrant category includes:

- lawful permanent residents, or LPRs (people with green cards)
- refugees, people granted asylum or withholding of deportation/removal, and conditional entrants
- people granted parole by the U.S. Department of Homeland Security (DHS) for a period of at least one year
- Cuban and Haitian entrants
- certain abused immigrants, their children, and/or their parents [5]
- certain survivors of trafficking [6]

All other immigrants, including undocumented immigrants, as well as many people who are lawfully present in the U.S., are considered "not qualified."[7]

In the years since the initial definition became law, there have been a few expansions of access to benefits beyond the qualified immigrant categories. In 2000, Congress established a new category of noncitizens—survivors of trafficking—who are eligible for federal public benefits to the same extent as refugees, regardless of whether they have a qualified immigrant status.[8] In 2003, Congress clarified that "derivative beneficiaries" listed on trafficking victims' visa applications (spouses and children of adult trafficking survivors;

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restore Medicaid eligibility before any individual's coverage was terminated; Hawaii similarly restored health coverage for certain noncitizens; and Washington continued to provide nutritional assistance to immigrants ineligible for federal SNAP, albeit at a lower benefit level.

[4] *Guide to Immigrant Eligibility for Federal Programs* update page, www.nilc.org/issues/economic-support/updatepage/.

[5] To be considered a "qualified" immigrant under the battered spouse or child category, the immigrant must have an approved visa petition filed by a spouse or parent, a self-petition under the Violence Against Women Act (VAWA) that has been approved or sets forth a prima facie case for relief, or an approved application for cancellation of removal under VAWA. The spouse or child must have been battered or subjected to extreme cruelty in the U.S. by a family member with whom the immigrant resided, or the immigrant's parent or child must have been subjected to such treatment. The immigrant must also demonstrate a "substantial connection" between the domestic violence and the need for the benefit being sought. And the battered immigrant, parent, or child must not be living with the abuser. While many U visa–holders are domestic violence survivors, U visa–holders are not considered qualified battered immigrants under this definition.

[6] Survivors of trafficking and their derivative beneficiaries who obtain a T visa or whose application for a T visa sets forth a prima facie case are considered "qualified" immigrants. This group was added to the definition of "qualified" by the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008, Pub. L. 110–457, § 211 (Dec. 23, 2008), http://tinyurl.com/23otojy.

[7] Throughout the remainder of this article, *qualified* will be understood to have this particular meaning, as will *not-qualified*; they will not be enclosed in quotation marks.

Before 1996, some of these immigrants were served by benefit programs under an eligibility category called "permanently residing in the U.S. under color of law" (PRUCOL). PRUCOL is not an immigration status, but a benefit eligibility category that has been interpreted differently depending on the benefit program and the region. Generally, it means that the Dept. of Homeland Security (DHS) is aware of a person's presence in the U.S. but has no plans to deport or remove him or her from the country. A few states, including California and New York, continue to provide services to immigrants meeting this definition using state or local funds.

[8] The Victims of Trafficking and Violence Protection Act of 2000, Pub. L. No. 106–386, § 107 (Oct. 28, 2000). Federal agencies are required to provide benefits and services to individuals who have been subjected to a "severe form of trafficking in persons" to the same extent as refugees, without regard to their immigration status. To receive these benefits, the survivor must be either under 18 years of age or certified by the U.S. Dept. of Health and Human Services (HHS) as willing to assist in the investigation and prosecution of severe forms of trafficking in persons. In the certification, HHS confirms that the person either (a) has made a bona fide application for a T visa that has not been denied, or (b) is a person whose continued presence in the U.S. is being ensured by the attorney general in order to prosecute traffickers in persons.

spouses, children, parents, and minor siblings of child survivors) also may secure federal benefits.[9]

Federal Public Benefits Generally Denied to "Not Qualified" Immigrants

With some important exceptions detailed below, the law prohibits not-qualified immigrants from enrolling in most federal public benefit programs.[10] Federal public benefits include a variety of safety-net services paid for by federal funds.[11] But the welfare law's definition does not specify which particular programs are covered by the term, leaving that clarification to each federal benefit–granting agency. In 1998, the U.S. Department of Health and Human Services (HHS) published a notice clarifying which of its programs fall under the definition.[12] The list of 31 HHS programs includes Medicaid, the Children's Health Insurance Program (CHIP), Medicare, TANF, Foster Care, Adoption Assistance, the Child Care and Development Fund, and the Low-Income Home Energy Assistance Program. Any new programs must be designated as federal public benefits in order to trigger the associated eligibility restrictions and, until they are designated as such, should remain open to broader groups of immigrants.

The HHS notice clarifies that not every benefit or service provided within these programs is a federal public benefit. For example, in some cases not all of a program's benefits or services are provided to an individual or household; they may extend, instead, to a community of people—as in the weatherization of an entire apartment building.[13]

The welfare law also attempted to force states to pass additional laws, after August 22, 1996, if they choose to provide state public benefits to certain immigrants.[14] Such micromanagement of state affairs by the federal government is potentially unconstitutional under the Tenth Amendment.[15]

Exceptions to the Restrictions

The law includes important exceptions for certain types of services. Regardless of their status, not-qualified immigrants are eligible for emergency Medicaid[16] if they are otherwise eligible for their state's Medicaid program.[17] The law does not restrict access to public health programs that provide immunizations and/or treatment of communicable disease symptoms (whether or not those symptoms are caused by such a disease). School breakfast and lunch programs remain open to all children regardless of immigration status, and every state has opted to provide access to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).[18]

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[9] Trafficking Victims Protection Reauthorization Act of 2003, Pub. L. No. 108–193, § 4(a)(2) (Dec. 19, 2003).

[10] Welfare law § 401 (8 U.S.C. § 1611).

[11] "Federal public benefit" is described in the 1996 federal welfare law as (a) any grant, contract, loan, professional license, or commercial license provided by an agency of the U.S. or by appropriated funds of the U.S., and (b) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment, benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the U.S. or appropriated funds of the U.S.

[12] HHS, Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), "Interpretation of 'Federal Public Benefit,'" 63 FR 41658–61 (Aug. 4, 1998). The HHS notice clarifies that not every benefit or service provided within these programs is a federal public benefit.

[13] HHS, Division of Energy Assistance, Office of Community Services, Memorandum from Janet M. Fox, Director, to Low Income Home Energy Assistance Program (LIHEAP) Grantees and Other Interested Parties, re. Revision-Guidance on the Interpretation of "Federal Public Benefits" Under the Welfare Reform Law (June 15, 1999).

[14] Welfare law § 411 (8 U.S.C. § 1621).

[15] See, e.g., *Matter of Application of Cesar Adrian Vargas for Admission to the Bar of the State of New York* (2015 NY Slip Op 04657; decided on June 3, 2015, Appellate Division, Second Department Per Curiam) (holding that the requirement under 8 U.S.C. § 1621(d) that states must pass legislation in order to opt-out of the federal prohibition on issuing professional licenses — in this case, admission to the New York State bar — to undocumented immigrants infringes on New York State's 10th amendment rights)

[16] Emergency Medicaid covers the treatment of an emergency medical condition, which is defined as "a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions: or (C) serious dysfunction of any bodily organ or part." 42 U.S.C. § 1396b(v).

[17] Welfare law § 401(b)(1)(A) (8 U.S.C. § 1611(b)(1)(A)).

[18] Welfare law § 742 (8 U.S.C. § 1615).

Short-term noncash emergency disaster assistance remains available without regard to immigration status. Also exempted from the restrictions are other in-kind services necessary to protect life or safety, as long as no individual or household income qualification is required. In 2001, the U.S. attorney general published a final order specifying the types of benefits that meet these criteria. The attorney general's list includes child and adult protective services; programs addressing weather emergencies and homelessness; shelters, soup kitchens, and meals-on-wheels; medical, public health, and mental health services necessary to protect life or safety; disability or substance abuse services necessary to protect life or safety; and programs to protect the life or safety of workers, children and youths, or community residents.[19]

Verification Rules

When a federal agency designates a program as a federal public benefit foreclosed to not-qualified immigrants, the law requires the state or local agency to verify the immigration and citizenship status of all program applicants. However, many federal agencies have not specified which of their programs provide federal public benefits. Until they do so, state and local agencies that administer the programs are not obligated to verify the immigration status of people who apply for them.

And under an important exception contained in the 1996 immigration law, nonprofit charitable organizations are not required to "determine, verify, or otherwise require proof of eligibility of any applicant for such benefits." This exception relates specifically to the immigrant benefits restrictions in the 1996 welfare and immigration laws.[20]

Eligibility for Major Federal Benefit Programs

Congress restricted eligibility even for many qualified immigrants by arbitrarily distinguishing between those who entered the U.S. before or "on or after" the date the law was enacted, August 22, 1996. The law barred most immigrants who entered the U.S. on or after that date from "federal means-tested public benefits" during the five years after they secure qualified immigrant status.[21] Federal agencies clarified that "federal means-tested public benefits" are Medicaid (except for emergency care), CHIP, TANF, SNAP, and SSI.[22]

TANF, Medicaid, and CHIP

States can receive federal funding for TANF, Medicaid, and CHIP to serve qualified immigrants who have completed the federal five-year bar.[23] Refugees, people granted asylum or withholding of deportation/removal, Cuban/Haitian entrants, certain Amerasian immigrants,[24] Iraqi and Afghan Special Immigrants,[25] and

[19] U.S. Dept. of Justice (DOJ), "Final Specification of Community Programs Necessary for Protection of Life or Safety under Welfare Reform Legislation," A.G. Order No. 2353– 2001, published in 66 FR 3613–16 (Jan. 16, 2001).

[20] IIRIRA § 508 (8 U.S.C. § 1642(d)).

[21] Welfare law § 403 (8 U.S.C. § 1613).

[22] HHS, Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), "Interpretation of 'Federal Means-Tested Public Benefit,'" 62 FR 45256 (Aug. 26, 1997); U.S. Dept. of Agriculture (USDA), "Federal Means Tested Public Benefits," 63 FR 36653 (July 7, 1998). The CHIP program, created after the passage of the 1996 welfare law, was later designated as a federal means-tested public benefit program. See Health Care Financing Administration, "The Administration's Response to Questions about the State Child Health Insurance Program," Question 19(a) (Sept. 11, 1997).

[23] States were also given an option to provide or deny federal TANF and Medicaid to most qualified immigrants who were in the U.S. before Aug. 22, 1996, and to those who enter the U.S. on or after that date, once they have completed the federal five-year bar. Welfare law § 402 (8 U.S.C. § 1612). Only one state, Wyoming, denies Medicaid to immigrants who were in the country when the welfare law passed. Colorado's proposed termination of Medicaid to these immigrants was reversed by the state legislature in 2005 and never took effect. In addition to Wyoming, five states (Alabama, Mississippi, North Dakota, Texas, and Virginia) do not provide Medicaid to all qualified immigrants who complete the federal five-year ban. Texas and Virginia, however, provide health coverage to lawfully residing children, regardless of their date of entry into the U.S. Five states (Indiana, Mississippi, Ohio, South Carolina, and Texas) fail to provide TANF to all qualified immigrants who complete the federal five-year waiting period.

[24] For purposes of the exemptions described in this article, the term *Amerasians* applies only to individuals granted lawful permanent residence under a special statute enacted in 1988 for Vietnamese Amerasians. See § 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in § 101(c) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in Title II of the Foreign Operations, Export

survivors of trafficking are exempt from the five-year bar, as are qualified immigrant veterans, active duty military, and their spouses and children. In addition, children who receive federal foster care are exempt from the five-year bar for Medicaid.

Over half of the states have used state funds to provide TANF, Medicaid, and/or CHIP to some or all of the immigrants who are subject to the five-year bar on federally funded services, or to a broader group of immigrants.[26] Several states or counties provide health coverage to children or pregnant women, regardless of their immigration status.

In 2009, when Congress first reauthorized the CHIP program, states were granted an option to provide federally funded Medicaid and CHIP to "lawfully residing" children and pregnant women, regardless of their date of entry into the U.S.[27] Twenty-nine states plus the District of Columbia (as of September 2015) have opted to take advantage of this federal funding for immigrant health care coverage, [28] which became available on April 1, 2009.

CHIP was reauthorized in April 2015 for an additional two years without any changes to immigrant coverage.

Sixteen states plus the District of Columbia use federal funds to provide prenatal care to women regardless of immigration status, under the CHIP program's option enabling states to enroll fetuses in CHIP. Thus the pregnant woman's fetus, rather than the woman herself, is technically the recipient of CHIP-funded services. This approach potentially limits the scope of services available to the pregnant woman to those directly related to the fetus's health.

The District of Columbia and New York provide prenatal care to women regardless of immigration status, using state or local funds.

Although the federal health care reform law, known as the Affordable Care Act (ACA),[29] did not alter immigrant eligibility for Medicaid or CHIP, it provided new pathways for lawfully present immigrants to obtain health insurance. Coverage purchased in the ACA's health insurance marketplaces is available to lawfully present noncitizens who are ineligible for Medicaid.[30]

SNAP

Although the 1996 law severely restricted immigrant eligibility for the Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamp Program), subsequent legislation restored access for many immigrants. Qualified immigrant children, refugees, people granted asylum or withholding of deportation/removal, Cuban/Haitian entrants, certain Amerasian immigrants, Iraqi and Afghan special immigrants, survivors of trafficking, qualified immigrant veterans, active duty military, and their spouses and children, lawful permanent residents with credit for 40 quarters of work history, certain Native Americans, lawfully residing Hmong and Laotian tribe members, and immigrants receiving disability-related assistance are eligible regardless of their date of entry into the U.S.[31] Qualified immigrant seniors who were born

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Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended).

[25] Iraqis and Afghans granted Special Immigrant Visas under § 1244(g) of the Refugee Crisis in Iraq Act of 2007 (subtitle C of title XII of division A of Public Law 110-181; 122 Stat. 398) or § 602(b)(8) of the Afghan Allies Protection Act of 2009 (title VI of division F of Public Law 111- 8; 123 Stat. 809) are now eligible for benefits to the same extent as refugees. Department of Defense Appropriations Act, 2010, Pub. L. No. 111-118, §8120 (Dec. 19, 2009).

[26] See *Guide to Immigrant Eligibility for Federal Programs*, 4th ed. (National Immigration Law Center, 2002), and updated tables at www.nilc.org/issues/economic-support/updatepage/.

[27] Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (H.R.2), Public Law 111-3 (Feb. 4, 2009).

[28] Post-partum care is not covered by these federal funds unless a state normally pays for this care as part of a bundled payment or global fee method. HHS Letter to State Health Officials (Nov. 12, 2002). See also *Medical Assistance Programs for Immigrants in Various States* (National Immigration Law Center, Sep. 2015), www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states-2015-09.pdf.

[29] Pub. Law No. 111-148, as amended by the Health Care and Education Act of 2010, Pub. Law No. 111-152. For more information about immigrant eligibility for coverage under the Affordable Care Act, see *Immigrants and the Affordable Care Act (ACA)* (NILC, Jan. 2014), www.nilc.org/issues/health-care/immigrantshcr/.

[30] For more information on the ACA, please see NILC's fact sheets at www.nilc.org/issues/health-care/acafacts/.

[31] For the purpose of "immigrants receiving disability-related assistance," disability-related programs include SSI, Social Security disability, state disability or retirement pension, railroad retirement disability, veteran's disability, disability-

before August 22, 1931, may be eligible if they were lawfully residing in the U.S. on August 22, 1996. Other qualified immigrant adults, however, must wait until they have been in qualified status for five years before they can secure critical nutrition assistance.

Five states—California, Connecticut, Maine, Minnesota, and Washington—continue to provide state-funded nutrition assistance to some or all of the immigrants who were rendered ineligible for the federal SNAP program.[32]

Supplemental Security Income (SSI)

Congress imposed its harshest restrictions on immigrant seniors and immigrants with disabilities who seek assistance under the SSI program.[33] Although advocacy efforts in the two years following the welfare law's passage achieved a partial restoration of these benefits, significant gaps in eligibility remain. SSI, for example, continues to exclude not-qualified immigrants who were not already receiving the benefits, as well as most qualified immigrants who entered the country after the welfare law passed and seniors without disabilities who were in the U.S. before that date.[34]

"Humanitarian" immigrants (including refugees, people granted asylum or withholding of deportation/removal, Amerasian immigrants, Cuban and Haitian entrants, Iraqi and Afghan Special Immigrants, and survivors of trafficking) can receive SSI, but only during the first seven years after having obtained the relevant status. The main rationale for the seven-year time limit was that it was intended to provide a sufficient opportunity for humanitarian immigrant seniors and those with disabilities to naturalize and retain their eligibility for SSI as U.S. citizens. However, a combination of factors, including immigration backlogs, processing delays, former statutory caps on the number of asylees who can adjust their status, language barriers, and other obstacles, made it impossible for many of these individuals to naturalize within seven years. Recognizing these barriers, in 2008 Congress enacted an extension of eligibility for refugees who faced a loss of benefits due to the seven-year time limit. However, that extension expired in 2011.[35] Subsequent attempts to reauthorize this extension were unsuccessful, and the termination from SSI of thousands of seniors and people with disabilities continues.

Five states—California, Hawaii, Illinois, Maine, and New Hampshire—provide cash assistance to immigrant seniors and people with disabilities who were rendered ineligible for SSI; some others provide much smaller general assistance grants to these immigrants.

The Impact of Sponsorship on Eligibility

Under the 1996 welfare and immigration laws, family members and some employers eligible to file a petition to help a person immigrate must become financial sponsors of the immigrant by signing a contract with the government (an affidavit of support). Under the enforceable affidavit (Form I-864), the sponsor promises to support the immigrant and to repay certain benefits that the immigrant may use.

Congress imposed additional eligibility restrictions on immigrants whose sponsors sign an enforceable affidavit of support. When an agency is determining a lawful permanent resident's financial eligibility for TANF, SNAP, SSI, nonemergency Medicaid, or CHIP,[36] in some cases the law requires the agency to "deem" the income of the immigrant's sponsor or the sponsor's spouse as available to the immigrant. The sponsor's income and resources are added to the immigrant's, which often disqualifies the immigrant as over-income for the program. The 1996 laws imposed deeming rules in certain programs until the immigrant becomes a citizen or secures credit for 40 quarters (approximately 10 years) of work history in the U.S.

Domestic violence survivors and immigrants who would go hungry or homeless without assistance ("indigent" immigrants) are exempt from sponsor deem-

based Medicaid, and disability-related General Assistance, if the disability determination uses criteria as stringent as those used for SSI.

[32] See NILC's updated tables on state-funded services at www.nilc.org/issues/economic-support/updatepage/.

[33] Welfare law § 402(a) (8 U.S.C. § 1612(a)).

[34] Most new entrants cannot receive SSI until they become citizens or secure credit for 40 quarters of work history (including work performed by a spouse during marriage, persons "holding out to the community" as spouses, and by parents before the immigrant was 18 years old).

[35] The SSI Extension for Elderly and Disabled Refugees Act, Pub. Law. 110-328 (Sept. 30, 2008).

[36] Welfare law § 421 (8 U.S.C. § 1631).

ing for at least 12 months.[37] Some programs apply additional exemptions from the sponsor-deeming rules.[38] The U.S. Department of Agriculture (USDA) has issued helpful guidance on the indigence exemption and other deeming and liability issues.[39]

Beyond Eligibility: Overview of Barriers That Impede Access to Benefits for Immigrants

Confusion about Eligibility

Confusion about eligibility rules pervades benefit agencies and immigrant communities. The confusion stems from the complex interaction of the immigration and welfare laws, differences in eligibility criteria for various state and federal programs, and a lack of adequate training on the rules as clarified by federal agencies. Consequently, many eligible immigrants have assumed that they should not seek services, and eligibility workers have turned away eligible immigrants mistakenly.

Fear of Being Considered a Public Charge

The immigration laws allow officials to deny an application for lawful permanent residence or to deny an immigrant entry into the U.S. if the authorities determine that he or she is "likely to become a public charge."[40] In deciding whether an immigrant is likely to become a public charge, immigration or consular officials review the "totality of the circumstances," including an immigrant's health, age, income, education and skills, employment, family circumstances, and, most importantly, the affidavits of support.

The misapplication of this public charge ground of inadmissibility immediately after the welfare law passed contributed significantly to the chilling effect on immigrants' access to services. The law on public charge did not change in 1996, and people's use of programs such as Medicaid or SNAP had never weighed heavily in determining whether they were inadmissible under the public charge ground.

Confusion and fear about these rules, however, became widespread.[41] Immigrants' rights advocates, health care providers, and state and local governments organized to persuade federal agencies to clarify the limits of the rules. In 1999, the Immigration and Naturalization Service (INS, whose functions were later assumed by the Department of Homeland Security) issued helpful guidance and a proposed regulation on the public charge doctrine.[42] The guidance clarifies that receipt of health care and other noncash benefits will not jeopardize the immigration status of recipients or their family members by putting them at risk of being considered a public charge.[43] Nevertheless, sixteen years after this guidance was issued, widespread confusion and concern about the public charge rules remain, deterring many eligible immigrants from seeking critical services.

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[37] IIRIRA § 552 (8 U.S.C. § 1631(e) and (f)).

[38] Children, for example, are exempt from deeming in the Supplemental Nutrition Assistance Program. In states that choose to provide Medicaid and CHIP to lawfully residing children and pregnant women, regardless of their date of entry, deeming and other sponsor-related barriers do not apply to these groups.

[39] 7 C.F.R. § 274.3(c). See also *Supplemental Nutrition Assistance Program: Guidance on Non-Citizen Eligibility* (USDA, June 2011), www.fns.usda.gov/sites/default/files/Non-Citizen_Guidance_063011.pdf. See also *Deeming of Sponsor's Income and Resources to a Non-Citizen* (HHS, TANF-ACF-PI-2003-03, Apr. 17, 2003), www.acf.hhs.gov/programs/ofa/resource/policy/pi-ofa/2003/pi2003-2htm-0.

[40] INA § 212(a)(4).

[41] Claudia Schlosberg and Dinah Wiley, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care* (National Health Law Program and NILC, May 22, 1998).

[42] DOJ, "Field Guidance on Deportability and Inadmissibility on Public Charge Grounds," 64 FR 28689–93 (May 26, 1999); see also DOJ, "Inadmissibility and Deportability on Public Charge Grounds," 64 FR 28676–88 (May 26, 1999); U.S. Dept. of State, INA 212(A)(4) Public Charge: Policy Guidance, 9 FAM 40.41.

[43] The use of all health care programs, except for long-term institutionalization (e.g., Medicaid payment for nursing home care), was declared to be irrelevant to public charge determinations. Programs providing cash assistance for income maintenance purposes are the only other programs that are relevant in the public charge determination. The determination is based on the "totality of a person's circumstances," and therefore even the past use of cash assistance can be weighed against other favorable factors, such as a person's current income or skills or the contract signed by a sponsor promising to support the intending immigrant.

Requirement of Affidavits of Support

The 1996 laws enacted rules that make it more difficult to immigrate to the U.S. to reunite with family members. Effective December 19, 1997, relatives (and some employers) who sponsor an immigrant have been required to meet strict income requirements and to sign a long-term contract, or affidavit of support (USCIS Form I-864), promising to maintain the immigrant at 125 percent of the federal poverty level and to repay any means-tested public benefits the immigrant may receive.[44]

The specific federal benefits for which sponsors may be liable have been defined to be TANF, SSI, SNAP, nonemergency Medicaid, and CHIP. Federal agencies have issued little guidance on sponsor liability, however. Regulations on the affidavits of support issued in 2006 make clear that states are not obligated to seek reimbursement from sponsors and that states cannot collect reimbursement for services used prior to issuance of public notification that the services are considered means-tested public benefits for which sponsors will be liable.[45]

Most states have not designated which programs would give rise to sponsor liability, and, for various reasons, agencies generally have not attempted to seek reimbursement from sponsors. However, the specter of making their sponsors liable financially has deterred eligible immigrants from applying for critical services.

Language Policies

Many immigrants face significant linguistic and cultural barriers to obtaining benefits. As of 2013, approximately 21 percent of the U.S. population (5 years of age and older) speaks a language other than English at home.[46] Although 97 percent of long-term immigrants to the U.S. eventually learn to speak English well,[47] many are in the process of learning the language, and around 8.5 percent of people living in the U.S. speak English less than very well.[48] These limited–English proficient (LEP) residents cannot effectively apply for benefits or meaningfully communicate with a health care provider without language assistance.

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funding from discriminating on the basis of national origin. Benefit agencies, health care providers, and other entities that receive federal financial assistance are required to take "reasonable steps" to assure that LEP individuals have "meaningful access" to federally funded programs, but compliance with this law varies widely, and language access remains a challenge.[49]

Verification

Rules that require benefit agencies to verify applicants' immigration or citizenship status have been misinterpreted by some agencies, leading some to demand immigration documents or Social Security numbers (SSNs) in situations when applicants are not required to submit such information.

In 1997, the U.S. Department of Justice (DOJ), the department primarily responsible for implementing and enforcing immigration laws prior to the creation of DHS in 2002, issued interim guidance for federal benefit providers to use in verifying immigration status.[50] The guidance, which remains in effect, directs benefit

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[44] Welfare law § 423, amended by IIRIRA § 551 (8 U.S.C. § 1183a).

[45] U.S. Dept. of Homeland Security, "Affidavits of Support on Behalf of Immigrants," 71 FR 35732, 35742–43 (June 21, 2006).

[46] *Percent of People 5 Years and Over Who Speak a Language Other Than English at Home* (American Community Survey table, 2013), http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_1YR_GCT1601.US01PR&prodType=table (hereinafter "American Community Survey").

[47] James P. Smith and Barry Edmonston, eds., *The New Americans: Economic, Demographic, and Fiscal Effects of Immigration* (Washington, DC: National Academy Press, 1997), www.nap.edu/catalog.php?record_id=5779#toc, p. 377.

[48] American Community Survey, *supra* note 46.

[49] See the federal interagency language access website, www.lep.gov, for a variety of materials, including guidance from the U.S. Dept. of Justice and federal benefit agencies.

[50] DOJ, "Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996," 62 FR 61344–416 (Nov. 17, 1997). In Aug. 1998, the agency issued proposed regulations that draw heavily on the interim guidance and the Systematic Alien Verification for Entitlements (SAVE) program. See DOJ, "Verification of Eligibility for Public Benefits," 63 FR 41662–86 (Aug. 4, 1998). Final regulations have not yet been issued. Once the regulations become final, states will have two years to implement a conforming system for the federal programs they administer.

agencies already using the computerized Systematic Alien Verification for Entitlements (SAVE) program to continue to do so.[51] Previously, the use of SAVE in the SNAP program was an option that could be exercised by each state, but the 2014 Farm Bill mandated that SAVE be used in SNAP nationwide.[52]

However, important protections for immigrants subject to verification remain in place. Applicants for most benefits are guaranteed a "reasonable opportunity" to provide requested immigration documents, including, in some cases, receipts confirming that the person has applied for replacement of lost documents. In the federal programs that are required by law to use SAVE, applicants who declare that they have a satisfactory status and who provide documents within the reasonable opportunity period should remain eligible for assistance while verification of their status is pending. And information submitted to the SAVE system may not be used for civil immigration enforcement purposes.

The 1997 guidance recommends that agencies make financial and other eligibility decisions before asking the applicant for information about his or her immigration status.

Questions on Application Forms

Federal agencies have worked to reduce the chilling effect of immigration status–related questions on benefits applications. In 2000, HHS and USDA issued a "Tri-Agency Guidance" document, recommending that states delete from benefits application forms questions that are unnecessary and that may chill participation by immigrant families.[53] The guidance confirms that only the immigration status of the applicant for benefits is relevant. It encourages states to allow family or household members who are not seeking benefits to be designated as nonapplicants early in the application process. Similarly, under Medicaid, TANF, and SNAP, only the applicant must provide a Social Security number. SSNs are not required for people seeking only emergency Medicaid.

In 2001, HHS said that states providing CHIP through separate programs (rather than through Medicaid expansions) are authorized, but not obligated, to require SSNs on their CHIP applications.[54] In 2011, the USDA issued a memo instructing states to apply these principles in their online application procedures.[55]

Reporting to the Dept. of Homeland Security

Another common source of fear in immigrant communities stems from a 1996 provision that requires benefits-administering agencies to report to DHS people who the agencies *know* are not lawfully present in the U.S. But this requirement is, in fact, quite narrow in scope.[56] It applies only to three programs: SSI, certain federal housing programs, and TANF.[57]

In 2000, federal agencies outlined the limited circumstances under which the reporting requirement is

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[51] SAVE is currently used by DHS to verify eligibility for several major benefit programs. See 42 U.S.C.§ 1320b-7. DHS verifies an applicant's immigration status through a computer database and/or through a manual search of its records. This information is used only to verify eligibility for benefits and may not be used to initiate deportation or removal proceedings (with exceptions for criminal violations). See the Immigration Reform and Control Act of 1986, 99 Pub. L. 603, § 121 (Nov. 6, 1986); DOJ, "Verification of Eligibility for Public Benefits," 63 FR 41662, 41672, and 41684 (Aug. 4, 1998).

[52] 113 Pub. L. 79, § 4015 (Feb. 7, 2014).

[53] Letter and accompanying materials from HHS and USDA to State Health and Welfare Officials: "Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits" (Sept. 21, 2000).

[54] HHS, Health Care Financing Administration, Interim Final Rule, "Revisions to the Regulations Implementing the State Children's Health Insurance Program," 66 FR 33810, 33823 (June 25, 2001). The proposed rule on Medicaid and CHIP eligibility under the Affordable Care Act of 2010 codifies the Tri-Agency Guidance, restricting the information that may be required from nonapplicants, but proposes to make SSNs mandatory for CHIP applicants. 76 FR 51148, 51191-2, 51197 (Aug. 17, 2011).

[55] *Conforming to the Tri-Agency Guidance through Online Applications* (USDA, Feb. 2011), www.fns.usda.gov/sites/default/files/Tri-Agency_Guidance_Memo-021811.pdf.

[56] Welfare law § 404, amended by BBA §§ 5564 and 5581(a) (42 U.S.C. §§ 608(g), 611a, 1383(e), 1437y).

[57] *Id.* See also H.R. Rep. 104–725, 104th Cong. 2d Sess. 382 (July 30, 1996). The Food Stamp Program (now called the Supplemental Nutrition Assistance Program, or SNAP) had a reporting requirement that preexisted the 1996 law.

triggered.[58] Only people who are actually seeking benefits (not relatives or household members applying on their behalf) are subject to the reporting requirement. Agencies are not required to report such applicants unless there has been a formal determination, subject to administrative review, on a claim for SSI, public housing, or TANF. The conclusion that the person is unlawfully present also must be supported by a determination by the immigration authorities, "such as a Final Order of Deportation."[59] Findings that do not meet these criteria (e.g., a DHS response to a SAVE computer inquiry indicating an immigrant's status, an oral or written admission by an applicant, or suspicions of agency workers) are insufficient to trigger the reporting requirement. Finally, the guidance stresses that agencies are not required to make immigration status determinations that are not necessary to confirm eligibility for benefits. Agencies are not required to submit reports to DHS unless they have knowledge that meets the above requirements.

There is no federal reporting requirement in health programs. To address the concerns of eligible citizens and immigrants in mixed–immigration status households, the DHS issued a memo in 2013 confirming that information submitted by applicants or family members seeking Medicaid, CHIP, or health care coverage under the Affordable Care Act would not be used for civil immigration enforcement purposes.[60]

Looking Ahead

The 1996 welfare law produced sharp decreases in public benefits participation by immigrants. Proponents of welfare "reform" see that fact as evidence of the law's success, noting that a reduction of welfare use, particularly among immigrants, was precisely what the legislation intended. Critics of the restrictions question, among other things, the fairness of excluding immigrants from programs that are supported by the taxes they pay.

These debates rage on at the federal, state, and local levels.

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[58] Social Security Administration, HHS, U.S. Dept. of Labor, U.S. Dept. of Housing and Urban Development, and DOJ – Immigration and Naturalization Service, "Responsibility of Certain Entities to Notify the Immigration and Naturalization Service of Any Alien Who the Entity 'Knows' Is Not Lawfully Present in the United States," 65 FR 58301 (Sept. 28, 2000). USDA similarly has clarified that "State agencies must conform to the reporting requirements of the Interagency Notice." See *Supplemental Nutrition Assistance Program: Guidance on Non-Citizen Eligibility* (USDA, June 2011), www.fns.usda.gov/sites/default/files/Non-Citizen_Guidance_063011.pdf, pp. 48-52. See also 7 C.F.R. § 273.4(b)(1).

[59] *Id.*

[60] *Clarification of Existing Practices Related to Certain Health Care Information* (DHS, Oct. 25, 2013), www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf.

TABLE
Medical Assistance Programs for Immigrants in Various States

Federally funded Medicaid and CHIP (Children's Health Insurance Program) is available to otherwise eligible "qualified" immigrants who entered the U.S. before August 22, 1996, and those who have held a "qualified" status for five years or longer. Refugees and other "humanitarian" immigrants, veterans, active duty military and their spouses and children, and certain other immigrants can get Medicaid or CHIP without a five-year waiting period.

This table describes state policies for providing health coverage to *additional* groups of immigrants, under federal options to cover lawfully residing children and pregnant women, regardless of their date of entry into the U.S., or to provide prenatal care to women regardless of status, using CHIP funds. It also describes immigrant coverage under programs using exclusively state funds.*

The information in this table is subject to change. Please check with your state or local health care agency or legal assistance office regarding the most current rules. If you have updated information, please contact Tanya Broder, National Immigration Law Center, broder@nilc.org.

August 2016

STATE	ELIGIBLE IMMIGRANTS
Alaska	"Qualified immigrants" and PRUCOLs can receive chronic and acute medical assistance if they have a terminal illness, cancer, diabetes, seizure disorders, mental illness, hypertension, or certain other medical conditions.
Arkansas	Prenatal care is available regardless of immigration status.[2]
California	"Qualified" immigrants, PRUCOLs, survivors of trafficking, U visa applicants, and U visa–holders. Lawfully residing children and pregnant women.[1] Prenatal care,[2] long-term care, breast and cervical cancer treatment, and certain other medical services are available regardless of immigration status. Beginning May 16, 2016, children under 19, regardless of immigration status, will be eligible (effective May 1, 2016).
Colorado	Lawfully residing children and pregnant women.[1] Lawfully residing immigrants who are ineligible for Medicaid, are over age 60, and are enrolled in the Old Age Pension Program (OAP) may be eligible for medical services (excluding long-term care, psychiatric services, and in-patient hospitalization) through the Old Age Pension Health and Medical Fund. Since January 2014, however, this program has imposed a five-year (or longer) waiting period for new immigrants. Lawfully residing immigrants under 250% FPL may be eligible for the Colorado Indigent Care Program (CICP), regardless of their date of entry into the U.S. CICP is a reimbursement mechanism for hospitals and primary care clinics.
Connecticut	Lawfully residing children and pregnant women.[1] Residents of nursing homes and persons receiving the Connecticut home care program for elders as of June 30, 2011, or who applied for these benefits on or prior to June 1, 2011.

* This table indicates whether a state takes advantage of federal coverage options, marked as follows:

[1] Federal funds are used to provide medical coverage to lawfully residing children and/or pregnant women, regardless of their date of entry into the U.S.; and/or

[2] Federal CHIP funds are used to provide prenatal care to women, regardless of their immigration status.

If an eligibility group or service is listed *without* a superscript "1" or "2," the services are provided *exclusively with state funds*.

Medical Assistance Programs for Immigrants in Various States

STATE	ELIGIBLE IMMIGRANTS
Delaware	Lawfully residing children and pregnant women.[1]
District of Columbia	Adults, regardless of immigration status, may be eligible for health coverage through the DC Health Care Alliance.[1] Children, regardless of immigration status, may be eligible for the Immigrant Children's Program (ICP), if ineligible for Medicaid.[1]
Florida	Children who do not meet the immigration status criteria for Medicaid or CHIP, but are otherwise eligible, can buy coverage at full cost under KidCare. Beginning on July 1, 2016, lawfully residing children.[1]
Hawaii	Lawfully residing children and pregnant women, including residents of Freely Associated States (Marshall Islands, Micronesia, and Palau).[1] Seniors and people with disabilities who are qualified immigrants, parolees, and nonimmigrants (including residents of Freely Associated States) receive coverage equivalent to Medicaid. Other lawfully present individuals under 100% FPL will receive state premium assistance in addition to federal subsidies under the health care marketplace created by the Affordable Care Act.
Illinois	All children under 300% FPL, regardless of immigration status, can get coverage through the All Kids program. Co-pays and premiums are required for certain families, based on their income.[1] "Qualified" abused immigrant adults are also eligible for coverage, regardless of their date of entry. Asylum applicants and torture victims can get up to 24 months of continuous coverage (this period can be extended to 36 months for some asylum applicants). Prenatal care is available regardless of immigration status.[2] Noncitizens with end-stage renal disease who receive emergency renal dialysis and meet state residency and other program rules may receive a kidney transplant, regardless of immigration status. Effective Jan. 1, 2018, individuals and derivative family members who have filed or are preparing to file an application for T or U status or asylum; terminates if have not filed application within one year (with limited exceptions) or if application finally denied.
Iowa	Lawfully residing children.[1]
Kentucky	Lawfully residing children.[1]
Louisiana	Prenatal care is available regardless of immigration status.[2]
Maine	Lawfully residing children and pregnant women.[1]
Maryland	Lawfully residing children and pregnant women.[1] Limited coverage is available to low- and moderate-income Montgomery County residents, regardless of immigration status, and to children in families earning up to 250% FPL, regardless of immigration status, in Prince George's County.

* This table indicates whether a state takes advantage of federal coverage options, marked as follows:

[1] Federal funds are used to provide medical coverage to lawfully residing children and/or pregnant women, regardless of their date of entry into the U.S.; and/or

[2] Federal CHIP funds are used to provide prenatal care to women, regardless of their immigration status.

If an eligibility group or service is listed *without* a superscript "1" or "2," the services are provided *exclusively with state funds*.

Medical Assistance Programs for Immigrants in Various States

STATE	ELIGIBLE IMMIGRANTS
Massachusetts	"Qualified," lawfully present, or PRUCOL seniors and persons with disabilities up to 100% FPL (excludes long-term care). "Qualified," lawfully present, or PRUCOL immigrant children under 19 years old are eligible up to 300% FPL; 19- and 20-year-olds are eligible up to 150% FPL.[1] All children, regardless of immigration status or income, are eligible for primary and preventive care through the Children's Medical Security Plan. Full-scope medical services for pregnant women up to 200% FPL, regardless of their immigration status.[1,2] Lawfully present nonpregnant adults are eligible for ConnectorCare; those under 300% FPL who purchase coverage through the ACA Marketplace and receive federal subsidies may qualify for additional state subsidies and cost-sharing equivalent to the levels that were available under Commonwealth Care. Other adults who are PRUCOL but not on HHS's lawfully present list are eligible for MassHealth benefits (excluding long-term care) with the same premium contributions required for ConnectorCare.
Michigan	Prenatal care is available regardless of immigration status.[2]
Minnesota	Lawfully residing children.[1] Prenatal care is available regardless of immigration status.[2] Individuals who receive services from the Center for Victims of Torture. Other lawfully present noncitizens under 200% FPL who are ineligible for Medicaid based on their status, are not Medicare recipients, and don't have access to other affordable coverage can receive more limited coverage through MinnesotaCare (excludes, e.g., home-based services, such as personal care assistance and home nursing services).
Montana	Lawfully residing children.[1]
Nebraska	Lawfully residing children and pregnant women.[1] Prenatal care is available regardless of immigration status.[2]
New Jersey	Lawfully residing children and pregnant women.[1] Parents who have been lawful permanent residents for less than 5 years and were enrolled in NJ FamilyCare on April 1, 2010, may continue receiving coverage only, in the agency's discretion, if being treated for a life-threatening illness or receiving ongoing life-sustaining treatment. NJ FamilyCare Advantage is available to children with family income exceeding 350% FPL, regardless of immigration status, based on payment of premium contribution ("buy-in"). Limited funds for prenatal services are available to women up to 200% FPL, regardless of immigration status. "Qualified" immigrants and PRUCOLs who were in Medicaid-certified nursing homes prior to Jan. 29, 1997, remain eligible for nursing home care.
New Mexico	Lawfully residing children and pregnant women[1] and "qualified" battered immigrants. PRUCOLs who entered the U.S. before Aug. 22, 1996.
New York	"Qualified" immigrants and PRUCOLs. Lawfully residing children and pregnant women.[1] Prenatal care is available regardless of immigration status. All children, regardless of immigration status, are covered under the state Child Health Plus program.
North Carolina	Lawfully residing children and pregnant women.[1]

* This table indicates whether a state takes advantage of federal coverage options, marked as follows:

[1] Federal funds are used to provide medical coverage to lawfully residing children and/or pregnant women, regardless of their date of entry into the U.S.; and/or

[2] Federal CHIP funds are used to provide prenatal care to women, regardless of their immigration status.

If an eligibility group or service is listed *without* a superscript "1" or "2," the services are provided *exclusively with state funds*.

Medical Assistance Programs for Immigrants in Various States

STATE	ELIGIBLE IMMIGRANTS
Ohio	Lawfully residing children and pregnant women.[1] People who were lawfully residing in the U.S. on Aug. 22, 1996, and some individuals under an order of supervision.
Oklahoma	Prenatal care is available regardless of immigration status, under Soon to be Sooners program.[2]
Oregon	Lawfully present children.[1] Prenatal care is available regardless of immigration status.[2] Beginning November 2016, COFA Premium Assistance Program for residents of Freely Associated States (Marshall Islands, Micronesia, and Palau) earning under 138% FPL who enroll in a qualified health plan.
Pennsylvania	Lawfully residing children and pregnant women.[1] State-funded Medical Assistance is available to lawfully residing immigrants who are otherwise eligible.
Rhode Island	Lawfully residing children.[1] Prenatal care is available regardless of immigration status.[2] Lawfully residing persons who were in the U.S. before Aug. 22, 1996, and were residents of Rhode Island before July 1, 1997, are also covered.
Tennessee	Prenatal care is available regardless of immigration status, under CoverKids (Healthy TN Babies).[2]
Texas	Lawfully residing children who entered the U.S. on or after Aug. 22, 1996, are eligible for children's Medicaid or CHIP, depending on their income.[1] Prenatal care is available regardless of immigration status through the CHIP Perinatal program.[2] NOTE: Texas denies federal Medicaid to most "qualified" immigrant adults who entered the country on or after Aug. 22, 1996, even after they complete the federal 5-year bar.
Utah	Effective July 1, 2016, lawfully residing children.[1]
Vermont	Lawfully residing children and pregnant women.[1]
Virginia	Lawfully residing children and pregnant women.[1]
Washington	Seniors and persons who are blind or have disabilities, and who are lawfully present may be eligible for a limited medical care services program. Prenatal care is available to otherwise-eligible women regardless of immigration status.[2] Children in households with income below 215% FPL are eligible for medical coverage without a share of cost, regardless of their immigration status.[1] Monthly premiums are required for children in families earning between 215% and 317% FPL.
West Virginia	Lawfully residing children and pregnant women.[1]
Wisconsin	Lawfully residing children and pregnant women.[1] Prenatal care is available regardless of immigration status.[2]

* This table indicates whether a state takes advantage of federal coverage options, marked as follows:

[1] Federal funds are used to provide medical coverage to lawfully residing children and/or pregnant women, regardless of their date of entry into the U.S.; and/or

[2] Federal CHIP funds are used to provide prenatal care to women, regardless of their immigration status.

If an eligibility group or service is listed *without* a superscript "1" or "2," the services are provided *exclusively with state funds.*

STATE	ELIGIBLE IMMIGRANTS
Wyoming	Lawfully residing pregnant women.[1] NOTE: Wyoming denies Medicaid to most nonpregnant lawful permanent residents who do not have credit for 40 quarters of work history in the U.S.

Key Terms Used in This Table

"Qualified" immigrants – are: (1) lawful permanent residents (LPRs); (2) refugees, asylees, persons granted withholding of deportation/removal, conditional entry (in effect prior to Apr. 1, 1980), or paroled into the U.S. for at least one year; (3) Cuban/Haitian entrants; (4) battered spouses and children with a pending or approved (a) self-petition for an immigrant visa, or (b) immigrant visa filed for a spouse or child by a U.S. citizen or LPR, or (c) application for cancellation of removal/suspension of deportation, whose need for benefits has a substantial connection to the battery or cruelty (parent/child of such battered child/spouse is also "qualified"); and (5) survivors of trafficking and their derivative beneficiaries who have obtained a T visa or whose application for a T visa sets forth a *prima facie* case. (A broader group of trafficking survivors who are certified by or receive an eligibility letter from the Office of Refugee Resettlement are eligible for benefits funded or administered by federal agencies, without regard to their immigration status.)

"PRUCOL" *or* permanently residing in the U.S. under color of law – is not an immigration status, but a benefit eligibility category. The term generally means that immigration authorities are aware of a person's presence but have no plans to deport/remove him or her from the country. It is interpreted differently, depending on the benefit program and jurisdiction.

Lawfully residing – means the person is lawfully present in the U.S. and meets the Medicaid state residency requirement. Lawfully present immigrants include "qualified" immigrants and individuals: paroled into the U.S. for less than a year; with a valid nonimmigrant status (e.g., citizens of Micronesia, Marshall Islands, and Palau, and survivors of serious crimes cooperating with law enforcement in prosecuting the perpetrators); granted withholding of removal under the Convention Against Torture, temporary protected status (TPS), deferred enforced departure (DED), deferred action; family unity, or temporary resident status; with approved visa petition who have filed an application to adjust to lawful permanent residence; granted employment authorization based on application for asylum or withholding of removal (or, if under 14, application pending for over 180 days), TPS, registry, legalization under IRCA (1986 law), adjustment under LIFE Act, suspension of deportation/cancellation of removal, or based on an order of supervision; and children who have applied for Special Immigrant Juvenile Status.

FPL – "federal poverty level," as determined by the U.S. Dept. of Health and Human Services' poverty guidelines (the guidelines for 2013 are available at http://aspe.hhs.gov/poverty/13poverty.cfm).

Deeming – in some cases, a sponsor's income and/or resources may be added to the immigrant's in determining eligibility. Exemptions from deeming may apply.

NOTE: The information in this table is subject to change. Please check with your state or local social services agency or legal assistance office regarding the most current rules.

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[1] Federal funds are used to provide medical coverage to lawfully residing children and/or pregnant women, regardless of their date of entry into the U.S.; and/or

[2] Federal CHIP funds are used to provide prenatal care to women, regardless of their immigration status.

If an eligibility group or service is listed *without* a superscript "1" or "2," the services are provided *exclusively with state funds*.

NHeLP
NATIONAL HEALTH LAW PROGRAM

What Makes Medicaid, Medicaid?
Services

By: Wayne Turner, Catherine McKee, Amy Chen, Abbi Coursolle

Key Takeaways

- Under current law, states have tremendous flexibility in designing their Medicaid programs with a wide array of optional services.
- Most Medicaid spending is on optional services and eligibility categories.
- Medicaid services address otherwise unmet health needs in vulnerable populations, such as persons with disabilities and children with complex medical conditions.
- Investments in services, such as maternity care, early detection and treatment of health conditions in children, treatment of chronic conditions, and prevention improve overall population health and help avoid more costly care and hospitalizations.
- Proposals to impose per capita caps and block grants in Medicaid would shift costs to the states and lead to drastic cuts in health services vital for persons who have no other way to obtain them.

Discussion

States have tremendous flexibility when deciding what Medicaid benefits and services they provide. Congress established a broad array of optional services that states can cover, as well as a minimum baseline of services that states must cover (see Appendix for a list of mandatory and optional services).[1] States routinely add, modify, or discontinue optional Medicaid services by amending their state plans; and can provide additional services through waiver programs and demonstration projects.[2] States can also require prior authorization or other utilization control measures to limit use of certain services and benefits. Studies have shown that these optional services account for 60 percent of state Medicaid spending.[3]

Because Medicaid beneficiaries are low income and often have unmet health needs, states developed their Medicaid services and benefits packages to address those needs. For example, Medicaid is the principle provider of nursing home care and in-home long term services and supports (LTSS). LTSS are critical for older adults and persons with disabilities, but are not typically covered by Medicare or private insurance.

This issue brief highlights select Medicaid services and their importance for low income populations, and the potential harmful impact to both mandatory and optional services under proposals to cap or cut Medicaid spending. These services include:

- Children's health services
- Pregnancy-related care
- Family planning services and supplies
- Outpatient prescription drugs
- Non-emergency medical transportation
- Long term services and supports

1. Children's health services

Children living in poverty have unique health care needs. These children face a number of challenges to their health and development – such as malnourishment and exposure to environmental toxins – that may result in regular developmental deficiencies in the population. Without aggressive intervention and case management, many of these children would never "catch-up" or attain their best possible function.

To address this deficit, children in Medicaid receive a special benefit known as **Early and Periodic Screening, Diagnostic and Treatment**, or "EPSDT." EPSDT ensures that low-income children are periodically screened for health and developmental problems and referred for further diagnosis and treatment as needed. EPSDT also guarantees that children will receive access to all Medicaid services when needed to correct or ameliorate the conditions, irrespective of any limits in the coverage package for adults.

> *The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.*
>
> Department of Health and Human Services, Centers for Medicare & Medicaid Services, *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014)

a. Required screenings

Federal law requires states to provide all Medicaid eligible children periodic screening, vision, and hearing services, at intervals that meet reasonable standards of medical practice.[4] These screenings help identify a range of health and developmental issues in children, from Autism Spectrum Disorder (ASD), to hearing or vision loss, to signs of physical abuse. The following chart outlines these screenings.

Medical Screens	Additional required screens
• Health and developmental history; • Unclothed physical exam; • Immunizations; • Lab tests, including lead blood tests; and • Health education.	• Vision, including eyeglasses; • Hearing, including hearing aids; and • Dental, including relief of pain, restoration of teeth and maintenance of dental health.

Checkups and screenings begin right away for newborns and continue on a frequent basis for infants and toddlers to help ensure early detection of problems. States establish a schedule for screenings and developmental assessments – a periodicity table. Most states base their periodicity tables, with some modifications, on a model developed by American Academy of Pediatrics through its Bright Futures program.

Any physical or mental illness or condition identified must be then be diagnosed and treated, even if the condition is identified outside a regular screening period.

Research has shown that early access to Medicaid coverage during childhood results in better long term health and achievement for children as they grow into adulthood.

b. Providing treatment

Medicaid not only screens and diagnoses illnesses or conditions in children; it also ensures that children are provided treatment as well. Medicaid programs are required to treat conditions that are detected in Medicaid eligible children.[5] States must "arrang[e] for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment" that a child needs.[6] For example, early detection and treatment of vision problems in children can affect school performance and avert long term medical and social consequences.[7]

EPSDT's mandate to screen, diagnose, and "correct or ameliorate" health conditions in low income children has given generations of Americans the opportunity to grow and thrive. However, per capita cap/block grant proposal threaten this Medicaid success story. Cuts in federal funding shift costs onto states, which may balk at the cost of early interventions, such as screening for elevated blood lead levels or providing Applied Behavioral Analysis therapy to children with ASD.

Tragically, cuts to these core services will most affect low income children with the greatest health care needs.

2. Pregnancy-related care

Medicaid finances almost half of all births in the United States, and in eight states funds 60 percent or more of all births.[8] Medicaid provides immediate coverage for infants born to women, who give birth while on Medicaid by automatically deeming those infants eligible and enrolling them until the infant's first birthday.[9] Research has shown that early access to Medicaid coverage during childhood results in better long term health and achievement for children as they grow into adulthood.[10] Medicaid also provides pregnant women with access to

regular prenatal care during pregnancy, which can help reduce the risk of future health complications for infants, such as fetal alcohol spectrum disorders and neural tube defects.[11]

Medicaid ensures that women of reproductive age have access to preconception care. These important services include screening and treatment for sexually transmitted infections; counseling and treatment for smoking, alcohol, and substance use; and treatment for chronic diseases such as diabetes, heart disease, obesity, and oral health problems.[12] For women who do become pregnant and continue their pregnancies, Medicaid provides comprehensive care, including prenatal care, labor and delivery, and prenatal screenings to help detect chromosome abnormalities, genetic disorders, and birth defects.[13]

Acknowledging that women may have post-pregnancy health needs, Medicaid pregnancy coverage continues through a postpartum period of at least 60 days.[14] Finally, by providing 75 percent of all publicly funded family planning services, Medicaid provides valuable inter-conception care, which allows women to appropriately plan for and space out their pregnancies.[15]

Block grants and per capita cap proposals reduce the amount of federal funding available to states to provide essential health care for pregnant women. States struggling to fund their Medicaid budgets could reduce or eliminate services available to pregnant women. For example, states could eliminate services such as oral health care, which is currently provided to pregnant women on Medicaid in many states, but by state option.[16] Poor oral health has been associated with preterm birth.[17] Cuts in pregnancy-related services will have long term effects not only on low income women, but their children as well.

3. Family planning services

The Medicaid Act provides family planning services and supplies for individuals of childbearing age, including minors.[18] The family planning benefit includes services to prevent or delay pregnancy and may also include infertility treatment.[19] As with many other Medicaid benefit categories, states have some flexibility to determine which particular family planning services and supplies to offer, but must ensure that coverage is "sufficient in amount, duration, and scope to reasonably achieve its purpose."[20]

Federal Medicaid law contains several additional protections designed to ensure that Medicaid enrollees have access to comprehensive family planning services.

First, states must provide family planning services without any cost-sharing.[21] Second, states must ensure that Medicaid enrollees are "free from coercion or mental pressure and free to choose the method of family planning to be used."[22] Given this requirement, CMS has recommended that states cover all FDA-approved contraceptive methods, including both prescription and non-prescription methods.[23] Third, Medicaid enrollees, including individuals who receive services through a managed care plan, have the right to receive family planning services from the qualified Medicaid provider of their choice.[24] Finally, states receive an enhanced federal reimbursement rate for costs attributable to offering, arranging, and furnishing family planning services and supplies, giving them an additional incentive to make these services widely available to enrollees.[25]

In further recognition of the value of family planning services, federal Medicaid law gives states the flexibility to cover family planning and family planning related services for individuals who are not eligible for full-scope Medicaid coverage.[26] Family planning related services are medical, diagnostic, and treatment services provided pursuant to a family planning visit.[27] Such services include treatment for conditions routinely diagnosed during a family planning visit (such as a urinary tract or sexually transmitted infection), preventive services routinely provided during a family planning visit (such as the HPV vaccine), and treatment for complications.[28] Family planning expansion programs provide a critical source of coverage for individuals who are uninsured and for those seeking confidential access to family planning services, such as minors and domestic violence survivors.

However, proposals to radically alter Medicaid's current financing structure by imposing per capita caps and block grants will likely negatively impact family planning services. Under such proposals, the enhanced federal match for family planning could be eliminated. Without this additional incentive, family planning services will be forced to compete with other state spending priorities, and could be reduced in availability and scope.

4. Outpatient prescription drugs

Although it is an optional service, all states have elected to provide outpatient prescription drug coverage in their Medicaid programs.[29] In general, states can provide all prescription drugs which are approved for safety and effectiveness under the federal Food, Drug, and Cosmetic Act.[30] Prescribed drugs must be for medically accepted indications, including approved off-label uses.[31] Congress established broad coverage requirements to help ensure full access to prescription drugs for low-income Medicaid enrollees.[32]

States that elect to provide outpatient prescription drug coverage must cover all drugs approved by the U.S. Food and Drug Administration (FDA) that are offered by any manufacturer that agrees to provide rebates.[33] Rebate agreements allow Medicaid programs to purchase prescription drugs at a much lower cost than retail amounts.[34]

Nevertheless, states have substantial discretion to use utilization control techniques to steer Medicaid beneficiaries toward or away from certain drugs, within limits.[35] Specifically, federal regulations require states to ensure that prescription drugs are provided in sufficient amount, duration, and scope to reasonably achieve their purpose.[36] In addition, states may place "appropriate limits" on drugs, as long as they take into account medical necessity or utilization control procedures.[37] States must ensure that drug coverage is designed in the "best interests" of Medicaid beneficiaries.[38] In addition, restrictions on outpatient prescription drugs must be reasonable.[39] States must also ensure that their utilization control policies are consistent with the requirements for behavioral health parity.[40]

States have substantial discretion and flexibility to develop appropriate limits and reasonable restrictions on outpatient prescription drugs.

Medicaid formularies must be developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the governor or the state's drug use review board.[41] If a state excludes an outpatient prescription drug from its formulary, the

state must permit coverage pursuant to a prior authorization program and on a case-by-case basis."[42]

Recently, some states resisted providing expensive new treatments for hepatitis C infection (HCV). The Centers for Medicare & Medicaid Services issued guidance reminding states of their obligation under federal law, "CMS is concerned that some states are restricting access to [HCV] drugs contrary to the statutory requirements [...] by imposing conditions for coverage that may unreasonably restrict access to these drugs."[43] As a result, states have been updating their HCV treatment coverage to conform to Medicaid requirements for outpatient prescription drugs.[44]

Under per capita caps and block grants, state Medicaid programs will likely limit or reduce access to prescription drugs. Persons with more costly treatment needs, such as people living with HIV/AIDS, would likely be the first to experience cuts.[45] For some conditions, like HIV/AIDS, disruptions in treatment can lead to drug resistance, whereby conventional therapies are no longer effective, leading to potentially deadly consequences. Moreover, while Medicaid enrollees currently have access to new FDA-approved medicines, under per capita caps and block grants, access to promising new therapies and cures will likely end for those with the fewest resources.

5. Non-emergency medical transportation

By one estimate, nearly 3.6 million adults miss or delay needed care each year due to difficulties with transportation.[46] Lack of transportation poses a serious barrier to care, especially for individuals with lower incomes who on average have fewer transportation options and more significant health care needs. Medicaid ensures that beneficiaries have access to non-emergency medical transportation (NEMT) to and from medical appointments.[47] States have the option to cover transportation as an administrative expense, as an optional medical service, or both.[48] Without these services, many enrollees would simply be unable to access health care, undermining the purpose of the Medicaid program.

Research shows that increasing access to NEMT can improve health outcomes and even save money. Transportation barriers can substantially reduce adherence to medications.[49] Better adherence can improve control of chronic conditions, reducing costly hospitalizations or emergency department visits. Thus, offering NEMT to individuals with common chronic conditions, like asthma, diabetes, and heart disease, can actually save more than the transportation benefit costs.[50] Similarly, improving access to prenatal visits through NEMT saves an estimated $367 per childbirth for pregnant women with limited transportation options, primarily by reducing premature births.[51]

States have considerable flexibility regarding how to administer NEMT services. First, states may contract with transportation providers. The state Medicaid agency or a third party administrator may authorize and coordinate the services. Second, states may contract with managed care entities to cover transportation services for enrollees. Finally, states may use a transportation broker to "more cost-effectively provide non-emergency transportation services"

to enrollees who need access to services and have no other means of transportation.[52] Currently, the majority of states use a broker for at least some Medicaid enrollees.[53]

Despite data showing its cost effectiveness, NEMT is often the first service on the chopping block as states seek to reduce Medicaid expenditures. Several states have obtained CMS approval to waive NEMT services under § 1115.[54] Proposals to cut federal Medicaid funding through per capita caps and block grants could lead states to cut or eliminate NEMT. However, evidence shows that waiving NEMT likely perpetuates or even exacerbates longstanding health care disparities for historically underserved populations.[55]

6. Long term services and supports

Medicaid is tailored to meet the needs of low-income populations and thus covers many vital services not covered by Medicare or most other insurance, including long term care. In fact, Medicaid pays for approximately two-thirds of the country's long term services and supports (LTSS), including nursing home care.[56] For individuals with both Medicare and Medicaid, Medicaid supplements Medicare, helping to fill in coverage gaps and ensure that older adults and people with disabilities have access to comprehensive care.

Long term services and supports include, but are not limited to:

- Institutional care – nursing facilities and intermediate care facilities for individuals with intellectual and developmental disabilities
- Personal care services – help with tasks of daily living, such as eating, bathing, and dressing, and also help preparing meals, managing medication, and housekeeping
- Private duty nursing – medical care in community settings
- Supported employment and other work opportunities
- Habilitation – learning key skills
- Adult day programs – providing for community interaction and care while supporting family members work
- Care planning and care coordination services – help beneficiaries and families navigate the health system and ensure that the proper providers and services are in place to meet beneficiaries' needs and preferences.

Providing care in a person's home is not only less expensive than providing care in an institutional setting, such as a nursing home, but also provides an enhanced quality of life and improved health outcomes.[57]

States can use HCBS waivers to provide long-term services and supports outside of institutions.[58] These waiver programs allow states to waive certain Medicaid requirements and allow them to craft a program of eligibility and services that is not available to the broader Medicaid population, such as respite for family caregivers which is often used for errands or other tasks and is important to the ongoing caregiving relationship.

Medicaid per capita caps and block grants reduce federal funding for states and shift costs onto states. When faced with the need to control costs to adjust to reduced federal funds, state will likely target populations with higher costs which are often individuals with disabilities and older adults, especially those receiving LTSS. States would likely target a wide-range of critical, yet optional, LTSS that are extremely important to older adults and persons with disabilities, such as home attendants or incontinence supplies. States would also likely place strict limits on the amount and frequency of services these enrollees could access, which could endanger individual's health and ability to remain at home instead of more placements, such as nursing homes.

LTSS are cost-effective services, but also represent a significant portion of state Medicaid budgets. These critical services for people with disabilities and older adults are often the target of budget reduction efforts; sometimes leading to greater long-term costs through increased use of institutions.

Moreover, the health care costs for the older adult population increase sharply as an increasing proportion of older adults surpass age 80. Under funding caps, federal funding is locked-in ahead of time, and states might not get additional support to address an increase in costs as the population ages.[59]

Conclusion

With an array of optional benefits and services, as well as optional eligibility categories, states can design their Medicaid programs to best suit the needs of residents. This flexibility, however, is threatened by proposals to turn Medicaid into a per capita cap or block grant program. States will lose billions of dollars in federal Medicaid funding under per capita caps and block grants, which will invariably lead to cuts in services. The prime targets for cuts are more costly services relied upon by low income and vulnerable populations, such as persons with chronic conditions, children, pregnant women, older adults, and persons with disabilities.

The impact of these cuts will reach far beyond Medicaid enrollees as communities experience the long term effects of children with untreated medical conditions and an aging population facing institutionalization because they lack access to home and community based care. For more than fifty years, Medicaid has brought much needed health services that would otherwise be unavailable to many, but per capita caps and block grants now threaten to roll back that success.

ENDNOTES

[1] 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(1)-(5), (17), and (21); 42 C.F.R. § 440.210.
[2] Robin Rudowitz, et. al., KFF & NAMD, *Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016,* at 56 (Oct. 2016), *available at* http://files.kff.org/attachment/report-medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016.
[3] Republic leaders on the Senate Finance and House Energy and Commerce Committees asked MACPAC to review federal and state spending on optional Medicaid services and categories, *see* https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/letters/20170111MACPAC.pdf. *See* Kaiser Comm. for Medicaid & the Uninsured, *Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services* (June 2005) *available at* https://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-an-overview-of-spending-on.pdf.
[4] 42 USC §§ 1396a(a)(10)(a), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). The Children's Health Insurance Program (CHIP) is another important source of child health coverage. CHIP covers children in limited-income families whose incomes are not low enough to qualify for Medicaid. States can implement CHIP by expanding their Medicaid programs (and, thus, EPSDT), or by establishing a separate CHIP. Thus, CHIP benefits for children "can vary significantly from state to state in coverage of vision care services. In general, only Alabama, Arkansas, Colorado, Maine and West Virginia specifically mandate direct access to eye care professionals." See Peter Shin and Brad Finnegan, George Washington Univ. Dep't of Health Pol., Policy Brief – Assessing the Need for On-Site Eye Care Professionals at Community Health Centers 17 (Feb. 2009).
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[6] *Id.* at § 1396a(a)(43)(C); *O.B. v. Norwood*, 170 F. Supp. 3d 1186 (N.D. Ill.), *aff'd* 838 F.3d 837 (7th Cir. 2016).
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[9] 42 U.S.C. § 1396a(e)(4); 42 C.F.R. § 435.117.
[10] *See,* e.g., Michel H. Boudreaux et al., *The Long-Term Impacts of Medicaid Exposure in Early Childhood: Evidence from the Program's Origin*, 45 J. HEALTH ECON. 161 (2016); Sarah Miller et al., *The Long-Term Health Effects of Early Life Medicaid Coverage* (2016), https://ssrn.com/abstract=2466691.
[11] Nat'l Inst. of Child Health & Human Dev., *What is Prenatal Care and Why is it Important?*, https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/pages/prenatal-care.aspx.
[12] Alexandra Gates et al., Kaiser Family Found., *Coverage of Preventive Services for Adults in Medicaid* (Nov. 2014), http://files.kff.org/attachment/coverage-of-preventive-services-for-adults-in-medicaid-issue-brief.
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[15] 42 U.S.C. § 1396d(a)(4)(C), 42 C.F.R § 441.20; Kaiser Family Found., *Women's Health Insurance Coverage* (Oct. 2016), http://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet.
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Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Oral-Health-Care-During-Pregnancy-and-Through-the-Lifespan.

[18] 42 U.S.C. § 1396d(a)(4)(C).

[19] CMS, State Medicaid Manual § 4270; CMS, Dear State Health Official Letter 2 (June 13, 2016).

[20] 42 C.F.R. § 440.230(c).

[21] 42 U.S.C. § 1396o(a)(2)(D); 42 C.F.R. § 447.56(a)(2)(ii).

[22] 42 C.F.R. § 441.20.

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[24] 42 U.S.C. § 1396a(a)(23).

[25] *Id.* § 1396b(a)(5).

[26] *Id.* §§ 1396a(a)(10)(A)(ii)(XXI), 1396a(ii), 1396a(10)(G)(XVI). *See also id.* § 1315(a).

[27] *Id.* § 1396a(10)(G)(XVI); CMS, Dear State Health Official Letter (June 14, 2016); CMS, Dear State Medicaid Director Letter (April 16, 2014).

[28] *See* CMS, Dear State Health Official Letter (June 14, 2016); CMS, Dear State Medicaid Director Letter (April 16, 2014).

[29] 42 U.S.C. § 1396d(a)(12). 42 C.F.R. §§ 440.120(a), .90, .100.

[30] 42 U.S.C § 1396r–8(k)(2)(A).

[31] 42 U.S.C § 1396r–8(d)(1)(B)(i).

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[33] 42 U.S.C. § 1396r-8(k)(2)(i).

[34] Id. § 1396r-8(a)(1).

[35] *See* 42 C.F.R. § 440.230(d).

[36] Id. § 440.230(b).

[37] Id. § 440.230(d).

[38] *Alexander v. Choate*, 469 U.S. 287, 303 (1985).

[39] 42 U.S.C. §§ 1396r–8(d)(1), (5); 42 C.F.R. § 440.230(d); *NB v. District of Columbia,* 34 F.Supp.3d 146, 153 (D.D.C.2014), rev. on other grounds, *NB v. District of Columbia*, 794 F.3d 31 (D.C.Cir.2015). See also 42 U.S.C. § 1396a(a)(17), "[a] State plan for medical assistance must ... include reasonable standards ... for determining eligibility for and the extent of medical assistance under the plan ... which are consistent with the objectives of this subchapter [of Medicaid]," and the implementing regulation requiring that each provided service, including prescription drugs, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b); *Detgen v. Janek*, 752 F.3d 627, 631 (5th Cir.2014). That requirement has been interpreted by the Supreme Court to include certain reasonable restrictions relating to costs, see Walsh, 538 U.S. at 666, 123 S.Ct. 1855 and *Beal v. Doe*, 432 U.S. 438, 444, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977), albeit budgetary considerations cannot be "the conclusive factor in decisions regarding Medicaid." *Arkansas Med. Soc., Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir.1993); *Bontrager v. Indiana Family & Soc. Servs. Admin.*, 697 F.3d 604, 611 (7th Cir.2012); *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, 109 F.3d 693, 704 (11th Cir.1997).

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Center for American Progress

The Medicaid Program and LGBT Communities

Overview and Policy Recommendations

By Kellan E. Baker, Ashe McGovern, Sharita Gruberg, and Andrew Cray
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In 1965, President Lyndon B. Johnson signed the Social Security Amendments Act, creating dual programs—Medicaid and Medicare—that have dramatically improved access to health care for some of the nation's most vulnerable communities. Nearly 50 years later, President Barack Obama signed the Affordable Care Act, or ACA, setting in motion one of the most significant set of changes to Medicaid since the program's inception.

Today, Medicaid is the nation's largest insurer, funding a significant portion of national spending on personal health care and providing low- or no-cost health coverage to nearly 70 million people—including many individuals who are lesbian, gay, bisexual, and transgender, or LGBT.[1] Importantly, LGBT people are more likely than non-LGBT people to be living in poverty and to be uninsured.[2] Overall, one in five Americans receives health insurance coverage through Medicaid in any given year, and nearly two-thirds of Americans report a close personal connection with the Medicaid program, either because they have received assistance from Medicaid or because they have close friends or family who have.[3]

This issue brief reviews the characteristics and benefits of Medicaid as they relate to LGBT individuals, including why the Medicaid program is essential to the health of LGBT communities. It also looks at how the program could be improved to ensure greater access to quality coverage for LGBT people and their families.

What is Medicaid, and whom does it cover?

Medicaid is a public program that provides health coverage for low-income individuals who fall into a range of eligibility categories, including people living with a disability, people who are pregnant, and people with dependent children.[4] Medicaid is a means-tested entitlement program, meaning that eligibility is linked to individual or

family income, and the program is required to cover all individuals who meet eligibility requirements. Medicaid is primarily administered by states within parameters set by federal law, and the program is jointly financed by states and the federal government—on average, the federal government pays 53 cents of every $1 spent by states on their Medicaid programs.[5]

When the ACA was signed into law in 2010, it substantially modified Medicaid's eligibility rules. Specifically, the ACA required state Medicaid programs to cover all individuals making up to 138 percent of the federal poverty level, or FPL.[6] In 2016, the FPL stands at $11,880 for an individual and $24,300 for a family of four.[7] When the U.S. Supreme Court considered the constitutionality of the ACA in June 2012, however, it ruled that the federal government cannot compel the states to expand Medicaid, leaving the decision of whether or not to expand the program to governors and state legislatures. As of July 2016, 31 states and the District of Columbia have expanded their Medicaid programs to cover all individuals with incomes up to 138 percent of the FPL.[8]

In the 19 states that have not adopted expansion, millions of people remain uninsured. For individuals making less than the federal poverty level, a lack of Medicaid expansion means that the ACA cannot offer them financial assistance to access health insurance coverage. Because the states that have not adopted expansion also have comparatively larger populations of communities of color and higher rates of poverty—including LGBT people of color and their families—the decisions made by these states disproportionately impact people of color and people who cannot otherwise afford insurance.[9]

There is no deadline for states to decide whether or not to move forward with Medicaid expansion, although states that delay expansion stand to lose substantial amounts of federal funding: The federal government paid 100 percent of the costs of expansion between 2014 and 2016, and this percentage drops slightly before settling at 90 percent in 2020 and beyond.[10] Overall, this financing arrangement meant that, if all states had expanded their Medicaid programs, the federal government would have picked up approximately 93 percent of the tab, meaning that all states together would have borne only 7 percent of the total cost of Medicaid expansion.[11]

What benefits does Medicaid cover?

In general, Medicaid provides more comprehensive benefits at a lower cost than private insurance coverage.[12] Benefits for adults enrolled in Medicaid vary, however, between states and by program. For those enrolled in traditional Medicaid—the coverage available to those who were eligible for Medicaid prior to the Affordable Care Act, including pregnant people and people with disabilities—there is a core set of benefits required by law, including but not limited to:

- Doctor visits
- Inpatient and outpatient hospital services
- Some mental health services
- Family planning services and supplies
- Long-term care facility services
- Home health care
- Emergency services
- Transportation to medical services
- Laboratory and X-ray services
- Early and Periodic Screening, Diagnostic, and Treatment services for children and adults younger than age 21

In addition to this list of mandatory services, states also have the flexibility within the parameters of federal guidance to offer a range of optional services, which typically include outpatient prescription drug coverage, dental services, and case management services, among others. More than 60 percent of state Medicaid spending is on optional services, which testifies to the degree to which states choose to offer coverage for optional services because of their importance to the health of Medicaid enrollees.[13] Because they are not required by federal law, however, optional benefits are vulnerable to being lost as a result of state budget cuts.

In states that have expanded Medicaid under the ACA, newly eligible individuals receive a slightly different package of benefits known as an Alternative Benefit Plan, or ABP.[14] The benefits covered by ABPs are based on the essential health benefit standard created by the ACA, which includes and in some cases expands on the benefits available through traditional Medicaid.[15] The 10 required essential health benefit categories of covered services are:[16]

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

In addition to the essential health benefit standard, ABPs are subject to the Mental Health Parity and Addiction Equity Act of 2008, which requires parity in mental health coverage.[17] ABPs are also subject to Section 2713 of the Affordable Care Act, which prohibits cost-sharing for a range of approved preventive screenings and services, lessening costs significantly for Medicaid beneficiaries. These requirements do not apply to traditional Medicaid.

In order to establish their ABPs, states have the option of choosing between four benchmark plan options that provide the basis for the design and breadth of the available benefits:[18]

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program
- A state employee plan
- The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state
- Coverage approved by the federal secretary of health and human services, which can include the benefits offered to traditional Medicaid enrollees

Most states that have expanded Medicaid have selected the secretary-approved option in order to closely align the benefits available to traditional and expansion Medicaid beneficiaries.[19]

Why is Medicaid an important program for LGBT communities?

LGBT communities report high rates of poverty and uninsurance

The high prevalence of poverty in LGBT communities, especially among transgender people and LGBT people of color, makes Medicaid a critical program for the health and well-being of LGBT communities. Nationwide, about one in five gay and bisexual men and one in four lesbian and bisexual women are living in poverty.[20] The 2011 National Transgender Discrimination Survey found that more than 25 percent of transgender people report an annual household income of less than $20,000 and that transgender people are four times more likely than the general population to be living below the poverty line.[21] In a 2014 nationwide survey of LGBT people with incomes less than 400 percent of the FPL, 61 percent of all respondents had incomes in the Medicaid expansion range—up to 138 percent of the FPL—including 73 percent of African-American respondents, 67 percent of Latino respondents, and 53 percent of white respondents.[22]

High rates of poverty in LGBT communities correlate with high rates of uninsurance. National Gallup poll data indicate that LGBT people are generally more likely to be uninsured than their peers.[23] In a separate study in 2013, the last year before the ACA's full coverage expansion went into effect, one in three—or 34 percent—of LGBT adults ages 18 to 64 with incomes less than 400 percent of the FPL were uninsured.[24] Of the uninsured in that study, almost half—48 percent—lived in southern states whose governments opposed Medicaid expansion.

Many LGBT individuals are unable to access coverage without Medicaid expansion because the traditional Medicaid eligibility categories exclude most childless adults, regardless of how low their incomes are. To cover childless adults who were not otherwise categorically eligible before the ACA's coverage expansion, states were required to either use solely their own funds or obtain a federal waiver. In 2009, only five states offered full Medicaid-comparable coverage to childless adults.[25]

For both LGBT childless adults and LGBT parents, Medicaid expansion is important because it standardizes the income eligibility thresholds that were previously widely variant depending on state guidelines—and that continue to vary in states without expansion. For example, in 2010, a working parent with two children became ineligible for Medicaid coverage in Texas by making more than 26 percent of the FPL for a family of three, or about $400 per month.[26] That same parent could have made more than $1,370 per month—90 percent of the FPL—and still been eligible for coverage under Ohio's Medicaid program, or close to $2,290 per month—150 percent of the FPL—and still have been eligible in New York.[27] In 2016, because Ohio adopted the Medicaid expansion while Texas did not, the monthly income limit for a working parent of two in Ohio is now $2,318—138 percent of the FPL—while in Texas the monthly limit has actually dropped to just above $300 per month—18 percent of the FPL.[28]

Medicaid expansion is also important for people living with HIV. Under traditional Medicaid's stringent categorical eligibility requirements, individuals with HIV frequently cannot qualify for Medicaid coverage until their health has deteriorated to the point where they qualify on the basis of disability because the disease has progressed to AIDS. The ACA's Medicaid expansion eliminates this barrier to timely HIV treatment by allowing all individuals with incomes up to 138 percent of the FPL to qualify for Medicaid coverage regardless of their disability status. In states that have not expanded Medicaid, however, this barrier to access remains.

Access for immigrants, even in states that have expanded Medicaid, is unfortunately restricted to only a handful of categories, including people with green cards, refugees, people granted asylum, Cubans and Haitians, and certain victims of trafficking.[29] There are an estimated 637,000 LGBT adult immigrants with legal status in the United States, many of whom become eligible for Medicaid benefits only after a five-year waiting period.[30] In 2012, the Obama administration barred beneficiaries of the Deferred Action for Childhood Arrivals, or DACA, program—which initially permitted undocumented young people who were brought to the United States as children to access Medicaid under the same conditions as lawfully present immigrants—not only from Medicaid but also all new health insurance options created under the ACA.[31] States can, however, elect to extend eligibility for the Children's Health Insurance Program, or CHIP, to pregnant people and children without the five-year waiting period, and in California, undocumented children younger than age 19 are eligible for Medi-Cal, the state's Medicaid program.[32]

Despite these significant lingering concerns, the ACA's coverage reforms, including Medicaid expansion, have had a substantial impact on uninsurance rates among LGBT people. Between 2013 and 2014, the number of uninsured LGBT adults with incomes less than 400 percent of the FPL dropped by almost a quarter, from 34 percent to 26 percent.[33] In 2013, 22 percent of them had coverage through Medicaid, including 40 percent of those with incomes up to 138 percent of the FPL, and in 2014, 28 percent of them had Medicaid coverage.[34]

In 2014, Medicaid covered 29 percent of insured low- and middle-income LGBT Latinx individuals and 37 percent of insured low- and middle-income African Americans; 37 percent of insured LGBT adults with incomes of 139 percent of the FPL or less; and 36 percent of those with a high school education or less.[35] States that expanded Medicaid between 2013 and 2014 saw a 10 percentage point drop in the overall rate of uninsurance among their low- and middle-income LGBT communities, compared to a 6-point drop in states that did not expand Medicaid—leading to an average uninsurance rate in this population of 18 percent in Medicaid expansion states versus 34 percent in non-expansion states in 2014.[36]

Discrimination against LGBT individuals affects access to health insurance coverage

The high rates of uninsurance in the LGBT population are linked not only to poverty but also to experiences of discrimination. Despite advances in legal protections and social acceptance for LGBT people over the past several decades, there is still no federal law that explicitly protects LGBT individuals from discrimination in employment and other areas of everyday life.[37] Only 20 states and the District of Columbia have passed legislation protecting transgender people from discrimination, and only 22 states and the District of Columbia protect lesbian, gay, and bisexual people.[38] In the absence of these protections, LGBT people in the majority of states are at risk of being legally evicted from their apartments, denied credit, refused hotel rooms, and fired from their jobs on the basis of their sexual orientation or gender identity.[39]

Studies show that up to 43 percent of gay workers and 90 percent of transgender workers have experienced discrimination and harassment in the workplace.[40] Employment discrimination pushes many LGBT people into low-wage jobs that do not offer benefits such as health insurance coverage, or into unemployment.[41] A 2009 state-level survey in California, for instance, found that 14 percent of lesbian, gay, and bisexual adults are unemployed, compared to 10 percent of heterosexual adults.[42] For transgender adults, unemployment rates are twice the rate of the population as a whole, rising to as high as four times the national unemployment rate for transgender people of color.[43] As a result of discrimination and unemployment, a 2014 study showed that only 38 percent of insured LGBT adults with incomes less than 400 percent of the FPL had insurance through their own employer or a spouse or partner's employer, in contrast to 58 percent of the insured non-LGBT population in the same income range.[44]

Insurance carriers also discriminate against LGBT individuals. In the same 2014 study, for instance, close to nine percent of respondents in same-sex relationships reported that an insurance carrier had discriminated against them on the basis of their sexual orientation. For example, some respondents reported encountering refusal to allow them to enroll in coverage with a same-sex spouse or partner as a family.[45] In the Medicaid context, many Medicaid programs did not consider same-sex spouses legally married for purposes of eligibility and enrollment even after the 2013 Supreme Court ruling that struck down the majority of the federal Defense of Marriage Act, or DOMA. Following *Obergefell v. Hodges*, the 2015 Supreme Court ruling that expanded marriage equality nationwide, however, the federal government began requiring all state Medicaid programs to recognize legally married same-sex couples on the same basis as different-sex couples.

Transgender individuals experience particularly high rates of discrimination in health insurance coverage

Insurance discrimination against transgender individuals, including in state Medicaid programs, is particularly pervasive. According to 2016 estimates, there are at least 1.4 million transgender people living in the United States, many of whom need medical treatment to help them physically transition from their assigned sex at birth to the sex with which they identify.[46] According to the standards of care maintained by the World Professional Association for Transgender Health, the health care services that may be medically necessary as part of gender transition include gender reassignment surgeries, hormone therapy, and mental health counseling.[47] Unfortunately, many health plans explicitly exclude coverage for all services related to gender transition, and carriers frequently expand these exclusions in practice to also deny coverage for sex-specific preventive screenings such as cervical Pap tests and mammograms, and sometimes for any care at all.[48]

Many of these exclusions date to the early 1980s, when the federal Medicare program adopted a policy excluding transition-related care from coverage on the assumption that it was "cosmetic" and "experimental," despite a widespread medical consensus deeming health care services related to gender transition medically necessary.[49] Numerous state Medicaid programs, as well as most private insurance plans, quickly followed suit. As a result, Medicaid coverage for transition-related health care has long been available only in a small handful of states on the basis of court rulings requiring these states' Medicaid programs to consider the medical necessity of transition-related care for transgender individuals on a case-by-case basis.[50]

Transgender exclusions, however, are slowly being eradicated. In 2001, a California superior court ruled against Medi-Cal's general exclusion of transition-related care and required the program to implement a coverage policy. This ruling cited a pair of court cases from the 1970s regarding Medicaid coverage for sex reassignment surgery for transgender women, in which the judges had found that "the proposed surgery is medically reasonable and necessary."[51] The judges in these rulings further noted, "we do not believe, by the wildest stretch of the imagination, that such surgery can reasonably and logically be characterized as cosmetic."[52]

Several years later, in 2006, California passed the Insurance Gender Nondiscrimination Act, which prohibits discrimination in insurance on the basis of gender identity. Regulations promulgated by the California Department of Insurance in 2012 clarify that the act requires insurance carriers to cover any medically necessary service for a transgender person, as long as the service is covered for non-transgender subscribers on the same plan.[53] This concept of parity has far-reaching implications, as the medical treatments that transgender people may need for gender transition are typically covered for non-transgender people for a variety of conditions, including endocrine disorders, cancer prevention or treatment, and reconstructive surgeries following an injury.[54]

On the heels of these regulations, insurance regulators in numerous states have begun to issue guidance clarifying that their own state laws—including human rights laws prohibiting gender identity discrimination, unfair trade practices statutes prohibiting sex-based discrimination in insurance coverage, and mental health parity requirements—prohibit transgender-specific insurance exclusions.[55] Medicare lifted its exclusion in 2014, and Medicaid agencies in several states have also recently amended their rules to remove transgender exclusions and expressly affirm the availability of coverage for transition-related care; as of August 2016, these states are California, Connecticut, Illinois, Maryland, Massachusetts, New York, Oregon, Rhode Island, Vermont, and Washington, plus the District of Columbia.[56] Unfortunately, Medicaid programs in 18 states continue to explicitly exclude care for transgender individuals, and the remainder do not address the issue of transgender coverage at all—which in practice has often meant that coverage is denied.[57]

Medicaid nondiscrimination protections

All state Medicaid programs are bound by federal nondiscrimination laws. The three laws that are particularly relevant to access for LGBT individuals are regulations promulgated under the federal Medicaid statute prohibiting arbitrary restrictions on Medicaid coverage on the basis of diagnosis or health condition, Section 1557 of the Affordable Care Act, and regulations governing the activities of Medicaid managed care organizations. The enforcement of these nondiscrimination protections is in addition to provisions within the federal Medicaid statute that require state Medicaid programs to grant a fair hearing to any individual whose claim for medical services is denied or not acted upon in a timely manner.[58]

Federal Medicaid statute requirements

A core aspect of federal law that affects access to Medicaid coverage for a variety of conditions is a longstanding Medicaid regulation prohibiting arbitrary coverage restrictions on the basis of diagnosis. Specifically, state Medicaid programs may not "arbitrarily deny or reduce the amount, duration, or scope of a required service under [the Medicaid statute] to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition" with which the individual is diagnosed.[59] Thus, if a service is a required service under Medicaid, this regulation forbids limits on that service that single out individuals with a particular condition or diagnosis—including conditions that disproportionately affect the LGBT population, such as HIV. While this provision has been invoked at the state level to support coverage of services related to gender transition, federal courts have not issued rulings specifically addressing the application of this provision to gender reassignment services.

Affordable Care Act Section 1557

Section 1557 of the Affordable Care Act, which is the health reform law's primary civil rights provision, prohibits discrimination on the basis of race, color, national origin, disability, age, or sex by any program or entity that receives federal financial assistance. Because every state Medicaid program receives financial support from the federal government, Section 1557 covers all Medicaid beneficiaries.

Section 1557 has been in effect since the ACA was passed in 2010. In May 2016, the U.S. Department of Health and Human Services Office for Civil Rights released final regulations clarifying the scope and intent of Section 1557.[60] Among other provisions, the final rule clarifies that Section 1557's sex-based nondiscrimination protections extend to gender identity and sex stereotyping. Section 1557 thus explicitly protects transgender and gender-nonconforming individuals and, while the regulations do not expressly define sexual orientation discrimination as a form of sex discrimination, they do protect gay, lesbian, and bisexual individuals and their families from discrimination on the basis of sex stereotypes. These stereotypes include, for example, the assumption that men should only seek romantic relationships with women, and vice versa.

The final rule prohibits discriminatory plan benefit design and marketing, including examples such as placing all HIV medications in the highest cost-sharing tier and failure to provide single-tablet therapy, which is the standard of care in HIV treatment. It also prohibits health insurance coverage programs and plans from categorically excluding all services related to gender transition or making coverage decisions in a manner that results in discrimination against a transgender individual—such as denying coverage for mental health services related to gender transition while covering them for depression, among many other examples. The final rule also requires health care providers to provide medically necessary health care services to transgender individuals, as long as those services are within the provider's scope of practice and are provided to non-transgender individuals. The provisions of the Section 1557 final rule took effect on July 18, 2016, for state Medicaid programs, meaning that the 18 states whose Medicaid programs still exclude transition-related care may face administrative remedies or private lawsuits if they do not remove these exclusions.

Medicaid managed care regulations

In April 2016, the Centers for Medicare and Medicaid Services, or CMS, issued regulations requiring Medicaid managed care organizations, or MCOs, to abide by LGBT-inclusive cultural competency and nondiscrimination requirements in addition to ACA Section 1557.[61] Medicaid MCOs are private insurance companies that contract with state governments to cover some or all of their Medicaid beneficiaries, in a practice known as Medicaid managed care. As of 2016, 39 states and the District of Columbia use Medicaid MCOs, and Medicaid MCOs cover approximately 80 percent of Medicaid beneficiaries nationwide.[62]

The 2016 Medicaid MCO regulations expressly prohibit enrollment discrimination on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. They also require state Medicaid programs and MCOs to develop methods of ensuring that all beneficiaries are able to receive health care services in a culturally competent manner, regardless of factors such as gender, sexual orientation, or gender identity.

Medicaid application and enrollment procedures

In addition to reforms such as Medicaid expansion and the nondiscrimination protections of Section 1557, the ACA also made a number of changes to the application and enrollment process for Medicaid. In particular, the ACA required states to eliminate application barriers that are unduly burdensome, such as asset tests. Under the "no wrong door" principle, Medicaid application and enrollment in all states is also now tied to health insurance marketplace application and enrollment. All states must either use the single, streamlined federal application or develop an alternate version of the application, which requires approval from CMS.

The single, streamlined application does not include demographic questions about sexual orientation or gender identity, which hinders efforts to understand how many LGBT individuals are enrolling in and receiving Medicaid coverage. The gender question currently on the application—which asks "what is your gender" and offers only the answer choices "male" and "female"—is also problematic for many transgender applicants, who report being unsure of how to answer when their gender identity does not match their official identity documents.[63]

While some transgender people have been able to change their sex on record with the Social Security Administration and in other state and federal records, there are many transgender people whose Social Security files and other records are still listed under the sex they were assigned at birth and therefore do not match their current gender identity.[64] When filling out the Medicaid application, these individuals must either misrepresent themselves or risk having their application delayed because they fail identity verification.

This question also poses difficulties for transgender individuals with regard to Medicaid eligibility. Specifically, some transgender men—men who were assigned female at birth—retain the ability to become pregnant and give birth to a child. Because pregnancy affects household size and eligibility for Medicaid benefits, it is important that transgender men are not screened out of questions on the electronic application regarding pregnancy. On the electronic version of the current application, however, transgender men cannot correctly identify themselves as men without being directed into a skip pattern that causes them to bypass the pregnancy questions.

Finally, the application's current gender question frequently results in denials of coverage due to a perceived mismatch between the individual's gender and the gender traditionally associated with certain preventive screenings, hormone prescriptions, and other health care services. For instance, a transgender woman who is enrolled in Medicaid as female may encounter denials of coverage for medically necessary services such as a prostate exam. On the other hand, if she is enrolled in Medicaid as male due to old records or identity documents that have not been updated, she may encounter denials of coverage for her estrogen therapy.

Recommendations

Below are some of the steps that the U.S. Department of Health and Human Services, state governments, and state Medicaid agencies can take to ensure that Medicaid provides equitable coverage and access to care for all beneficiaries, including LGBT people.

Close the coverage gap by expanding Medicaid

All states should expand eligibility for their Medicaid programs to all individuals with incomes up to 138 percent of the federal poverty level, in order to insure that vital health care services are accessible to low-income LGBT individuals and others who cannot afford private health insurance coverage.

States should also extend Medicaid access to qualified immigrants. California, for example, has extended Medicaid coverage to undocumented young people younger than age 19 and extended CHIP to children and pregnant people without requiring the five-year waiting period. The federal government should remove the bar to Medicaid access for DACA recipients and ensure that there is no Medicaid exclusion in any implemented version of the Deferred Action for Parents of Americans program.

Clarify the application of ACA Section 1557's nondiscrimination protections to state Medicaid programs

In order to ensure that all state Medicaid programs are aware of how Section 1557 of the ACA applies to them, the U.S. Department of Health and Human Services—specifically the Centers for Medicare and Medicaid Services and the Office for Civil Rights—should release a letter to state Medicaid directors or other guidance that outlines key aspects of Section 1557's requirements. This guidance should include a clear statement of the impermissibility of transgender-specific insurance exclusions and examples of policy language and utilization management practices that violate Section 1557 by resulting in discrimination against transgender individuals. An example of discriminatory plan language, for instance, would be a blanket exclusion for gender reassignment surgery.

Remove transgender-specific exclusions from Medicaid and institute affirmative coverage protocols

The provision of the ACA Section 1557 final rule that expressly prohibits transgender-specific exclusions in Medicaid went into effect on July 18, 2016. To ensure compliance with these requirements, state Medicaid programs should immediately remove these exclusions.

Furthermore, the experience of many state Medicaid programs indicates that simply removing exclusions is insufficient, as disputes still arise regarding the scope of covered services and transgender individuals continue to face denials of medically necessary care under the improper application of "cosmetic" or "experimental" coverage exclusions. To address this issue, all state Medicaid programs should promulgate clear protocols outlining coverage for gender transition on the basis of the most up-to-date expert standards of care in the field of transgender medicine. A number of expert medical bodies, including the World Professional Association for Transgender Health, the Endocrine Society, and the American Psychological Association, maintain evidence-based standards of care that outline the range of medically necessary services that may be part of gender transition.[65]

Importantly, affirmative protocols should not incorporate any list of procedures or services that are never covered, as the science is rapidly evolving concerning the full range of health care services that may be medically necessary as part of gender transition. Moreover, there are instances in which a procedure or service that is medically necessary for gender transition may typically be considered "cosmetic" for most other indications. Medicaid transgender coverage protocols should follow the example of states such as Connecticut, which clarifies that procedures such as facial feminization surgeries, electrolysis, and chest contouring may be medically necessary and will be reviewed for coverage on a case-by-case basis.[66] These protocols should also specifically clarify the availability of services such as puberty-delay medications, hormone therapy, mental health counseling, and surgeries for transgender youth through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit.

Include sexual orientation and gender identity nondiscrimination protections in the Medicare and Medicaid conditions of participation

In June 2016, CMS released a draft regulation proposing to amend the Medicare and Medicaid conditions of participation for hospitals and critical access hospitals to explicitly require nondiscrimination on the basis of sexual orientation and gender identity. These protections will provide an important corollary to those of ACA Section 1557 and should be codified as proposed in the final regulation.

Amend the single, streamlined application to collect better data related to sexual orientation and gender identity

In order to provide accurate data on the proportion of Medicaid beneficiaries who identify as lesbian, gay, bisexual, and/or transgender, the U.S. Department of Health and Human Services should update the single, streamlined federal application to include gender identity and sexual orientation questions that reflect established best practices in the field.

Specifically, the application should use a two-part question that asks about both current gender and sex assigned at birth. The California Health Interview Survey recently tested and adopted a version of a two-step question developed by the Center of Excellence for Transgender Health at the University of California at San Francisco, which reads as follows:

What is your gender?

- *Female*
- *Male*
- *Transgender*

What is your sex assigned at birth, on your original birth certificate?

- *Female*
- *Male*

This two-step question design allows transgender individuals to be identified in two ways: either because they select the "transgender" answer option for the first part of the question, or because they select different answers for the first and second parts of the question. For instance, a transgender woman might select "female" for the first part and "male" for the second. This would correctly identify her as a woman who is transgender and who thus may need health care services that are not typically associated with women, such as a prostate exam. An individual who identifies outside the male/female gender binary might select "transgender" for the first part, thus allowing that person to be correctly identified as a non-binary individual with the preventive screening needs associated with the sex they were assigned at birth.

In addition to making it possible for transgender applicants to be correctly identified, this question design will also reduce the risk of identity verification failure, ensure that the application appropriately assesses eligibility for Medicaid benefits for all individuals who can become pregnant, and help Medicaid programs and MCOs process claims

for services even if the gender of the service conflicts with the individual's gender as listed in the claim. Specifically, these data will allow a flag to be added to the individual's Medicaid file that overrides gender edits for any services and thereby allows these claims to go through without erroneous denials.

The application should also include a voluntary demographic question about sexual orientation, such as:

Do you consider yourself to be:

- *Straight or heterosexual*
- *Gay or lesbian*
- *Bisexual*
- *Other* _____

Conclusion

Medicaid provides access to vital health care services for millions of Americans, including LGBT people and their families. Expanding Medicaid in all states to cover all low-income adults and strengthening the traditional Medicaid program are critical advocacy priorities for LGBT communities and their allies. In particular, there are a number of steps that the federal and state governments can take—such as removing transgender coverage exclusions and amending the Medicaid application to accurately count and enroll LGBT individuals—to eliminate barriers to Medicaid coverage. LGBT individuals and advocates must also be aware that Medicaid provides enforceable rights and protections under federal law, meaning that active engagement with the government and the filing of complaints about issues such as discriminatory benefit design and denials of coverage are critical components of ensuring that state Medicaid programs serve everyone who needs them.

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EXECUTIVE ORDER

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ENHANCING PUBLIC SAFETY IN THE INTERIOR OF THE UNITED STATES

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Immigration and Nationality Act (INA) (8 U.S.C. 1101 *et seq.*), and in order to ensure the public safety of the American people in communities across the United States as well as to ensure that our Nation's immigration laws are faithfully executed, I hereby declare the policy of the executive branch to be, and order, as follows:

Section 1. Purpose. Interior enforcement of our Nation's immigration laws is critically important to the national security and public safety of the United States. Many aliens who illegally enter the United States and those who overstay or otherwise violate the terms of their visas present a significant threat to national security and public safety. This is particularly so for aliens who engage in criminal conduct in the United States.

Sanctuary jurisdictions across the United States willfully violate Federal law in an attempt to shield aliens from removal from the United States. These jurisdictions have caused immeasurable harm to the American people and to the very fabric of our Republic.

Tens of thousands of removable aliens have been released into communities across the country, solely because their home countries refuse to accept their repatriation. Many of these aliens are criminals who have served time in our Federal, State, and local jails. The presence of such individuals in the United States, and the practices of foreign nations that refuse the repatriation of their nationals, are contrary to the national interest.

Although Federal immigration law provides a framework for Federal-State partnerships in enforcing our immigration laws to ensure the removal of aliens who have no right to be in the United States, the Federal Government has failed to discharge this basic sovereign responsibility. We cannot faithfully execute the immigration laws of the United States if we exempt

classes or categories of removable aliens from potential enforcement. The purpose of this order is to direct executive departments and agencies (agencies) to employ all lawful means to enforce the immigration laws of the United States.

Sec. 2. Policy. It is the policy of the executive branch to:

(a) Ensure the faithful execution of the immigration laws of the United States, including the INA, against all removable aliens, consistent with Article II, Section 3 of the United States Constitution and section 3331 of title 5, United States Code;

(b) Make use of all available systems and resources to ensure the efficient and faithful execution of the immigration laws of the United States;

(c) Ensure that jurisdictions that fail to comply with applicable Federal law do not receive Federal funds, except as mandated by law;

(d) Ensure that aliens ordered removed from the United States are promptly removed; and

(e) Support victims, and the families of victims, of crimes committed by removable aliens.

Sec. 3. Definitions. The terms of this order, where applicable, shall have the meaning provided by section 1101 of title 8, United States Code.

Sec. 4. Enforcement of the Immigration Laws in the Interior of the United States. In furtherance of the policy described in section 2 of this order, I hereby direct agencies to employ all lawful means to ensure the faithful execution of the immigration laws of the United States against all removable aliens.

Sec. 5. Enforcement Priorities. In executing faithfully the immigration laws of the United States, the Secretary of Homeland Security (Secretary) shall prioritize for removal those aliens described by the Congress in sections 212(a)(2), (a)(3), and (a)(6)(C), 235, and 237(a)(2) and (4) of the INA (8 U.S.C. 1182(a)(2), (a)(3), and (a)(6)(C), 1225, and 1227(a)(2) and (4)), as well as removable aliens who:

(a) Have been convicted of any criminal offense;

(b) Have been charged with any criminal offense, where such charge has not been resolved;

(c) Have committed acts that constitute a chargeable criminal offense;

(d) Have engaged in fraud or willful misrepresentation in connection with any official matter or application before a governmental agency;

(e) Have abused any program related to receipt of public benefits;

(f) Are subject to a final order of removal, but who have not complied with their legal obligation to depart the United States; or

(g) In the judgment of an immigration officer, otherwise pose a risk to public safety or national security.

Sec. 6. Civil Fines and Penalties. As soon as practicable, and by no later than one year after the date of this order, the Secretary shall issue guidance and promulgate regulations, where required by law, to ensure the assessment and collection of all fines and penalties that the Secretary is authorized under the law to assess and collect from aliens unlawfully present in the United States and from those who facilitate their presence in the United States.

Sec. 7. Additional Enforcement and Removal Officers. The Secretary, through the Director of U.S. Immigration and Customs Enforcement, shall, to the extent permitted by law and subject to the availability of appropriations, take all appropriate action to hire 10,000 additional immigration officers, who shall complete relevant training and be authorized to perform the law enforcement functions described in section 287 of the INA (8 U.S.C. 1357).

Sec. 8. Federal-State Agreements. It is the policy of the executive branch to empower State and local law enforcement agencies across the country to perform the functions of an immigration officer in the interior of the United States to the maximum extent permitted by law.

(a) In furtherance of this policy, the Secretary shall immediately take appropriate action to engage with the Governors of the States, as well as local officials, for the purpose of preparing to enter into agreements under section 287(g) of the INA (8 U.S.C. 1357(g)).

(b) To the extent permitted by law and with the consent of State or local officials, as appropriate, the Secretary shall take appropriate action, through agreements under section 287(g) of the INA, or otherwise, to authorize State and local law enforcement officials, as the Secretary determines are qualified and appropriate, to perform the functions of immigration officers in relation to the investigation, apprehension, or detention of aliens in the United States under the direction and the supervision of the Secretary. Such authorization shall be in addition to, rather than in place of, Federal performance of these duties.

(c) To the extent permitted by law, the Secretary may structure each agreement under section 287(g) of the INA in a manner that provides the most effective model for enforcing Federal immigration laws for that jurisdiction.

Sec. 9. Sanctuary Jurisdictions. It is the policy of the executive branch to ensure, to the fullest extent of the law, that a State, or a political subdivision of a State, shall comply with 8 U.S.C. 1373.

(a) In furtherance of this policy, the Attorney General and the Secretary, in their discretion and to the extent consistent with law, shall ensure that jurisdictions that willfully refuse to comply with 8 U.S.C. 1373 (sanctuary jurisdictions) are not eligible to receive Federal grants, except as deemed necessary for law enforcement purposes by the Attorney General or the Secretary. The Secretary has the authority to designate, in his discretion and to the extent consistent with law, a jurisdiction as a sanctuary jurisdiction. The Attorney General shall take appropriate enforcement action against any entity that violates 8 U.S.C. 1373, or which has in effect a statute, policy, or practice that prevents or hinders the enforcement of Federal law.

(b) To better inform the public regarding the public safety threats associated with sanctuary jurisdictions, the Secretary shall utilize the Declined Detainer Outcome Report or its equivalent and, on a weekly basis, make public a comprehensive list of criminal actions committed by aliens and

any jurisdiction that ignored or otherwise failed to honor any detainers with respect to such aliens.

(c) The Director of the Office of Management and Budget is directed to obtain and provide relevant and responsive information on all Federal grant money that currently is received by any sanctuary jurisdiction.

Sec. 10. Review of Previous Immigration Actions and Policies. (a) The Secretary shall immediately take all appropriate action to terminate the Priority Enforcement Program (PEP) described in the memorandum issued by the Secretary on November 20, 2014, and to reinstitute the immigration program known as "Secure Communities" referenced in that memorandum.

(b) The Secretary shall review agency regulations, policies, and procedures for consistency with this order and, if required, publish for notice and comment proposed regulations rescinding or revising any regulations inconsistent with this order and shall consider whether to withdraw or modify any inconsistent policies and procedures, as appropriate and consistent with the law.

(c) To protect our communities and better facilitate the identification, detention, and removal of criminal aliens within constitutional and statutory parameters, the Secretary shall consolidate and revise any applicable forms to more effectively communicate with recipient law enforcement agencies.

Sec. 11. Department of Justice Prosecutions of Immigration Violators. The Attorney General and the Secretary shall work together to develop and implement a program that ensures that adequate resources are devoted to the prosecution of criminal immigration offenses in the United States, and to develop cooperative strategies to reduce violent crime and the reach of transnational criminal organizations into the United States.

Sec. 12. Recalcitrant Countries. The Secretary of Homeland Security and the Secretary of State shall cooperate to effectively implement the sanctions provided by section 243(d) of the INA (8 U.S.C. 1253(d)), as appropriate. The Secretary of State shall, to the maximum extent permitted by law, ensure that diplomatic efforts and negotiations with foreign states include as a condition precedent the acceptance by those foreign states of their nationals who are subject to removal from the United States.

Sec. 13. Office for Victims of Crimes Committed by Removable Aliens. The Secretary shall direct the Director of U.S. Immigration and Customs Enforcement to take all appropriate and lawful action to establish within U.S. Immigration and Customs Enforcement an office to provide proactive, timely, adequate, and professional services to victims of crimes committed by removable aliens and the family members of such victims. This office shall provide quarterly reports studying the effects of the victimization by criminal aliens present in the United States.

Sec. 14. Privacy Act. Agencies shall, to the extent consistent with applicable law, ensure that their privacy policies exclude persons who are not United States citizens or lawful permanent residents from the protections of the Privacy Act regarding personally identifiable information.

Sec. 15. Reporting. Except as otherwise provided in this order, the Secretary and the Attorney General shall each submit to the President a report on the progress of the directives contained in this order within 90 days of the date of this order and again within 180 days of the date of this order.

Sec. 16. Transparency. To promote the transparency and situational awareness of criminal aliens in the United States, the Secretary and the Attorney General are hereby directed to collect relevant data and provide quarterly reports on the following:

(a) the immigration status of all aliens incarcerated under the supervision of the Federal Bureau of Prisons;

(b) the immigration status of all aliens incarcerated as Federal pretrial detainees under the supervision of the United States Marshals Service; and

(c) the immigration status of all convicted aliens incarcerated in State prisons and local detention centers throughout the United States.

Sec. 17. Personnel Actions. The Office of Personnel Management shall take appropriate and lawful action to facilitate hiring personnel to implement this order.

Sec. 18. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP

THE WHITE HOUSE,
January 25, 2017.

NHeLP
NATIONAL HEALTH LAW PROGRAM

What is a "Public Charge" and Does Receipt of Health Benefits Impact It?

By: Mara Youdelman

The purpose of this issue brief is to provide background information about "public charge" in light of a potential Executive Order that could redefine longstanding policies. Even the rumor of a potential Executive Order has raised concerns and fear in immigrant communities about accessing health care programs and services. Unless and until an Executive Order is issued, however, current policies remain in place.[1]

1. What is a "public charge"?

Public charge is an immigration term. A person may be determined a "public charge" if the person is likely to become "primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash for income maintenance, or institutionalization for long-term care at government expense."[2] A public charge determination is made when an individual applies to enter the U.S. or to adjust to lawful permanent resident status (*e.g.*, green card holder). Lawful permanent residents who are applying for citizenship are **not** subject to a public charge determination.

Congress first enacted a public charge exclusion in 1882.[3] At this time, federal and state governments offered few public health benefits or programs. Rather, the government supported almshouses – most of them in deplorable conditions – in which people with physical disabilities, abandoned children, drifters, petty criminals, and a growing number of immigrants who were poor were housed.[4] An immigrant who was a public charge was essentially an immigrant who was likely to end up in an almshouse.

2. What does the law require?

The Immigration and Nationality Act (INA) states that an individual seeking admission to the U.S. or seeking to adjust status to lawful permanent residence (green card) is inadmissible if the individual:

at the time of application for admission or adjustment of status, is likely at any time ***to become*** a public charge.[5] (emphasis added)

The language "to become" implies a future state such that receipt of benefits should not automatically preclude one from admission or adjustment of status. Further, the law generally requires a prospective "totality of circumstances" test so that someone who may have received benefits in the past but is now self-sufficient should not automatically be determined to be a public charge.

3. How have federal agencies interpreted the INA?

As federal and state governments began offering a range of benefits to citizens and immigrants, USCIS (U.S. Citizenship and Immigration Services, formerly the Immigration and Naturalization Service or INS) and the Department of State were forced to consider how to take such benefits into account in determining whether an individual was likely to become a public charge. Congress provided no guidance in this matter. Although public charge determinations were referenced in several sections of the INA (*e.g.*, with respect to deciding whom to exclude from entry), Congress never identified specifically which types of government support may be considered in a public charge determination.

After enactment of the Immigration Reform and Control Act (IRCA) in 1986 – the last comprehensive immigration reform law – INS confirmed that the determination as to whether an immigrant is likely to become a public charge must be based on the totality of circumstances at the time of the individual's application. INS would make a prospective "determination of financial responsibility" based on the individual's "age, health, income, and vocation."[6] In this case, if an individual's advanced age, poor health, lack of significant income, or lack of any foreseeable vocation indicated to INS that the individual may become completely destitute and reliant on the state for complete or primary support, the individual would be considered "likely to become a public charge."[7]

The last congressional actions occurred in the mid-1990's during debates on welfare and immigration reform. The only amendment Congress made to the public charge provision was to codify the longstanding "totality of the circumstances" test already in use.[8] This requires, at a minimum, consideration of an applicant's age; health; family status; assets, resources and financial status; and education and skills.[9] Instead of broadening the scope of public charge, Congress denied most immigrants eligibility for a range of benefits for the first five years they legally reside in the U.S. Congress also implemented broader "sponsor deeming"[10] rules and adopted a stricter affidavit of support which requires sponsors of immigrants to repay federal or state governments for benefits received by an immigrant.[11]

4. **Does public charge exclude any immigrant who has or might use public benefits from entering the U.S.?**

No. The basic purpose of the public charge exclusion was **not** to exclude every immigrant who might use some government funded benefits. Rather, the purpose was to exclude only those who would become completely destitute and dependent on the government. In making a public charge determination, USCIS or a consular officer uses a "totality of the circumstances" test so receipt of public benefits must be weighed against other factors.

5. **Why did federal agencies issue policies regarding public charge?**

After restrictions on immigrants' eligibility for benefits were enacted in 1996, concerns about public charge had a significant chilling effect on immigrants' receipt of benefits and particularly access to health care programs and services. Many immigrants were fearful of not just applying for benefits for which they or their children were eligible but feared even going to the doctor or the hospital. Immigrants found themselves unable to ascertain what would be considered in a public charge determination.

To alleviate the confusion, the Department of Justice (DOJ) took efforts to clarify which federal programs would – and more importantly would not – lead to a public charge determination. As noted in a 1999 proposed rule from DOJ:

> By defining "public charge," the Department seeks to reduce the negative public health consequences generated by the existing confusion and to provide [immigrants] with better guidance as to the types of public benefits that will and will not be considered in public charge determinations.[12]

6. **Under current policies, which benefits are considered in a public charge determination?**

Receipt of only the following types of benefits could result in a public charge determination:

- cash benefits for income maintenance (*e.g.*, TANF or state-funded cash assistance);
- Supplemental Security Income; and
- institutionalization for long-term care at government expense.[13]

But even receipt of these benefits would not automatically result in a public charge determination since the evaluation must be prospective based on the totality of the circumstances.[14]

7. **Under current policies, what health programs are excluded in making a public charge determination?**

Receipt of the following benefits or services has **not** been included in a public charge determination:

- Medicaid, including Vaccines for Children;
- CHIP;
- state-funded health insurance;
- other health insurance;
- health services – including public assistance for immunizations and for testing and treatment of symptoms of communicable diseases;
- use of health clinics;
- pre-natal care;
- emergency medical services; and
- short-term rehabilitation.[15]

8. **Why were these benefits excluded?**

When DOJ issued the proposed rule, their consensus was that noncash benefits provide **supplemental** support and do not lead to complete subsistence on the government. Indeed, receipt of these supports can help ensure that workers remain productive and self-reliant. According to the Department of Health and Human Services:

> it is extremely unlikely that an individual or family could subsist on a combination of non-cash support benefits or services alone. . . . HHS is unable to conceive of a situation where an individual, other than someone who permanently resides in a long-term care institution, could support himself or his family solely on non-cash benefits so as to be primarily dependent on the [G]overnment.[16]

9. **Are many immigrants currently affected by public charge determinations if they receive public benefits?**

Most lawfully present immigrants should not be determined to be a public charge because they are barred from receiving many public benefits for the first five years they are in the U.S.[17] And because of the "totality of the circumstances" test, even past receipt of benefits would not automatically lead to a determination of public charge.[18]

10. Can an Executive Order (EO) change the INA?

No. Unless Congress changes the law, a public charge determination must still consider the totality of the circumstances. For immigrants applying to enter the U.S. or adjust their status, the public charge determination must be prospective rather than retrospective (for deportations, the evaluation can determine whether the individual has become a public charge).

11. What can an Executive Order do to change current policies?

An EO can direct a federal agency – in this case U.S. Citizenship and Immigration Services and the Department of State – to expand the types of benefits that may be considered part of a public charge determination. Since the regulation defining public charge was proposed but never finalized, agencies likely will not have to follow normal procedural requirements to change a final regulation. Instead, they could issue new guidance (or propose regulations) with their interpretation of which benefits are included in a public charge determination. The guidance would still have to comply with the restrictions set forth in the statute.

12. If health programs are added to the public charge determination, will immigrants automatically be found ineligible for entry or adjustment?

No. The statute requires consideration of a number of factors in the "totality of the circumstances." So if receipt of Medicaid is considered, it could lead to a public charge determination **only if** the totality of the circumstances leads to the conclusion that the individual would be likely to become a public charge. But the chilling effect will preclude many immigrants from securing health care programs or services.

13. Can someone be deported as a public charge?

Yes, although this provision has been implemented only a few times in over 100 years. Deportations on public charge grounds have been rare since deportation standards are strict. Under the Immigration and Nationality Act, an immigrant is deportable if he or she becomes a public charge within five years after the date of entry into the U.S. for reasons that did not arise after entry.[19] Since most immigrants are barred from receiving Medicaid, CHIP and other public benefits for their first five years in the U.S., this is unlikely to occur (although some states have opted to provide benefits during the five years pursuant to the Immigrant Children's Health Improvement Act or with state funding). Further, the mere receipt of a public benefit within five years of entry does not make an immigrant deportable as a public charge. An immigrant is deportable only if:

- the state or other government entity that provides the benefit has the legal right to seek repayment from the individual or another obligated party (for example, a sponsor under an affidavit of support);
- the responsible program official makes a demand for repayment; and
- the immigrant or other obligated party, such as the immigrant's sponsor, fails to repay.[20]

Deportation cases from the 1940's through 1970's involved immigrants who were in government-funded mental institutions.

14. From a policy perspective, should a public charge determination be made based on receipt of public benefits?

No. The programs potentially affected by the proposed EO are essential, not only for immigrants and their family members, but for the health and well-being of the broader community. The broader fear generated by this EO already threatens to undermine public health, as well as to ensure healthy pregnancies, development of newborns, and children's growth and learning.

Many reasons exist as to why immigrants may access public benefits the U.S. As noted in a recent interview of a visiting assistant professor at City College of New York, expanding the public charge ground of inadmissibility would exacerbate the discrimination rooted in our immigration laws:

> The "likely to become a public charge" clause—poverty-based immigration control—can be really dangerous, precisely because it seems racially and ethnically neutral. Historically, the clause allowed racial and religious bigotry to flourish by giving too much power to law enforcers.[21]

ENDNOTES

[1] For additional resources on "public charge," see materials from the National Immigration Law Center, https://www.nilc.org/get-involved/community-education-resources/pubcharge/.
[2] *Field Guidance on Deportability and Inadmissibility on Public Charge Grounds*, 64 Fed. Reg. 28689 (May 26, 1999).
[3] In the Immigration Act of 1882, Congress authorized certain state officials to "go on board and through any . . .ship or vessel" arriving at state ports, examine the passengers, and deny landing permission to any passenger who was a "convict, lunatic, idiot, or any person unable to take care of himself or herself without becoming a public charge." 22 Stat. 214, Section 2.
[4] See David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, at 198-200, 290-221 (1971).
[5] *Id.*
[6] 8 C.F.R. § 245a.4(i).
[7] A specific statutory provision for immigrants seeking legalization under IRCA establishes a special rule for such individuals even if they are found, under the totality of the circumstances test, to be public charges. 8 U.S.C. § 1225a(d)(2)(B)(iii). This special rule focuses on a prospective determination that includes the "past acceptance of public cash assistance within a history of consistent employment." *Id., see also* 8 C.F.R. § 245a.3(g)(4)(iii). Non-cash benefits were explicitly excluded from this assessment. 8 C.F.R. § 245a.1(i).
[8] 8 U.S.C. § 1182(a)(4)(B).
[9] 8 U.S.C. § 1182(a)(4).
[10] Immigrants who have sponsors – generally via family or an employer – have the sponsor's income "deemed" available to the immigrant. Adding a sponsor's income and resources to that of an immigrant will often disqualify the immigrant as over-income for many federal programs.
[11] 8 U.S.C. §1183a.
[12] *Proposed Rule: Inadmissibility and Deportability on Public Charge Grounds,* 64 Fed. Reg. 28676 (May 26, 1999).This rule was not finalized. DOJ also issued guidance that currently governs public charge determinations which clarified longstanding policy and practice. *See,* Department of Justice, *Field Guidance on Deportability and Inadmissibility on Public Charge Grounds*, 64 Fed. Reg. 28689 (May 26, 1999), *available at* https://www.uscis.gov/ilink/docView/FR/HTML/FR/0-0-0-1/0-0-0-54070/0-0-0-54088/0-0-0-55744.html.
[13] *Id.*
[14] Proposed 8 C.F.R. § 212.106.
[15] Proposed 8 C.F.R. § 212.105. *See also,* U.S. Citizenship and Immigration Services, *Public Charge Fact Sheet, available at* https://www.uscis.gov/news/fact-sheets/public-charge-fact-sheet.
[16] 64 Fed. Reg. 28676, 28686 (May 26, 1999), Letter to INS Commissioner Doris Meissner from HHS Deputy Secretary Kevin Thurm, dated March 25, 1999.
[17] If a lawful permanent resident leaves the U.S. for more than six months and seeks to reenter, the immigrant would be subject to a public charge determination.
[18] 8 U.S.C. § 1182(a)(4).
[19] 8 U.S.C. § 1227(a)(5). Immigrants may also be deported for other reasons such as inadmissibility at time of entry or adjustment of status, criminal offenses, failure to register and falsification of documents, security and related groups, and unlawfully voting.
[20] 8 U.S.C. § 1183A. The benefit granting agency must seek repayment within 5 years of the immigrant's entry into the United States, obtain a final judgment, take all steps necessary to collect on that judgment, and be unsuccessful in those attempts. Even if these conditions are met, the immigrant has the opportunity to show that the reasons he or she became a public charge arose after the immigrant's entry into the U.S. An immigrant who can make such a showing is not deportable as a public charge.
[21] Emma Green, *First, They Excluded the Irish* (Feb. 2, 2017), *available at* https://www.theatlantic.com/politics/archive/2017/02/trump-poor-immigrants-public-charge/515397/.

INTERIM MEMO FOR COMMENT
Posted: 04-13-2012
Comment period ends: 04-27-2012
This memo is in effect until further notice.

U.S. Department of Homeland Security
U.S. Citizenship and Immigration Services
Office of the Director (MS 2000)
Washington, DC 20529-2000

U.S. Citizenship and Immigration Services

April 10, 2012 **PM-602-0061**

Policy Memorandum

SUBJECT: Adjudication of Immigration Benefits for Transgender Individuals; Addition of *Adjudicator's Field Manual* (AFM) Subchapter 10.22 and Revisions to AFM Subchapter 21.3 (AFM Update AD12-02)

Purpose
This Policy Memorandum (PM) and accompanying revisions to the AFM articulate USCIS policy regarding assigning appropriate gender designations on documents issued to transgender individuals and the adjudication of benefits applications involving the marriage of transgender individuals. The memorandum supersedes the following: *Memorandum for Regional Directors et al, Adjudication of Petitions and Applications Filed by or on Behalf of, or Document Requests by, Transsexual Individuals* (April 16, 2004); and *Adjudication of Petitions and Applications Filed by or on Behalf of Transsexual Individuals (January 14, 2009).*

Scope
Unless specifically exempted herein, this PM applies to and binds all USCIS employees.

Authority
Section 103(a) Immigration and Nationality Act; 8 CFR 103.1; Defense of Marriage Act, Pub. L. No. 104-199, 110 Stat. 2419 (1996); *Matter of Lovo-Lara*, 23 I&N Dec. 746 (BIA 2005).

Background
The *Memorandum for Regional Directors et al, Adjudication of Petitions and Applications Filed by or on Behalf of, or Document Requests by, Transsexual Individuals* (April 16, 2004) had been previously superseded, in part, with respect to issues of marriage by the memorandum on *Adjudication of Petitions and Applications Filed by or on Behalf of Transsexual Individuals (January 14, 2009).* The policy with respect to other documents was never updated, however. To clarify and unify the standards being applied to document issuance, as well as eligibility for benefits based upon marriage, the entire memo is now superseded and replaced with more comprehensive guidance on the same topics.

In 2005, the Board of Immigration Appeals (Board) issued the precedent decision *Matter of Lovo-Lara*, 23 I&N Dec. 746 (BIA 2005). The case involved a petitioner born in North Carolina who underwent sex reassignment surgery and then amended her birth certificate, reflecting her

transition from male to female. Subsequently, she married her husband in North Carolina and filed an I-130 petition on his behalf. The Board noted that North Carolina law does not permit individuals of the same gender to marry each other. The petitioner legally amended her birth certificate to reflect her change in gender designation, and the evidence the petitioner submitted to the Board included her amended birth certificate. Consequently, the Board found North Carolina considered the petitioner to be female under its laws and deemed her marriage to the beneficiary to be a valid heterosexual marriage. Although evidence of sex reassignment surgery was submitted in the *Lovo-Lara* case, the Board's decision does not require submission of evidence of surgery in order to establish a valid heterosexual marriage. Rather, the reasoning underlying the Board's decision suggests that the federal government should defer to how the state/local jurisdiction in which a claimed marriage takes place recognizes a legal change in gender for purposes of heterosexual marriage.

In 2009, USCIS issued guidance to the field to implement *Lovo-Lara*. This guidance required, in the case of a spousal Form I-130 or I-129F involving the claimed marriage between two persons of the same birth sex, the submission of evidence showing that one of the individuals had in fact undergone sex reassignment surgery to show a change of gender. Not all states or foreign jurisdictions that recognize a legal change of gender require the completion of gender reassignment surgery before an individual can legally change his or her gender. For this reason, USCIS is superseding previous guidance relating to transgender individuals to reflect the broader range of clinical treatments that can result in a legal change of gender under the law of the relevant jurisdiction.

Policy
USCIS officers will follow the policy stated in the Adjudicator's Field Manual, as amended by this PM, in adjudicating petitions or applications filed by or on behalf of transgender individuals.

Implementation
The *Adjudicator's Field Manual* (AFM) is amended as follows:

1. A new Chapter 10.22 is added to read as follows:

Chapter 10 An Overview of the Adjudication Process

* * * * *

10.22 Document Issuance Involving Status and Identity for Transgender Individuals

USCIS issues a variety of documents that show identity and immigration status in the United States. These include, but are not limited to, Employment Authorization Documents, Refugee Travel Documents, Permanent Resident Cards, and Naturalization Certificates. Applicants who claim to have changed their gender may seek issuance of these types of documents reflecting the new gender. While some of these documents indicate the individual's gender, and the applicant's gender may sometimes have bearing on underlying issues of eligibility for

immigration benefits (such as an approval of a Petition for Alien Relative, derivative spouse status, or marriage to a U.S. citizen for section 319(a) naturalization), the purpose of the document itself is to document the individual's identity and immigration status. Therefore, USCIS will issue an initial or amended document reflecting the individual's post-transition gender if the individual presents the following:

- An amended birth certificate, passport, or court order recognizing the new gender; or
- Medical certification of the change in gender from a *licensed* physician (a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)). This is based on standards[1] and recommendations[2] of the World Professional Association for Transgender Health who are recognized as the authority in this field by the American Medical Association.[3] Medical certification of gender transition received from a *licensed* physician (an M.D. or D.O.) is sufficient documentation, alone, of gender change. Additional information about medical certifications:
    - For the purposes of this chapter, only an M.D. or a D.O. qualifies as a licensed physician. Officers may accept medical certifications from any number of specialties as well as from general practitioners.
    - Statements from persons who are not licensed physicians, such as psychologists, physician assistants, nurse practitioners, social workers, health practitioners, chiropractors, *are not acceptable*.
    - The medical certification should include the following information:
        - Physician's full name;
        - Medical license or certificate number;
        - Issuing state, country, or other jurisdiction of medical license/certificate;
        - Drug Enforcement Administration registration number assigned to the doctor or comparable foreign registration number, if applicable;
        - Address and telephone number of the physician;
        - Language stating that that the individual has had appropriate clinical treatment for gender transition to the new gender (male or female);
        - Language stating that he/she *has either treated* the applicant in relation to the applicant's change in gender *or has reviewed and evaluated the medical history of the applicant in relation to the applicant's change in gender* and that he/she has a doctor/patient relationship with the applicant; and
- The applicant must submit evidence that any name change was completed according to the relevant state or foreign law;
- The applicant may also be asked to submit acceptable evidence of identity in the new gender, if available. State law and foreign laws vary as to whether a driver's license or other form of government issued identity document may be issued reflecting a gender change. If evidence of change of gender in the identity documents is not obtainable because of state, local or foreign requirements, the document may still be issued in the new gender based on the medical certification; and

[1] Standards of Care, 7th Version
[2] Identity Recognition Statement
[3] http://www.tgender.net/taw/ama_resolutions.pdf

- A recent facial photograph that reflects a good likeness of, and satisfactorily identifies the applicant must be submitted. The photograph must agree with the submitted identification evidence and reflect the applicant's current and true appearance. This can be submitted with the application or provided through biometrics collection at an ASC.

NOTE: Proof of sex reassignment surgery is *not* required to issue the requested document in the new gender and evidence of such surgery will not be requested. If such surgery has taken place, a statement to that effect in the medical certification is sufficient to establish the fact. USCIS will not ask for records relating to any such surgery.

As in all adjudications, if an officer finds significant substantive discrepancies, has reason to question the accuracy or authenticity of documents submitted, or finds other indicators of fraud, the case may be referred to FDNS in accordance with current national and local policies.

2. Chapter 21.3(a)(2)(J) is amended to read as follows.

21.3 Petition for Spouse.

(a) Petition by Citizen or LPR for a Spouse.

* * * * *

(2) Adjudicative issues.

* * * * *

(J) Transgender issues and marriage.

Benefits based upon marriage may be approved on the basis of a marriage between a transgender individual and an individual of the other gender if the Petitioner/Applicant establishes 1) the transgender individual has legally changed his or her gender and *subsequently*[4] married an individual of the other gender, 2) the marriage is recognized as a heterosexual marriage under the law where the marriage took place (*Matter of Lovo-Lara,* 23 I&N Dec. 746 (BIA 2005)), and 3) the law where the marriage took place does not bar a marriage between a transgender individual and an individual of the other gender.

While a timely registered heterosexual marriage certificate from the appropriate civil authority is prima facie evidence of the validity of a marriage, when an officer determines, based on the

[4] Note that subsequent marriage is at issue when looking at an initial marriage based benefit. For an individual who transitioned gender subsequent to a grant of conditional permanent residence, adjudication of a Petition to Remove the Conditions on Residence does not require the validity of the marriage at the time of filing or adjudication, rather the adjudication is dependent upon whether the marriage was valid and bona fide at inception and time of obtaining conditional permanent residence. The same does not hold true, however, for 319(a) adjudications which require that the marriage continues to be valid.

record or through interview or other means, that a party to a petition has changed gender, the officer must ascertain that the marriage is a valid heterosexual marriage under the laws of the jurisdiction in which it was contracted.

The validity of the marriage must be established by the preponderance of the evidence. As with most administrative immigration proceedings, the petitioner bears the "preponderance of the evidence" burden. Thus, even if there is some doubt, if the petitioner submits relevant, probative, and credible evidence that leads the director to believe that the claim is "probably true" or "more likely than not," the applicant or petitioner has satisfied the standard of proof. *See U.S. v. Cardozo-Fonseca*, 480 U.S. 421 (1987) (defining "more likely than not" as a greater than 50 percent probability of something occurring). As such, officers should be satisfied that this burden is met if the marriage is recognized in the jurisdiction in which it was contracted as a heterosexual marriage. USCIS will presume the validity of the marriage involving a transgender individual in the absence of jurisdictional law and/or precedent that would place the validity of such marriage in doubt. Only in jurisdictions where a specific law or precedent either prohibits or sets specific requirements for a legal change of gender for purposes of that jurisdiction's marriage laws is the individual required to demonstrate that he or she has met the specific requirements needed to establish the legal change of gender and the validity of the marriage. The individual may also show, in an appropriate case, that the law barring a legal change of gender for purposes of marriage has changed and that the marriage is valid under current law.

Where an individual claims to have legally changed his or her gender, USCIS will recognize that such individual's gender changed based upon the following documentation:

- Amended birth certificate; or
- Other official recognition of new gender, such as a passport, court order, certificate of naturalization or citizenship, or driver's license (note that some jurisdictions may have a lower threshold for issuing a driver's license than to establish a legal change of gender for purposes of the marriage laws, and USCIS would require additional evidence that the individual met the threshold for marriage, if applicable); or
- Medical certification of the change in gender from a *licensed* physician (a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)). This is based on standards[5] and recommendations[6] of the World Professional Association for Transgender Health, who are recognized as the authority in this field by the American Medical Association.[7] Medical certification of gender transition received from a *licensed* physician (an M.D. or D.O.) is sufficient documentation, alone, of gender change. If the physician certifies the gender transition, USCIS will not "go behind" the certificate by asking for specific information about the individual's treatment. Additional information about medical certifications:
    - For the purposes of this chapter only an M.D. or a D.O. qualifies as a licensed physician. Officers may accept medical certifications from any number of specialties as well as from general practitioners.

[5] Standards of Care, 7th Version
[6] Identity Recognition Statement
[7] http://www.tgender.net/taw/ama_resolutions.pdf

- Statements from persons who are not licensed physicians, such as psychologists, physician assistants, nurse practitioners, social workers, health practitioners, chiropractors, *are not acceptable*.
- The medical certification should include the following information:
  - Physician's full name;
  - Medical license or certificate number;
  - Issuing state, country, or other jurisdiction of medical license/certificate;
  - Drug Enforcement Administration registration number assigned to the doctor or comparable foreign registration number, if applicable;
  - Address and telephone number of the physician;
  - Language stating that that the individual has had appropriate clinical treatment for gender transition to the new gender (male or female);
  - Language stating that he/she *has either treated* the applicant in relation to the applicant's change in gender *or has reviewed and evaluated the medical history of the applicant in relation to the applicant's change in gender* and that he/she has a doctor/patient relationship with the applicant

Sex reassignment surgery is *not* required in order for USCIS to approve a Form I-130 to establish a legal change of gender unless the law of the place of marriage clearly requires sex reassignment surgery in order to accomplish a change in legal gender. The *fact* of sex reassignment surgery, however, would generally be reflected in the medical certification. USCIS will not ask for records relating to any such surgery.

These documents are listed in order of evidentiary preference. Officers must recognize, however, that the personal circumstances and jurisdictions involved in an individual's case will affect availability of specific types of documentation. As evidence of the new gender, officers should treat an amended birth certificate as carrying the same weight as USCIS would normally give to other timely registered primary evidence.

This guidance also applies to the adjudication of all immigration benefits based upon marriage, including but not limited to a Petition for Alien Fiancé(e). In the case of a proposed marriage involving a transgender individual, the petition may be approved assuming the same conditions are met for legal gender change and validity of the marriage as described above. If the record indicates the parties' specific intent to marry in a jurisdiction where the marriage would not be valid, the officer will issue an intent to deny in which the petitioner is informed that the marriage would not be valid for immigration purposes and why. USCIS will provide the petitioner the opportunity to submit evidence that USCIS's interpretation of the jurisdiction's law and/or precedent is incorrect or provide an affidavit attesting that the intended marriage will take place in a jurisdiction where the marriage will be valid for immigration purposes.

The same principles for determining the validity of a marriage involving a transgender individual for a spousal Petition for Alien Relative apply to those who may derive an immigrant or nonimmigrant benefit by virtue of a spousal relationship.

If an officer has questions about the validity of a marriage involving a transgender individual, the officer should contact local USCIS counsel.

As in all adjudications, if an officer finds significant substantive discrepancies, has reason to question the accuracy or authenticity of documents submitted, or finds other indicators of fraud, the case may be referred to FDNS in accordance with current national and local policies.

***

3. The AFM Transmittal Memorandum button is revising by adding, in numerical order, a new entry to read:

AD 12-02 04/10/2012	Chapter 10.22; **Chapter** 21.3(a)(2)(J)	Provides guidance on the adjudication of applications and petitions for immigration benefits filed by or in behalf of transgendered individuals.

Use

This PM is intended solely for the guidance of USCIS personnel in the performance of their official duties. It is not intended to, does not, and may not be relied upon to create any right or benefit, substantive or procedural, enforceable at law or by any individual or other party in removal proceedings, in litigation with the United States, or in any other form or manner.

Contact Information

Questions or suggestions regarding this PM should be addressed through appropriate channels to the Field Operations Directorate or the Service Center Operations Directorate *and* the Office of Chief Counsel and Office of Policy and Strategy.

HUMAN RIGHTS WATCH

"Do You See How Much I'm Suffering Here?"

Abuse against Transgender Women in US Immigration Detention

HUMAN RIGHTS WATCH

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"Do You See How Much I'm Suffering Here?"

Abuse against Transgender Women in US Immigration Detention

Background

US Immigration Law

Under US immigration law, transgender women who are fleeing persecution because of their gender identity or gender expression may have a valid claim to asylum.

As a party to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (the "Convention against Torture"), the US is obligated not to return somebody to a country "where there are substantial grounds for believing that [they] would be in danger of being subjected to torture."

In making this determination, the convention obligates governments to "take into account all relevant considerations including, where applicable, the existence in the State concerned a consistent pattern of gross, flagrant or mass violations of human rights."[10]

In the groundbreaking decision of *Avendano-Hernandez v. Lynch* in September 2015, the US Court of Appeals for the Ninth Circuit ruled that an undocumented transgender woman from Mexico who had a prior felony conviction could not be deported from the United States due to the high likelihood that she would experience future torture if she were returned to Mexico.[11] The court found that the US Board of Immigration Appeals (BIA) had erred in an earlier decision to deny the woman deportation relief under the Convention against Torture "because it [had] failed to recognize the difference between gender identity and sexual orientation."[12]

The decision set an important precedent for transgender people seeking protection in the US and provides clear guidance to immigration judges reviewing future claims of persecution based on gender identity or expression.

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10. Convention against Torture, art. 3(1).

11. *Avendano-Hernandez v. Lynch,* No. 13-73744 (9th Cir. 2015), p. 10.

12. Ibid, p. 2.

Mandatory Custody

Regardless of whether they may be able to remain in the US, transgender women and other asylum seekers who are in removal proceedings are often held in detention facilities until immigration courts decide their cases.

In the past two decades, the United States has made a major shift in immigration policy, using detention as a primary means of enforcement, regardless of whether an individual non-citizen is a flight risk or a danger to the community.

Two 1996 laws drastically expanded "mandatory custody" without bond to large categories of non-citizens, including asylum seekers and permanent residents who are detained as a result of mostly low-level criminal convictions.[13]

These same laws also established a new procedure that allows immigration inspectors to summarily remove immigrants arriving without proper documentation. Under this policy, the vast majority of migrants who cross the US-Mexico border without authorization are mandated to detention and undergo a hasty two-part assessment by US officials under either "expedited removal" for first-time border crossers, or "reinstatement of removal," for migrants who have previously been deported from the US.[14] These processes include fast-track screenings for a migrant's fear of persecution or torture upon return to their home country or an intention to apply for asylum.[15]

According to data for 2011 and 2012 that Human Rights Watch obtained from US Customs and Border Protection under the Freedom of Information Act, a vast majority of migrants from Mexico, Honduras, El Salvador, and Guatemala who arrive at the US border are placed in fast-track expedited removal and reinstatement of removal proceedings.[16] The data also show that only a minuscule minority of these individuals, ranging from 0.1 to 5.5 percent, were flagged for credible fear assessments which would allow them to apply for asylum or

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13. Antiterrorism and Effective Death Penalty Act of 1996, P.L. 104-132; Illegal Immigration Reform and Immigrant Responsibility Act of 1996, P.L. 104-208 (Division C).

14. Human Rights Watch, *'You Don't Have Rights Here': US Border Screening and Returns of Central Americans to Risk of Serious Harm,* October 2014, https://www.hrw.org/report/2014/10/16/you-dont-have-rights-here/us-border-screening-and-returns-central-americans-risk, p 7.

15. Ibid, p.2.

16. Ibid, p. 8.

other forms of protection.[17] By comparison, 21 percent of migrants from other countries who underwent the same proceedings in the same years were flagged for credible fear interviews by CBP.[18]

Under expedited removal, a would-be asylum seeker faces mandatory custody until and unless an official with the US asylum office makes a preliminary determination that they have a credible claim to protection.

Under reinstatement of removal, a would-be asylum seeker is mandatorily detained until they can prove that they qualify for protection in an immigration court, a process that regularly takes a year or more to complete.

Mandatory custody also applies to non-citizens with certain criminal offenses, including nonviolent offenses, which can lead to deportation.[19] These provisions require ICE to detain non-citizens who have finished serving sentences for certain crimes without even the possibility of a bond hearing to determine whether it is appropriate to release them pending the outcome of deportation proceedings.

This is in contrast to the US criminal justice system, where no one is held in comparable circumstances (in pretrial detention, for example) without a hearing to determine if they are a flight risk or dangerous.[20]

The nonviolent crimes that can result in mandatory custody after the criminal sentence is served include controlled substance offenses (including simple possession) and certain crimes involving "moral turpitude" (including involvement in sex work), depending on the status of the non-citizen and the sentence imposed.[21]

Among the transgender women that we interviewed, nearly half were mandated to detention because of mostly low-level criminal convictions, including sex work, false

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17. Ibid, p. 8.

18. Ibid, p. 8.

19. 8 U.S.C. Section 1226(c).

20. Human Rights Watch, *Costly and Unfair: Flaws in US Immigration Detention Policy*, May 2010, https://www.hrw.org/report/2010/05/06/costly-and-unfair/flaws-us-immigration-detention-policy, p. 3.

21. Human Rights Watch, *A Price Too High: US Families Torn Apart by Deportations for Drug Offenses*, June 2015, https://www.hrw.org/report/2015/06/16/price-too-high/us-families-torn-apart-deportations-drug-offenses, p. 46.

identification, and minor drug possession charges. While most of these convictions were so minor that they resulted in little or no prison time in the criminal justice system, they still mandated transgender women to be detained, often in settings where they experienced abuse and neglect.

Immigration Detention under Obama

The US detains immigrants in a vast network of about 250 facilities nationwide. These vary widely: some are local jails that have agreed to provide space to the federal government to detain non-citizens, some are operated by private prison companies, and a few are run by ICE itself.

In all, under current congressional appropriations language, ICE is required to "maintain a level of not less than 34,000 detention beds" across these many facilities.[22]

Though immigration detention is civil detention, jail-like conditions persist in many of the facilities in which non-citizens are held. In 2009, the Obama administration announced its plan to transform immigration detention into a "truly civil detention system" and to improve conditions for those who are vulnerable to abuse in detention.[23]

Since then, ICE has developed a number of specific policies aimed to prevent sexual assault and limit the use of solitary confinement in detention, including a number of dedicated protections for transgender people.[24]

For instance, ICE's 2011 detention standards state that housing placements "should not be based solely on the identity documents or physical anatomy of the detainee,"[25] and that, whenever possible, transgender people should be able to choose the gender of a guard performing a strip search.[26]

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22. H.R. 2029, 114th Congress (2015-2016). Available: http://docs.house.gov/billsthisweek/20151214/CPRT-114-HPRT-RU00-SAHR2029-AMNT1final.pdf.

23. Nina Bernstein, "U.S. to Reform Policy on Detention for Immigrants," *New York Times*, August 6, 2009, http://www.nytimes.com/2009/08/06/us/politics/06detain.html (accessed December 1, 2015).

24. US Immigration and Customs Enforcement, "Performance-Based National Detention Standards 2011" (PBNDS 2011), available: http://www.ice.gov/detention-standards/2011.

25. US Immigration and Customs Enforcement, PBNDS 2011, "Custody Classification," section 2.2, p. 73.

26. US Immigration and Customs Enforcement, PBNDS 2011, "Searches of Detainees," section 2.11, p. 144.

In May 2012, President Barack Obama issued a memorandum requiring federal agencies that operate confinement facilities, including ICE detention facilities operating under the supervision of the US Department of Homeland Security (DHS), adhere to the requirements of the Prison Rape Elimination Act (PREA), which Congress passed unanimously in 2003.

DHS issued detailed standards complying with the presidential memorandum in February 2014, stating a formal commitment to "prevent, detect, and respond to sexual abuse" in immigration detention facilities.[27]

But these advances are of limited relevance to the majority of people that ICE detains because most are held in county jails, privately operated prisons, and other contracted facilities that often operate with limited independent oversight and inadequate implementation of federal detention standards.[28]

Transgender Immigrant Detention under Obama

In June 2015, ICE announced a new set of transgender detention guidelines (the "guidelines") that formally recognizes the vulnerability of transgender people in detention.

The policy is an important development for transgender women, who until recently were housed primarily among male populations and have long faced disproportionately high rates of sexual assault by both guards and male detainees. The guidelines instruct immigration officials to "consider whether the use of detention resources is warranted" and to assess "on a case by case basis, all relevant factors in this determination, including whether an individual identifies as transgender."[29]

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27. US Department of Homeland Security, "DHS Announces Finalization of Prison Rape Elimination Act Standards," http://www.dhs.gov/news/2014/02/28/dhs-announces-finalization-prison-rape-elimination-act-standards (accessed December 17, 2015).

28. National Immigrant Justice Center and Detention Watch Network, "Lives in Peril: How Ineffective Inspections Make ICE Complicit in Detention Center Abuse," October 2015, http://immigrantjustice.org/lives-peril-how-ineffective-inspections-make-ice-complicit-detention-center-abuse-0 (accessed November 23, 2015).

29. US Immigration and Customs Enforcement, "Further Guidance Regarding the Care of Transgender Detainees," June 19, 2015, available https://www.ice.gov/sites/default/files/documents/Document/2015/TransgenderCareMemorandum.pdf, p. 1.

In an effort to improve the safety of transgender people in detention, the guidelines:

- Instruct immigration officials to make individualized housing assessments following an assessment by medical and mental health experts, allowing transgender people to be housed in men's or women's facilities; in segregated units that exclusively house transgender women; or under exceptional circumstances, in solitary confinement.
- Call for guard sensitivity trainings and improved access to gender-affirming medical care.
- Establish specialized intake procedures intended to gather important demographic information and to ensure that individuals who identity as transgender are properly identified and referred to by guards and staff with the use of their preferred gender pronouns.
- Call for the establishment of a "Transgender Care and Classification Committee" (TCCC) at facilities that have voluntarily incorporated its provisions.[30] The guidelines instruct that these committees should be composed of medical and mental health personnel, detention facility supervisors, and other relevant ICE officials or facility staff, who will convene upon a transgender person's admission to a detention facility and develop a plan regarding their housing placement, medical care, and necessary security provisions.[31]
- State that transgender people should be housed "in a location away from the general population" for up to 72 hours while the committee's assessment is being completed. Housing accommodations during this period may include placement in a "medical unit or protective custody" or, if there is no other available option, in administrative segregation.[32]

Despite these advances, the measures lack an independent oversight mechanism to ensure their implementation in the nearly 250 facilities where detained immigrants are held throughout the US.

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30. US Immigration and Customs Enforcement, "Further Guidance Regarding the Care of Transgender Detainees," Attachment 1: ICE Detention Facility Contract Modification for Transgender Care, sections 2-3.

31. Ibid.

32. US Immigration and Customs Enforcement, "Further Guidance Regarding the Care of Transgender Detainees," Attachment 1: ICE Detention Facility Contract Modification for Transgender Care, section 1.

The immigration detention system includes service processing centers operated directly by ICE, contract detention facilities managed by private prison companies, and reserved bed space at state and county jails.

The policy instructs immigration authorities to give priority to the placement of transgender women in facilities that have either adopted the transgender detention guidelines or in facilities that operate a segregated housing unit for transgender women. However, these units will only be established at a select number of facilities that voluntarily elect to negotiate the provisions into their existing operating contracts with ICE.

Beyond these shortcomings, the guidelines permit the continued use of solitary confinement solely on the basis of an individual's gender identity, stating that "placement into administrative segregation due to a detainee's identification as transgender should be used only as a last resort and when no other temporary housing option exists."[33] Indefinite solitary confinement is a form of human rights abuse and is not a legitimate way of protecting individuals in detention from other forms of abuse.

The policy also states that transgender individuals should "not be disciplined for refusing to answer any gender identity-related questions during processing, for not disclosing complete information in response to questions asked about gender identity, or for falsely reporting that he or she is not transgender."[34] Transgender people may fear disclosing their gender identity to detention facility staff or ICE officials due to fear of abuse or retaliation. ICE officials should therefore provide transgender people continuous opportunities to disclose their gender identity and to request alternative housing accommodations.[35]

Santa Ana

Since March 2012, ICE has operated a segregated housing unit, or "pod," at the Santa Ana City Jail in Santa Ana, California, for transgender women and gay and bisexual men.

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33. US Immigration and Customs Enforcement, "Further Guidance Regarding the Care of Transgender Detainees," section 3(c).

34. Ibid, section 2(f).

35. As of February 2016, Human Rights Watch was aware of at least two recent cases where transgender women who had declined to disclose their gender identity to detention facility staff or ICE officials were being held among the general male population.

Since August 2015, the pod has been used to exclusively house transgender women,[36] and ICE has begun transferring transgender women there who were previously housed in men's facilities. It is currently the only formally designated unit used to exclusively house transgender women in ICE custody. As of February 2016, 26 transgender women were being held in the unit according to ICE—a large proportion of all transgender women in immigration detention.

Nevertheless, at time of writing the facility had yet to incorporate the 2015 Transgender Care Memorandum into its operating agreement with ICE. Although ICE has conducted guard sensitivity trainings at the facility since the unit was established, Human Rights Watch found that transgender women held there continued to face abusive and humiliating treatment by guards, including:

- Invasive strip searches conducted by male guards;
- Frequent "lockdowns" for mostly minor disciplinary infractions, involving being confined to their cells for 22 to 24 hours per day; and
- Severely inadequate medical and mental health services to address their unique needs and particular vulnerabilities.

Human Rights Abuses against Transgender Women in the US

Transgender women face high levels of poverty, violence, and discrimination throughout the US. This often includes targeted police profiling, which has contributed to their disproportionate involvement in the criminal justice system and may leave them particularly vulnerable to the requirements of mandatory custody.[37]

Previous Human Rights Watch research has found that in some jurisdictions, transgender women are frequently profiled, stopped and searched by police, and then accused of involvement of sex work simply because they are carrying condoms.[38]

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36. Jessica Kwong, "Santa Ana distances itself from immigration agency in rare rejection of jail contract expansion," *Orange County Register*, February 2, 2016, http://www.ocregister.com/articles/santa-702571-housing-detainees.html (accessed February 4, 2016).

37. For more information, see Movement Advance Project and Center for American Progress, "Unjust: How the Broken Criminal Justice System Fails LGBT People," February 2016, http://www.lgbtmap.org/news/lgbt-criminal-justice-release (accessed March 1, 2016).

38. Human Rights Watch, *Sex Workers at Risk: Condoms as Evidence of Prostitution in Four US Cities*, July 2012, https://www.hrw.org/report/2012/07/19/sex-workers-risk/condoms-evidence-prostitution-four-us-cities, p. 9.

Transgender people also report higher rates of personal drug use than compared to the general population. According to the 2011 National Transgender Discrimination Survey, 26 percent of transgender people reported either currently or previously using drugs or alcohol to cope with the impacts of discrimination related to their gender identity.[39]

Transgender women in the US experience disproportionately high rates of sexual assault in confinement facilities, including in jails and prisons within the criminal justice system and in civil immigration detention facilities. Numerous studies have found that transgender women of color and those who are poor or undocumented often experience verbal, physical, and sexual abuse while they are held in police custody.[40]

A 2013 investigation by the US Government Accountability Office found that three out of fifteen substantiated incidents of sexual assault in US immigration detention facilities involved transgender women. Two of these cases involved transgender women who were sexually assaulted by male guards while they were housed in solitary confinement. [41]

Similarly, the 2014 National Inmate Survey, conducted by the US Bureau of Justice Statistics, found that 33.2 percent of transgender women in state and federal prisons reported experiencing sexual abuse by other prisoners, and 15.2 percent reported abuse by facility staff.[42] During the same period, 15.8 percent of transgender women at local jails reported abuse by other prisoners, and 18.3 percent reported abuse by facility staff.[43]

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39. National Center for Transgender Equality and the National LGBTQ Task Force, "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey," 2011, http://www.transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf, p. 81.

40. National Center for Transgender Equality and the National LGBTQ Task Force, "Injustice at Every Turn," 2011; National Coalition of Anti-Violence Programs, "Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate Violence 2014," http://www.avp.org/storage/documents/Reports/2014_HV_Report-Final.pdf; Noah Remnick; "Activists Say Police Abuse of Transgender People Persists Despite Reforms," *New York Times*, September 6, 2015, http://www.nytimes.com/2015/09/07/nyregion/activists-say-police-abuse-of-transgender-people-persists-despite-reforms.html?_r=0 (accessed December 1, 2015).

41. US Government Accountability Office, "Immigration Detention: Additional Actions Could Strengthen DHS Efforts to Address Sexual Abuse," (GAO-14-38), November 20, 2013, http://www.gao.gov/products/GAO-14-38 (accessed December 1, 2015), p. 60.

42. US Department of Justice, Bureau of Justice Statistics, "Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12; Supplemental Tables: Prevalence of Sexual Victimization Among Transgender Adult Inmates," December 2014, http://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf (accessed December 1, 2015), Table 2, p. 2.

43. Ibid.

In total, approximately 40 percent of surveyed transgender people held in state and federal prisons during this period reported that they experienced sexual abuse, compared to 14 percent of gay, lesbian and bisexual prisoners, and 3.1 percent of heterosexual prisoners.[44]

The financial and psychological impacts of detention can pose particular challenges for transgender women, who according to the 2011 National Transgender Discrimination Survey, face systemic levels of poverty, violence, and discrimination throughout the US.[45] Similarly, a 2013 survey by the TransLatin@ Coalition found that transgender immigrants in the US face structural barriers that severely limit their access to housing, medical care, and mental health services, and that many experience high rates of unemployment and depression.[46]

Despite these challenging circumstances, community-based organizations throughout the US have developed a network of resources to support transgender women who face substantial barriers in their attempts to access housing, counseling, legal assistance, and other essential services when they are released from detention.

For several years, transgender immigrant activists and their allies have led local and national advocacy efforts seeking to improve treatment of transgender women and advocating their release from detention. Organizations such as Familia: Trans Queer Liberation Movement and the Transgender Law Center have organized public demonstrations and online social media efforts, including the #FreeMarichuy,[47]

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44. Deborah Sontag, "Push to End Prison Rapes Loses Earlier Momentum," *New York Times*, May 12, 2015, http://www.nytimes.com/2015/05/13/us/push-to-end-prison-rapes-loses-earlier-momentum.html?_r=0 (accessed March 4, 2016).

45. National Center for Transgender Equality and the National LGBTQ Task Force, "Injustice at Every Turn," 2011.

46. TransLatin@ Coalition, "TransVisible: Transgender Latina Immigrants in US Society," January 2014, http://www.chicano.ucla.edu/files/news/transvisiblereport.pdf (accessed March 4, 2016), pp. 2-4.

47. Jorge Rivas, "LGBT activists protest abuses suffered by transgender detainee," *Fusion*, August 8, 2014, http://fusion.net/story/6237/lgbt-activists-protest-abuses-suffered-by-transgender-detainee/ (accessed December 1, 2015).

#FreeNicoll,[48] and #FreeChristina[49] campaigns, which have brought new attention to the plight of detained transgender immigrants.[50]

Transgender Women and the Call for Alternatives to Detention

While ICE plans to begin collecting data relating to sexual orientation and gender identity of people in immigration detention, there is currently very limited statistical data available on these populations.[51]

ICE officials estimate that among a nationally detained population of approximately 30,000 migrants and asylum seekers, there are approximately 65 transgender women in detention on any given day.[52] According to a December 2015 investigation by *Univision*, ICE officials stated that there were 36 transgender women held in the segregated unit at Santa Ana, and 20 held in other detention facilities throughout the US at that time.[53]
When Human Rights Watch requested the same information from ICE on February 2, 2016, officials said there were 26 transgender women at Santa Ana at that time. However, the officials claimed not to have information regarding the number of transgender women being held in other facilities, or their conditions of confinement.[54]

A recent report by the Center for American Progress indicates that ICE does not effectively conduct individualized assessments when determining whether people who are mandated

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48. Adam Frankel, "Dispatches: Fighting to be Free in the US – Nicoll's Story," Human Rights Watch dispatch, March 18, 2015, https://www.hrw.org/news/2015/03/18/dispatches-fighting-be-free-us-nicolls-story (accessed November 11, 2015).

49. "Trans Latina women demand ICE to #FreeChristina," November 18, 2015, video clip, YouTube, https://www.youtube.com/watch?v=P5Rvm59-jSw (accessed December 29, 2015).

50. Liam Stack, "Activist Removed After Heckling Obama at L.G.B.T. Event at White House," *New York Times*, June 24, 2015, http://www.nytimes.com/2015/06/25/us/politics/activist-removed-after-heckling-obama-at-lgbt-event.html?_r=0 (accessed December 1, 2015).

51. According to a statement by ICE officials to Human Rights Watch in February 2016, "At this time, ICE is not able to provide such cumulative data. As part of the implementation of its Transgender Care Memorandum, ICE recently updated electronic data systems to capture a detainee's self-identification as Transgender. ICE is continuing to work on the next phase of implementation, which would allow for the generation of a report detailing the number of transgender individuals in ICE custody nationwide." Human Rights Watch email communication with Lana Khoury, ICE senior advisor for LGBTI care, February 2, 2016.

52. Brianna Lee, "Immigration Reform: Transgender Immigrants Skeptical of New Detention Guidelines Designed To Protect Them," *International Business Times*, July 9, 2015, http://www.ibtimes.com/immigration-reform-transgender-immigrants-skeptical-new-detention-guidelines-designed-2000057 (accessed December 1, 2015).

53. Norma Ribeiro, "Inmigrantes transgénero denuncian que el Centro de Detención de Santa Ana es un 'infierno;" *Univision*, December 16, 2015, http://www.univision.com/noticias/univision-investiga/inmigrantes-transgenero-denuncian-que-el-centro-de-detencion-de-santa-ana-es-un-infierno (accessed December 29, 2015).

54. Human Rights Watch email communication with Lana Khoury, ICE senior advisor for LGBTI care, February 2, 2016.

to detention should be held in institutional detention facilities or released to community-based alternatives to detention.[55]

Since January 2013, ICE has used a computer-automated "risk classification assessment" tool to assess housing arrangements in detention facilities and to determine whether individuals should be released from ICE custody.[56]

Despite automated recommendations to provide release as an option in 70 percent of cases where individuals expressed a fear of abuse in detention due to their sexual orientation or gender identity, ICE officers used their individual discretion and elected to detain people in 68 percent of these cases.[57]

According to an analysis of ICE data obtained by the Center for American Progress, ICE officers elected to detain LGBT individuals in 19 percent of cases where they were explicitly recommended for release from detention.[58] Comparatively, a recent study by the Inspector General of the US Department of Homeland Security found that ICE officers only used their discretion to detain individuals who were explicitly recommended for release in 7.6 percent of all cases among the general population.[59]

In June 2015, 35 members of Congress urged US Secretary of Homeland Security Jeh Johnson to develop community-based alternatives for transgender women and others who are uniquely vulnerable to abuse in detention.[60]

Community-based alternatives to detention, which may involve individual case management and referrals to legal, medical, and psychological support services, could in

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55. "No Way Out: Congress' Bed Quota Traps LGBT Immigrants in Detention," Center for American Progress, May 14, 2015, https://www.americanprogress.org/issues/lgbt/news/2015/05/14/111832/no-way-out-congress-bed-quota-traps-lgbt-immigrants-in-detention/ (accessed December 1, 2015).

56. US Department of Homeland Security, Office of Inspector General, "US Immigration and Customs Enforcement's Alternatives to Detention (Revised)," OIG-15-22, February 2015, https://www.oig.dhs.gov/assets/Mgmt/2015/OIG_15-22_Feb15.pdf (accessed October 5, 2015), p. 4.

57. "No Way Out: Congress' Bed Quota Traps LGBT Immigrants in Detention," Center for American Progress, May 14, 2015.

58. Ibid.

59. US Department of Homeland Security, Office of Inspector General, "U.S. Immigration and Customs Enforcement's Alternatives to Detention (OIG-15-22)," February 2015, p. 14.

60. Letter from Members of the United States Congress to US Homeland Security Secretary Jeh Johnson, June 23, 2015, http://grijalva.house.gov/uploads/2015_6_23_LGBT_Detainee_Letter.pdf (accessed October 7, 2015).

many cases ensure high rates of appearance in immigration proceedings without subjecting transgender women to dangerous abuse in detention.[61]

[61] See United States Conference of Catholic Bishops and the Center for Migration Studies, "Unlocking Human Dignity: A Plan to Transform the U.S. Immigrant Detention System," 2015, http://www.usccb.org/about/migration-and-refugee-services/upload/unlocking-human-dignity.pdf (accessed October 7, 2015), pp. 28-29.

IV. Medical and Mental Health Care

The US immigration detention system has broadly failed to provide adequate medical care to detained immigrants. As a result, people in immigration detention have experienced unnecessary health complications and in extreme cases, even death.[157]

In one such instance in July 2007, Victoria Arellano, a 23-year-old Mexican transgender woman, died in ICE custody after medical staff refused to provide her access to her HIV medication.[158] Previous research by Human Rights Watch and others have documented systemic failures in provision of basic medical care to women,[159] people living with HIV/AIDS,[160] and mothers and their children held in US immigration detention.[161]

Transgender women in immigration detention—including those housed in the segregated unit at Santa Ana—have faced obstacles in their attempts to access essential services including gender-affirming hormone replacement therapy and life-sustaining HIV/AIDS medications. They have also experienced discriminatory interactions with medical providers, delays or denial of access to routine care, and breaches of confidentiality.

A 2013 study on mental health challenges facing LGBT forced migrants found that many "have significant and sometimes incapacitating psychological scars" resulting from years of verbal harassment, physical, and sexual abuse. Commonly viewed symptoms among

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157. American Civil Liberties Union, Detention Watch Network, and National Immigrant Justice Center, "Fatal Neglect: How ICE Ignores Death in Detention," February 2016, https://www.aclu.org/report/fatal-neglect-how-ice-ignores-death-detention (accessed March 1, 2016).

158. Human Rights Watch, *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States,* pp. 25-26.

159. Human Rights Watch, *Detained and Dismissed: Women's Struggles to Obtain Health Care in United States Immigration Detention,* March 2009, http://www.hrw.org/report/2009/03/17/detained-and-dismissed/womens-struggles-obtain-health-care-united-states.

160. Human Rights Watch, *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States,* December 2007, https://www.hrw.org/report/2007/12/05/chronic-indifference/hiv/aids-services-immigrants-detained-united-states; "HIV screening and care for immigration detainees," by Homer D. Venters, Jennifer McNeely, and Allen S. Keller, *Health and Human Rights* 11/2, December 2009, http://www.hhrjournal.org/2013/08/hiv-screening-and-care-for-immigration-detainees/.

161. Human Rights First, "U.S. Detention of Families Seeking Asylum: A One-Year Update," June 2015, http://www.humanrightsfirst.org/sites/default/files/hrf-one-yr-family-detention-report.pdf; "Deplorable Medical Treatment at Family Detention Centers: Mothers Lodge Complaint with DHS Offices for Civil Rights and Civil Liberties and Inspector General," Women's Refugee Commission news release, July 30, 2015, https://womensrefugeecommission.org/news/press-releases-and-statements/2297-deplorable-medical-treatment-at-family-detention-centers-mothers-lodge-complaint-with-dhs-offices-for-civil-rights-and-civil-liberties-and-inspector-general.

this population include "recurrent depression, dissociative disorders, panic disorder, generalised anxiety disorder, social anxiety, traumatic brain injury and substance abuse." Moreover, the study finds that children who others perceive to express gender variant behaviors at a young age often experience trauma and abuse early in childhood.[162]

Similarly, a 2003 study conducted by researchers at the Bellevue/NYU Program for Survivors of Torture and Physicians for Human Rights, found that most detained asylum seekers included in the study experienced depression, anxiety, and post-traumatic stress disorder.[163] The study concluded that "detaining asylum seekers exacerbates symptoms of depression, anxiety, and post-traumatic stress disorder in this vulnerable population."[164]

All of the transgender women whom Human Rights Watch interviewed described mental health problems associated with their time in detention, including depression, anxiety, sleep problems, and in certain cases, thoughts of self-harm or suicidal ideation that for many compounded lifelong histories of trauma at home and during flight.

Transgender women held in the segregated unit at Santa Ana said that they experienced lengthy delays in accessing mental health services and only had the option to meet with providers through a videoconferencing system, rather than in person. Several of these women said that they were prescribed psychiatric medications but that mental health providers did not grant them adequate time or attention to address their chronic and severe emotional distress.

Access to HIV Medication and HIV-Related Care

While there is no public data available regarding HIV-prevalence among people held in US immigration detention, studies suggest that transgender women are nearly 50 times as likely to become infected with HIV than other adults of reproductive age.[165]

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162. Ariel Shidlo and Joanne Ahola, "Mental health challenges of LGBT forced migrants," *Forced Migration Review* 42, April 2013, available: http://www.fmreview.org/sogi/tabak-levitan-detention#_edn1.

163. Allen S. Keller, Barry Rosenfeld, Chau Trinh-Shevrin, Chris Meserve, Emily Sachs, Jonathan A Leviss, Elizabeth Singer, Hawthorne Smith, John Wilkinson, Glen Kim, Kathleen Allden, and Douglas Ford, "Mental health of detained asylum seekers," *The Lancet*, vol. 362, November 22, 2003, http://www.survivorsoftorture.org/files/pdf/keller_etal2003.pdf, pp. 1721-23.

164. Ibid., p. 1722.

165. US Centers for Disease Control and Prevention, "HIV Among Transgender People," http://www.cdc.gov/hiv/group/gender/transgender/ (accessed October 29, 2015).

According to the US Department of Health and Human Services, strict adherence to antiretroviral therapy is "key to sustained HIV suppression, reduced risk of drug resistance, improved overall health, quality of life, and survival, as well as decreased risk of HIV transmission."[166] If individuals do not have consistent access to treatment, they can develop resistance to their HIV medications, which can put them at increased risk for opportunistic infections and other serious HIV-associated illnesses.[167]

Recognizing the potential risks caused by inconsistent or delayed access to treatment, ICE medical standards require uninterrupted access to HIV/AIDS medication for detained immigrants.[168] Nevertheless, medical researchers have found that detention facilities often fail to identify individuals who are living with HIV/AIDS because HIV testing is only conducted when a detainee specifically requests it.[169]

The Inspector General of the US Department of Homeland Security has recently raised concerns about medical screenings at immigration detention facilities, noting that they can be conducted by medical personnel or by detention officers who "may not have the necessary medical training" to conduct proper assessments.[170]

Several transgender women told Human Rights Watch that they were unable to access their HIV medications for periods ranging from two to three months after entering detention, including one transgender woman who was held in the segregated unit at Santa Ana. In another case, a transgender woman held at Santa Ana said that she had been provided medication in detention for a tuberculosis infection that an external physician later informed her had temporarily reduced the effectiveness of her HIV medication.[171]

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166. US Department of Health and Human Services, "Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents," section K-1, p. 187. Available: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf (accessed October 29, 2015).

167. Homer D. Venters, Jennifer McNeely, and Allen S. Keller, "HIV screening and care for immigration detainees," *Health and Human Rights* 11/2, December 2009.

168. US Immigration and Customs Enforcement, PBNDS 2011, "Medical Care," section 4.3.

169. Venters, McNeely, and Keller, "HIV screening and care for immigration detainees," *Health and Human Rights* 11/2, December 2009.

170. US Department of Homeland Security, Office of Inspector General, "U.S. Immigration and Customs Enforcement's Alternatives to Detention (OIG-15-22)," February 2015, p. 12.

171. For further information on treatment of tuberculosis in HIV-infected patients, see: US Department of Health and Human Services, AIDS*info*, "Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, Considerations for Antiretroviral Use in Patients with Coinfections," March 27, 2012, available: https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/27/hiv-tb.

Linda F., a transgender woman from El Salvador, said that a Border Patrol agent confiscated her HIV medication when she was apprehended near an unidentified US Port of Entry in South Texas in May 2015. She said that she did not see a physician until disclosing her HIV-status to a guard during an intake screening at an immigration detention facility where she was transferred several days later.

> The [Border Patrol] officer took my medication and told me it 'wasn't his responsibility to hold on to my things.' I was afraid to tell them that I had HIV because I thought they could discriminate against me. I told one of the guards [at the facility where I was transferred] about the HIV medication the week I got here. When I saw the doctor, I told her that I was missing my medication and that I felt something strange in my body. It took them two months [to provide me my medication]. I just started receiving the medication today.[172]

Linda was also concerned about confidentiality and said that a facility guard reviewed her medical records without her authorized consent. When Linda asked the guard not to do so, she was told she would be sent to the "hole," or solitary confinement."[173]

ICE medical policy requires "the highest degree of confidentiality regarding HIV status and medical condition," and states that medical records may only be accessed by "authorized individuals and only when necessary."[174]

Medical researchers have cautioned that "[t]here are substantial overlapping drug toxicities and drug-drug interactions that must be considered when cotreating HIV and TB," and that "[t]he risk of adverse reactions to TB treatment is higher in HIV-infected individuals than in HIV-uninfected individuals."[175]

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172. Human Rights Watch interview with Linda F. (pseudonym), South Texas Detention Complex, Pearsall, Texas, July 8, 2015.

173. Ibid.

174. US Immigration and Customs Enforcement, PBNDS 2011, "Medical Care," section 4.3.

175. Annie Luetkemeyer, MD, "Tuberculosis and HIV," HIV InSite Knowledge Base Chapter, University of California San Francisco, January 2013. Available: http://hivinsite.ucsf.edu/InSite?page=kb-05-01-06#S6.2X (accessed November 4, 2015).

Access to Gender-Affirming Care

Several transgender women also reported experiencing lengthy delays in their attempts to access gender-affirming hormone replacement therapy while in detention.

The World Professional Association for Transgender Health (WPATH) advises that hormone replacement therapy "is a medically necessary intervention for many transsexual, transgender, and gender-nonconforming individuals with gender dysphoria,"[176] and that transgender people in institutionalized settings should be able to receive the same level of care they would be able to access within the community.[177] WPATH guidelines further advise that "[t]he consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality."[178]

ICE medical policy largely adheres to these guidelines by stating that transgender women who were previously undergoing hormone replacement therapy should have continued access to treatment in detention, and that a medical professional should assess those who had not already begun treatment prior to detention and that hormones should be provided when appropriate.[179]

Despite these regulations, more than half of the transgender women who spoke to Human Rights Watch—including more than half of those we interviewed who were detained in the segregated unit at Santa Ana—told Human Rights Watch that they were unable to access hormones for periods ranging from one to five months after entering detention. In two other cases, transgender women housed in the pod were given the option of receiving hormone therapy in pill form, but decided to discontinue treatment because they preferred hormonal injections. These women said the oral supplements had caused them symptoms

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176. World Professional Association for Transgender Health, "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People," version 7, (2012), http://www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf, p. 33.

177. Ibid, p. 67.

178. Ibid, p. 67.

179. US Immigration and Customs Enforcement, "Further Guidance Regarding the Care of Transgender Detainees," Attachment 1: ICE Detention Facility Contract Modification for Transgender Care, section 3(e).

such as stomach pain and dizziness, which they did not experience with hormonal injections.

Carla Y., a transgender woman from Iran, was held at a privately operated men's detention center in California for approximately four months, beginning in January 2014.[180] She said that she "had to beg to get hormones," and faced lengthy delays in scheduling medical appointments. Ultimately, she was only able to receive hormone replacement therapy during the last two weeks that she was in detention.

Monserrath López, from Honduras, said that she was undergoing hormone replacement therapy prior to entering immigration detention in Texas in December 2014. She repeatedly requested access to hormones during the five months that she was in detention, but was never able to access them. Monserrath also said that facility medical staff verbally harassed her on two occasions.

> I was taking hormones before I was detained. I would always ask for them and they would say, 'We don't have them.' The only thing they gave me was ibuprofen. We [the other transgender women and I] would go to the doctor almost every day because we had headaches and we were feeling really sick. One time a doctor told us, 'We're tired of seeing you here, you need to drink six glasses of water an hour. We're sick of it, either drink water or we'll send you to the hole [solitary confinement]. Another doctor told us, 'You all think you're women, but you're really men. You're acting ridiculous.' The other doctors and nurses just laughed.[181]

Elsa T., a transgender woman from Mexico, was subject to mandatory custody due to an earlier criminal conviction and admitted to the segregated unit at Santa Ana in June 2015.[182] She said that she was receiving prescribed hormone replacement therapy prior to entering detention but was unable to access hormones at the facility for at least two months. She also said that a nurse at the facility had referred to her with male pronouns, which discouraged her from seeking further medical care.

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180. Human Rights Watch telephone interview with Nanya Thompson, immigration attorney, San Diego, California, August 11, 2015.

181. Human Rights Watch interview with Monserrath López, Houston, Texas, July 7, 2015.

182. Human Rights Watch interview with Elsa T. (pseudonym), Santa Ana City Jail, Santa Ana, California, August 25, 2015.

> But I don't want to make any more medical requests. [The nurses] don't have the sensitivity to deal with our community. One of them called me 'he.' I said, 'Don't you see that you're talking to a woman?'[183]

Alba N., a transgender woman from Honduras admitted to the segregated unit at Santa Ana in June 2015, said she still had not received hormones one month after requesting them.

> I feel depressed. The personal changes make me feel worse about being here, it's really hard. We have to fight [to take care of] our intimate needs.[184]

Access to Routine and Emergency Medical Care

Routine and emergency medical care in US immigration detention is often widely inadequate. This has particular consequences for transgender women, who are often detained after fleeing physical and sexual abuse, and who may have been unable to access adequate medical care in their home countries due to discrimination among medical providers.

Transgender women held in the segregated unit at Santa Ana told Human Rights Watch they were often required to make repeated written requests and experienced lengthy delays when seeking medical care. Many of the women also said that the facility's nursing staff often told them to drink water or take ibuprofen for any range of symptoms, regardless of the severity of their condition, including vomiting, diarrhea, and indigestion.

Sofia G., a transgender woman from El Salvador who was housed in the segregated unit at Santa Ana was taken to a local hospital for an emergency appendectomy on May 7, 2015. Sofia told Human Rights Watch that she and her cellmate had made repeated requests to facility guards before she was ultimately transported to a hospital for the emergency procedure. She says that despite notifying guards that she was experiencing unbearable abominable pain, they shackled her around her waist, hands, and feet while transporting her to the hospital.

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183. Ibid.

184. Human Rights Watch interview with Alba N. (pseudonym), Santa Ana City Jail, Santa Ana, California, August 26, 2015.

Previous Human Rights Watch research found that the use of restraints among detained pregnant women was typical during transportation between detention facilities and to and from off-site medical providers.[185] ICE's current medical policy, revised in 2011 to include new restrictions on the use of restraints, states they should be used "only as a precaution against escape during transfer" or "for medical reasons, when directed by the medical officer."[186] The policy also requires that facilities document medical approval when using restraints for medical and mental health reasons. Nevertheless, there is no written record of the use of restraints included within this patient's medical records.

Timeline from Sofia G.'s medical record[187]

5/7/2015 (2:05 AM): Patient seen by nurse on previous evening (5/6/2015) after reportedly vomiting three times after dinner. Nurse observed pain level of 8/10 and abdominal distention; provided patient with Pepto-Bismol.
5/7/2015 (7:05 AM): Patient seen by nurse and complained of stomach discomfort. Begun crying during medical assessment. Nurse provided patient with Tums.
5/7/2015 (7:45 AM): Nurse visited patient for follow-up; patient is currently sleeping.
5/7/2015 (2:44 PM): Patient seen by nurse and states that pain level is 10/10 and cannot be tolerated. Patient states that pain started on way back from court yesterday morning.
5/7/2015 (2:58 PM): Nurse contacts hospital emergency room.

185. Human Rights Watch, *Detained and Dismissed: Women's Struggles to Obtain Health Care in United States Immigration Detention*, pp. 34-35.
186. US Immigration and Customs Enforcement, PBNDS 2011, "Use of Force and Restraints," section 2.15.
187. Provided by Sofia G.'s immigration attorney to Human Rights Watch with her consent.

> I started feeling pain in my appendix [on May 6, 2015]. I asked for help many times and they didn't give it to me. The next day I felt like I was going to die from pain. I had complained [to guards] the day before ... I couldn't lay down, I couldn't sleep. My roommate asked them to take me to the hospital [on May 7, 2015], and the guards laughed at me. ... They took me to the hospital with shackles around my hands, feet, and stomach. I told them the shackles were too tight and they didn't pay attention to me. I couldn't bear the pain. My stomach burst at the hospital because they didn't take me in time. I felt it. I still had the shackles [on] and everything.[188]

In another instance, Julieta L., a transgender woman from Mexico who was tortured and physically assaulted by violent gang members in Guadalajara, Mexico in 2015, said that she was unable to continue receiving antibiotics that she had been taking before being transferred from a detention facility in Arizona to the segregated unit at Santa Ana. A physician told her that one of her breast implants had burst during the assault and that she needed chest surgery. Julieta says that she began to receive death threats several days after the surgery, and that she immediately fled, without time to see her doctor and have her sutures removed, to seek protection in the US.

Several days later, Julieta presented herself to Border Patrol agents at the US Port of Entry in Laredo, Texas, and requested asylum. She was then transferred to a privately operated detention center in Texas.

> I had to wait twelve days until they took the stitches out of my chest. The thread was getting buried underneath my skin. I asked them for antibiotics because I was afraid my body would reject the [silicone] implant. They gave me anti-inflammatory [medication] but they refused to give me the antibiotics.[189]

Julieta says that she was unable to receive antibiotics during the 20 days she was held at the South Texas detention facility, or at the Santa Ana City Jail to which she was subsequently moved.

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188. Human Rights Watch interview with Sofia G. (pseudonym), July 17, 2015, Burbank, California.

189. Human Rights Watch interview with Julieta L. (pseudonym), Santa Ana City Jail, August 26, 2015

I told them my chest was hot and that I needed antibiotics. It was burning inside. I wrote requests but they won't give me the medication.[190]

190. Ibid.

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Persecution Experiences and Mental Health of LGBT Asylum Seekers

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ABSTRACT

Asylum seekers are a unique population, particularly those who have endured persecution for their sexual orientation or gender identity. Little data exist about the specific experiences and needs of asylum seekers persecuted due to lesbian, gay, bisexual, or transgender (LGBT) identity. Quantitative data were gathered regarding demographics, persecution histories, and mental health of 61 clients from a torture survivors program in New York City who reported persecution due to LGBT identity. Thirty-five clients persecuted due to their LGBT identity were matched by country of origin and sex with clients persecuted for other reasons to explore how persecution and symptoms may differ for LGBT clients. LGBT asylum seekers have a higher incidence of sexual violence, persecution occurring during childhood, persecution by family members, and suicidal ideation. Understanding the type of persecution experiences and how these influence mental health outcomes is an essential step toward designing and delivering effective treatments.

KEYWORDS

Asylum; bisexual; gay; lesbian; LGBT; posttraumatic stress disorder; refugee; survivor of torture; transgender; trauma

Asylum seekers[1] are often the victims of torture in their home countries (United Nations, 1984), with estimated rates of maltreatment ranging from 3%–35% (Office of Refugee Resettlement, 2012). Asylum seekers who have endured such harm are at higher risk than the general population for mental health disturbances including posttraumatic stress disorder (PTSD), major depression, loneliness and isolation, cultural bereavement, problems with acculturation, and feelings of guilt, shame, mistrust, and helplessness (Longacre, Silver-Highfield, Lama, & Grodin, 2012; Reading & Rubin, 2011; Steel et al., 2009).

For LGBT individuals, this relationship between early victimization and negative mental health outcomes may be more pronounced. The early life

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abuse, rejection, victimization, and internalized homophobia of United States–based LGBT individuals are associated with a myriad of mental health difficulties later in life (D'Augelli, Grossman, & Stark, 2006; Gold, Dickstein, Marx, & Lexington, 2009; Gold, Marx, & Lexington, 2007; McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012; Ryan, Huebner, Diaz, & Sanchez, 2009).

Many investigations in the United States have offered insight into the mental health experiences of LGBT individuals, who face victimization early in life, but little is known about the mental health and experience of LGBT asylum seekers coming into the United States. What we know comes from a few studies showing that pre-migration abuse can have greater consequences on adult mental health (Alessi, Kahn, & Chatterji, 2015; Briere, Kaltman, & Green, 2008; Cloitre et al., 2009; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

LGBT asylum seekers have unique early life experiences that are characterized by verbal, sexual, and physical abuse by parents and caregivers at home, peers and personnel at school, and in the larger community in their home countries. (Alessi, Kahn, & Chatterji, 2015; Reading & Rubin, 2011; Shidlo & Ahola, 2013; United Nations Human Rights Council, 2011). In these countries, LGBT individuals are often subject to threats and harassment, neglect, alienation, and restricted access to community or familial resources. These punishments for gender nonconformity or homosexuality often begin in childhood and can occur daily from multiple persecutors (Reading & Rubin, 2011; Shidlo & Ahola, 2013; United Nations Human Rights Council, 2011).

The literature suggests that prolonged torture and abuse contributes to the development and severity of traumatic stress (Briere et al., 2008; Cloitre et al., 2009; Silove, 1999), as does rejection by family (Ryan et al., 2009). Additionally, early onset and longer duration of neglect, maltreatment, and physical and sexual abuse are associated with increased severity and variability of mental health symptoms (Cook, Blaustein, Spinazzola, & Van Der Kolk, 2003). These can include symptoms of PTSD, dissociation, somatization, relational and attachment conflicts, behavioral inhibition, depression, anxiety, and changes in personality (Briere et al., 2008; Bryer, Nelson, Miller, & Kroll, 1987; Cloitre et al., 2009; Cook et al., 2003; Herman, 1992; Maercker, Fehm, Becker, & Margaf, 2004; Shidlo & Ahola, 2013).

In particular, sexual trauma experienced by these individuals has been shown to be a strong predictor of PTSD (Cortina & Kubiak, 2006; Kessler et al., 1995; McCutcheon et al., 2010; Perkonigg, Kessler, & Wittchen, 2000). Evidence of higher rates of sexual trauma has been clinically and qualitatively uniquely observed in the LGBT asylum seeker community (Alessi, Kahn, & Chatterji, 2015; Reading & Rubin, 2011).

LGBT individuals often migrate to the United States with the expectation of improvement in their lives and mental health (Lewis, 2014). However, even after arriving in the United States, it is common for LGBT asylum seekers to experience feelings of isolation and alienation (Heller, 2009; Reading & Rubin, 2011). Although the majority of non-LGBT asylum seeker populations have the support of immediate family members, friends, or other members of their persecuted group, LGBT asylum seekers are often alone in their migration as a result of their LGBT identity. They struggle to relate to LGBT individuals from the United States due to cultural differences and shame about their history of persecution, yet their ethnic communities living in the United States continue to be a source of harassment and fear (Portman & Weyl, 2013; Shidlo & Ahola, 2013). Due to the involvement of family and community members in persecution, LGBT asylum seekers' ability to place trust in new support systems can be severely disrupted, increasing isolation (Herman, 1992; Shidlo & Ahola, 2013). In the absence of family and social support, asylum seekers are challenged with meeting basic needs prior to obtaining legal status in the United States. This contributes to additional psychological sequelae, as lack of social support after a traumatic event is a risk factor for PTSD (Brewin, Andrews, & Valentine, 2000).

Therefore, LGBT asylum seekers experience an accumulation of trauma, characterized by multiple events, in multiple areas of life, over time, which continue even after attempting escape to a new country. As described by Shidlo and Ahola (2013, p. 2), "the relentlessness, pervasiveness, and inescapable character of this type of persecution and discrimination [against LGBT individuals] leads to a potent cumulative effect of these traumatic events."

LGBT asylum seekers may face an even greater risk for negative outcomes without targeted intervention due to both the unique early life experiences of persistent and consistent trauma and post-migration factors. Given these unique early life experiences and general circumstances, LGBT asylum seekers present to service centers with needs that are different from the general asylum seeker population.

To date, there is no quantitative data to confirm that asylum seekers persecuted for their LGBT identity are more likely than other asylum seekers to have experienced sexual trauma, childhood trauma, interfamilial trauma, or specific mental health impacts of prolonged trauma.

This article focuses on a torture treatment program located in a large metropolitan area of the United States. This program works with individuals from around the world who have experienced torture and other human rights violations in their countries of origin. Many of these individuals seek asylum in the United States. Medical, mental health, social, and legal services are provided. A subset of these individuals have experienced persecution for their identity as lesbian, gay, bisexual, or gender non-conforming, and these individuals have described similar experiences as those described in Alessi and colleagues' 2015 paper (Alessi, Kahn, & Chatterji, 2015).

The current study aims to take these qualitative and clinical observations further and examine the unique experiences of LGBT asylum seekers compared with matched controls. The authors attempt to establish a baseline of data on LGBT-heterosexual differentials in mental health outcomes, specifically PTSD and suicidality. The authors sought to examine: (1) Are the rates of sexual trauma, identity of persecutors, and age of onset of trauma significantly different between LGBT asylum seekers and non-LGBT asylum seekers? (2) Are these variables related to trauma symptom severity? The authors hypothesized that asylum seekers persecuted for LGBT identity have higher incidences of sexual violence and familial trauma, earlier age of onset of traumatic events, greater PTSD symptom severity, and higher rates of suicidality than other asylum seeker populations. Currently, no other quantitative studies exist on this topic.

Method

Participants

Participants are clients who completed an intake assessment between January 1, 2008 and April 30, 2013. During this time, the program accepted 839 new clients. Of these, 61 (7.27%) reported persecution due to LGBT identity. These clients emigrated from 29 countries in Eastern Europe, Africa, the Americas, Central Asia, and the Middle East. Most clients (82.0%) identified as Christian or Muslim, with a minority identifying as Jewish, Not Religious, or Other. These groups were collapsed to de-identify participants. Further demographic data are reported in Table 1.

Of the 61 clients persecuted for LGBT identity, 35 (57.37%) had matched-counterparts who were clients of the same sex and country of origin but who were persecuted for reasons not related to their perceived sexual orientation or gender identity. Previous research has suggested that female sex is a risk factor for developing PTSD (Ai, Peterson, & Ubelhor, 2002; Brewin et al., 2000) and that women are particularly vulnerable to sexual violence in the absence of social

Table 1. Demographics of clients persecuted due to perceived-LGBT status ($N = 61$).

Demographics	*n*	%	Demographics	*n*	%
Sex (Male)	38	62.29	**Immigration Status**		
Age *M* (SD)	28.79 (6.99)		Undocumented	27	44.26
Region of Origin			Temporary Visa	5	8.19
Eastern Europe	26		Asylum application pending	21	34.42
West Africa	13		Asylee/Refugee	4	6.56
South America	7		Missing	4	6.56
Central Asia/Middle East	5		**Education Level**		
Central/North Africa	5		At least some primary	4	6.56
Caribbean	5		At least some secondary	11	18.03
			Post-Secondary	37	60.66
Functional English	49	80.32	Graduate degree	6	9.84
Months in the U.S. *M* (*SD*)	31.9 (31.6)		Missing	3	4.92

structures (Hynes & Cardozo, 2000). For these reasons it was important to limit any variability in sex between the LGBT and matched case groups. Clients were matched on country of origin to isolate the impact of LGBT status on persecution history within a sociopolitical context. Twenty-six LGBT clients (46.6%) were not included in the comparative analyses because no match with the same sex and country of origin was available. These omitted LGBT clients did not differ significantly from other LGBT clients with respect to sex, age, functional English, immigration status at intake, religious affiliation, highest level of education, rate of childhood persecution, history of sexual violence, incidence of head injury, past or present suicidal ideation, or identity of persecutors. The omitted clients, however, experienced a trend toward greater PTSD symptom severity at intake (M 2.9, SD .5) than those with match cases (M 2.7, SD .5; $t(55) = 1.9$, $p = .07$), lived in the United States for a significantly longer number of years (M 3.9, SD 3.0 vs. M 1.7, SD 1.8; $t(35) = 3.2$, $p < .01$), and originated from countries where the majority of, if not all, clients enrolled in the program were persecuted due to their LGBT identity. Of note, we were not aware of any transgender individuals in our sample. However, we referred to clients as LGBT rather than perceived LGB, as we are aware from the work of Shidlo and Ahola (2013) that identities may shift over time.

Measures

Intake and 6-month assessments

Data for this study were drawn from client records. Intake assessments are conducted by supervised trainees in the mental health fields and by licensed clinical staff. The intake assessment is conducted under the supervision of a licensed mental health professional. During the interview, the limits of confidentiality are reviewed and participants have the right to discontinue the interview at any time. They are informed that these data are used to understand their needs and to determine appropriate service recommendations. The intake interview protocol includes a risk assessment for harm to self and others, emotional support to manage distressing affect connected to sharing clients' experiences, and an outline of the next steps in the process. For clients who endorse a moderate to high level of risk to self or others, collaborative safety planning is implemented, and, when needed, clients are escorted to the nearest hospital emergency room for further evaluation.

The intake includes standardized measures and a semistructured interview used to elicit information regarding demographics, social and legal concerns, trauma history, psychiatric symptoms, and physical complaints. Following the intake, interviewers produce a narrative report reflecting the aforementioned areas in addition to DSM-IV diagnoses and recommendations. Six months following the intake assessment, clients are invited to participate in an interview

that includes standardized measures and semistructured questions about the domains of functioning assessed during the intake interview.

Posttraumatic stress disorder

The Harvard Trauma Questionnaire (HTQ) is a self-report instrument that assesses PTSD symptoms (Mollica et al., 1992). Sixteen items on the measure focus on symptoms of posttraumatic stress that are scored on a 4-point Likert scale (from *not at all* = 1 to *extremely* = 4) for intensity in the past week. The HTQ is used widely in research and clinical settings with refugee populations and has been shown to have strong validity, sensitivity, and specificity based on PTSD as defined by the DSM-III-R (Mollica et al., 1992).

Suicidal ideation

Interviewers obtained information regarding clients' past and present suicidal ideation. History of suicidal ideation was recorded by the interviewer on the interview form. For this study, a binomial variable of present and/or past suicidal ideation was used (i.e., yes/no).

Trauma history

Interviewers obtained specific details of the clients' trauma histories including reasons for persecution, identity of the persecutors, age of first persecution, types of persecution acts endured, and whether or not the persecution involved sexual violence. These key indicators were elicited during the unstructured portion of the interview, allowing for patients to report their trauma history in narrative format.

LGBT status

The intake interview form did not include specific questions regarding LGBT status. For the purposes of this study, patients were categorized as LGBT if they spontaneously reported during their intake interview that they were persecuted due to being lesbian, gay, bisexual, or transgender.

Sexual violence

During the intake interview patients were asked, "Have you ever been assaulted or harmed sexually?" The interviewer recorded the patient's response as "yes" or "no." This broad variable relied on patients' and interviewers' interpretations of the definition of sexual assault. Due to the interpretative nature of this field, the variable was further validated by a qualitative review of the intake narrative reports by the research team. Incidents of sexual violence were identified and recorded in three groups as outlined by the Centers for Disease Control: sex act, abusive sexual contact, or non-contact sexual abuse (Basile & Saltzman, 2002).

Identity of persecutors

Based on the clients' narratives, interviewers had the option to select up to two types of persecutors from a list of possible identities, including government authorities, paramilitary group, rebel group, other country's forces, organized crime/street gang, religious organization, family members, and "other." Emergent coding of the intake narrative reports was conducted to record any additional information about persecutors. This coding generated an additional persecutor identity variable of community members (neighbors, classmates, teachers, or a stranger living in the same place).

Data analysis

Descriptive data are provided for demographics, persecution experiences, and mental health variables for all clients persecuted for LGBT status ($N = 61$). Independent sample t-tests and chi-square analyses were used to determine if history of sexual violence and age of first persecution were associated with higher HTQ scores or suicidal ideation, as suggested by previous research (Cook et al., 2003; Cortina & Kubiak, 2006; Kessler et al., 1995; McCutcheon et al., 2010; Perkonigg et al., 2000). Independent t-tests were used to analyze how identity of persecutors was associated with HTQ scores.

Comparative analyses were conducted with the matched cases ($N = 35$); univariate analyses were used to determine if survivors of persecution due to LGBT identity experienced trauma events distinct from their counterparts. Chi-square analyses were conducted to determine if asylum seekers persecuted for LGBT identity were significantly different from matched cases in religious affiliation, immigration status, education level, functional English, identities of persecutors, childhood persecution, history of sexual trauma, history of head injuries, presence of physical injuries from abuse, or rates of suicidal ideation. Independent sample t-tests were used to determine if LGBT clients were significantly different than matched cases in age at intake, intake HTQ scores, follow-up HTQ scores, or longest period of detention.

Results

Demographics, persecution histories, and mental health of LGBT Clients

Sixty-one clients reported persecution for LGBT identity. Details of demographic information are provided in Table 1.

The most common trauma experience was sexual violence, which is further described in Table 2. Clients also experienced high rates of beatings ($n = 36$, 59.0%); threats ($n = 18$, 29.5%); slapping, kicking, and punching ($n = 14$, 23.0%); and blows with heavy objects ($n = 12$, 19.7%).

Table 2. Trauma events experienced by asylum seekers perceived as LGBT ($N = 61$).

	n	%		*n*	%
Identity of persecutors ($N = 57$)			**Any sexual violence** ($N = 58$)	38	65.52
Family members	26	45.61	Completed sexual act	26	44.83
Government authorities	37	64.91	Abusive sexual contact	15	25.86
Organized Crime/Gang	11	19.30	Non-contact sexual abuse	18	31.03
Religious group	2	3.50	**First persecution during childhood (<18 years)** ($N = 52$)	36	69.23
Community members	34	59.65	<5 years old	7	14.46
			5–13 years old	13	25.00
			14–17 years old	16	30.77

Clients reported having suffered persecution at the hands of one or more types of perpetrators, including family members. Many experienced their first persecutions before the age of 18 years, with some experiencing violence prior to 5 years of age. See Table 2 for details of age, perpetrators, and sexual violence.

Average HTQ scores at intake were above the clinical cutoff for PTSD ($N = 57$; M 2.8, SD .5) and were just below the cutoff at the 6-month follow-up ($N = 34$; M 2.4, SD .64). Forty-four (72.1%) clients reported current or past suicidal ideation.

History of sexual violence was associated with higher HTQ scores at intake ($t(52) = -2.3$, $p = .03$) but not higher rates of suicidal ideation ($\chi^2 = 1.4$, $p = .2$). Age of first persecution was not significantly associated with either HTQ scores at intake or presence of suicidal ideation. Persecution by specific groups (i.e., family members, government authorities, organized crime/street gangs, religious group, and community members) was not associated with higher HTQ scores at intake or presence of suicidal ideation.

Comparing LGBT and non-LGBT clients

With regard to religious affiliation, immigration status, education level, proficiency in English, time since arrival in the United States, and age, there were no significant differences identified between the 35 clients who were persecuted for LGBT identity and 35 matched cases persecuted for reasons other than LGBT identity (e.g., ethnic minority status, religious affiliation, political affiliation). The client groups differed significantly in their persecution experiences (Table 3)—specifically, rates of sexual violence, age of first trauma, and identities of persecutors. They did not differ in rates of physical violence or length of detention.

LGBT clients endorsed significantly higher rates of past or present suicidal ideation ($n = 29$, 82.9%) than their matched cases ($n = 19$, 54.3%; $\chi^2(1) = 6.6$, $p = .01$). Intake and 6-month follow-up HTQ scores were not significantly different between the LGBT clients (Intake: $M = 2.6$, $SD = .5$; 6-month follow-up: $M = 2.2$, $SD = .5$) and their matched cases (Intake: $M = 2.8$, $SD = .6$; 6-month follow-up: $M = 2.1$, $SD = .5$).

Table 3. Trauma events experienced by asylum seekers perceived as LGBT compared to their controls.

	LGBT Group (N = 35)		Non-LGBT Group (N = 35)				
Identity of persecutors	n	%	n	%	df	χ^2 or t	p
Family members	13	37.14	0	0	1	16.62	<.01
Government authorities	25	71.43	26	74.29	1	0.01	.95
Paramilitary/Rebel/Other country forces	0	0	3	8.57	1	3.05	.08
Organized Crime/Gangs	7	20.00	6	17.14	1	0.14	.71
Religious group	1	2.86	1	2.86	1	0.00	.98
Community members	8	22.85	4	11.43	1	1.77	.18
First persecution during childhood (<18 years)	22	62.86	13	37.14	1	4.43	.04
History of any sexual violence[a]	22	66.67	8	23.53	1	12.60	<.01
Completed sexual act	13	39.39	4	11.76	1	6.75	.01
Abusive sexual contact	4	12.12	3	8.82	1	0.20	.66
Non-contact sexual abuse	11	33.33	3	8.82	1	6.09	.01
Self-report head injury	28	80.00	30	85.71	1	2.72	.10
Any physical injury from abuse	29	82.86	29	82.85	1	0.00	1.0
Months detained in persecution	12.85 (25.42)		24.71 (82.73)		55	t = .70	0.49

Note. [a]LGBT N = 33, Controls N = 34.

Discussion

Our results suggest that asylum seekers persecuted due to their LGBT identity may experience higher rates of sexual violence, earlier age of first trauma, higher incidence of persecution at the hands of family members, and higher rates of suicidality than asylum seekers persecuted for other reasons (e.g., religious, political, or ethnic affiliation). These differences underscore the unique experiences of this population and the need for specific mental health treatment.

Among the 61 LGBT asylum seekers identified, 66% had experienced sexual violence as part of their persecution history. Consistent with previous research, these clients had greater PTSD symptom severity than LGBT clients without a history of sexual violence. In addition, when compared to matched cases, LGBT asylum seekers had a higher incidence of rape (i.e., completed sexual act) and non-contact sexual harassment. Previous research has suggested that sexual violence is more commonly experienced by women and LGBT-identified individuals (Balsam, Rothblum, & Beauchaine, 2005) and is predictive of suicide attempts and of worse psychological outcomes, with symptoms increasing with greater exposure (Cortina & Kubiak, 2006; Keller et al., 2006; Kessler et al., 1995; McCutcheon et al., 2010; Perkonigg et al., 2000; Rees et al., 2011). In one all-female sample, Keller et al. (2006) found that rape was one of the few predictors of higher PTSD symptom severity. Although the literature regarding female victims of sexual assault is more robust, there is a body of literature that suggests that factors related to the LGBT experience—specifically, internalized homophobia—may increase the negative effects of sexual assault (Gold et al., 2009, 2007). The findings from this study, along with

previous research, highlight the need to address sexual trauma and the unique sociopolitical context in which it occurs when treating LGBT asylum seekers.

Of note, 46% of LGBT asylum seekers experienced persecution at the hands of their family members. In stark contrast, not one of the 35 matched cases did. This finding suggests that LGBT asylum seekers may be at a greater risk for persecution by family members than asylum seekers of similar demographic backgrounds who are persecuted for other reasons. Asylum seekers that are persecuted for their ethnic or religious group membership often share that membership with their family. In contrast, it is reasonable to assume that family members of persons persecuted for LGBT status do not identify or feel affiliated with that group. As such, LGBT persons may be particularly vulnerable not only within the community but also within their family structure. Family-inflicted trauma may reflect the rejection of LGBT family member(s), which research has demonstrated predicts negative health outcomes, including depression and suicidality (Ryan et al., 2009).

As predicted, LGBT asylum seekers had a higher incidence of childhood persecution, with 69.2% reporting incidents of persecution before the age of 18. This is a common experience for sexual minority youth (Schneeberger, Dietl, Muenzenmaier, Huber, & Lang, 2014) and may be related to gender non-conforming physical characteristics, mannerisms, or preferences. Gender non-conforming attributes are related to victimization in U.S. youth populations (D'Augelli, Grossman, & Stark, 2006). Although childhood victimization was not significantly associated with either PTSD symptom severity or suicidal ideation in this study, childhood trauma is known to have negative consequences on adult mental health (Briere et al., 2008; Cloitre et al., 2009; Kessler et al., 1995). In a study of 582 women, Cloitre and colleagues (2009) found that trauma-related symptoms such as dissociation, social avoidance, and difficulty with anger management, also termed "complex" symptoms, were strongly associated with the number of childhood traumatic events and not significantly correlated with increased number of such events in adulthood. Similarly, Briere and colleagues (2008) found that increased complex symptoms are correlated with cumulative traumatic events during childhood, most significantly childhood rape and physical abuse. The lack of significant associations between age of persecution and mental health outcomes in this study may be the result of methodological limitations due the archival nature of the data. Despite these findings, the high incidence of childhood persecution in this population demands attention, and the mental health outcomes must be explored in future research.

Interestingly, while LGBT individuals did have a higher incidence of persecution factors thought to contribute to worse mental health outcomes (history of sexual violence, childhood persecution, and persecution by family members), this group did not differ from their matched cases in PTSD symptom severity. This finding is inconsistent with our understanding of sexual violence as a

predictor for poor mental health outcomes in U.S. samples (Cortina & Kubiak, 2006; Kessler et al., 1995; McCutcheon et al., 2010; Perkonigg et al., 2000; Rees et al., 2011). However, it may be that these factors hold different weight in an asylum seeker population, which has a multitude of current and past severe stressors. Recent research has found that post-migration stressors are equally important to psychological distress among asylum seekers as pre-migration traumatic events (Schweitzer, Melville, Steel, & Lacherez, 2006; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). Post-migration factors such as social support, financial independence, and access to basic needs are critical for the mental health of all asylum seekers and should be addressed in any interventions developed for LGBT asylum seekers.

An additional explanation for this difference from previous studies may be that the decision to seek asylum reflects asylum seekers' resilience (Lewis, 2014.) For example, U.S.-based asylum seekers are a group of clients that decided to flee their home countries by accessing internal and external resources. Unlike refugees, asylum seekers do not enter into the United States with access to social resources that address their basic needs like housing, health insurance, and work authorization. Their ability to access these resources and overcome linguistic, cultural, physical, and psychological constraints reflects resilience and other protective factors.

In the present study, LGBT asylum seekers reported significantly higher incidence of suicidality than their matched cases. Although suicidality is also increased in the United States LGBT population, (Haas et al., 2011; Marshal et al., 2011), this finding is of particular interest given that PTSD symptom severity was not significantly different between these groups. There were limited data on other psychiatric symptoms, such as depression and anxiety, which could affect suicidality. It is important to consider factors such as sexual trauma, internalized homophobia, or stressors connected to being members of an oppressed group. Previous research in the LGBT population found that suicidality was directly linked to victimization, and this relationship was influenced by family support, connectedness, and community support (Duncan & Hatzenbeuler, 2013; Eisenberg & Resnick, 2006; Hershberger & D'Augelli, 1995). The complex relationship between suicidality, victimization, and family and community support may be a key aspect of the unique experience of LGBT asylum seekers and the mental health symptoms from which they suffer.

Limitations

Important limitations to this study exist due to the archival nature of the dataset. First, the only symptom-based measure in the study focused on posttraumatic stress. Consequently, there is a wide range of common psychiatric morbidity that may have been missed, particularly given the presence of suicidal ideation.

The impact of mood and the presence of psychotic symptoms or anxiety that may be affecting the mental health of this population cannot be assessed.

It is also worth considering whether the PTSD symptoms assessed by the HTQ are the most relevant for this population, given the literature on child maltreatment, which suggests that exposure to trauma is expressed in other ways when the onset is early in life. Common symptoms include dissociation, sexual concerns, difficulties with self-concept, interpersonal problems, and behavioral and emotional dysregulation (Briere et al., 2008; Cloitre et al., 2009; Maercker et al., 2004). Future research and assessment measures should evaluate these difficulties in more detail.

Sample selection is also a limitation to this study. As a retrospective case-control paper, all data are gathered from chart review of clients from a program in a major U.S. metropolitan area. The program has criteria for admission including a history of torture or other human rights violations. Moreover, most clients find the program through their social support networks (e.g., attorneys, community center, friends or family). Thus this support-seeking sample may not be generalized to all asylum seeker populations. Another artifact of participants coming from one treatment program is the program's explicit focus on survivors of torture and human rights abuses. Specifically, the United States and United Nations definitions of torture require the active persecution and/or acquiescence of government officials. This contributes to the high incidence of persecution by government officials in both groups. Thus it is a reflection of the broader sociopolitical context in which torture and other human rights abuses occur.

The data consist of self-reported trauma narratives. Self-reported retrospective data are inherently affected by a person's perception and memory of events. This challenge in gathering information is compounded by the realities of working with torture victims: due to discomfort and difficulty with trust, they may not fully disclose all traumatic events during the first interview with a new provider or organization, and, as part of their symptom cluster, they may not recall all aspects of the traumatic events.

LGBT status was not determined by directly asking all clients. A person's sexuality and gender identity was known only if the client described being persecuted for their identity as LGBT, as part of the trauma narrative. Therefore, we do not have information about the sexual orientation or gender identity of clients who were persecuted for other reasons. Because of the archival nature of the data, there was no way of verifying this information. This may be a confounding variable, as many aspects of minority stress specific to the LGBT population are still present, even if the individual was not tortured for this reason.

We also are unaware of transgender individuals in our sample. However, we recognize from the work of Shidlo and Ahola (2013) that it is possible for our clients' identities to shift to include a transgender identity. We believe that a number of the challenges faced by LGB individuals may also be true

for transgender individuals, and that excluding the possibility of this demographic would be limiting without increasing precision in the study results.

We attempted to control for sex differences by matching case-control by sex. However, it is not known how the gay experience may differ from the lesbian experience for asylum seekers. This question is beyond the scope of this article and should be further explored in future research.

Some of the literature that was reviewed for this article is based on studies done in Western countries. Even though findings in these studies such as patterns of suicidality and effects of sexual trauma in childhood might not generalize to individuals who come from non-Western cultures, we are forced to rely on this literature due to the lack of studies conducted in the specific countries where our asylum seekers come from.

Conclusions and implications

Survivors of persecution for LGBT status experience a higher incidence of childhood persecution, persecution by family members, sexual violence, and suicidal ideation. Given the changing legal climate in the United States toward LGBT rights and the contrary in other parts of the world, we can expect that more individuals in this demographic will seek asylum in this country. Results suggest that LGBT asylum seeker populations present with unique trauma histories and symptoms. Further research regarding the traumatic events LGBT asylum seekers experience prior to seeking asylum and the unique post-migration stressors they encounter once resettled will contribute to specialized assessment, intervention, and policies that address their needs.

These data suggest that LGBT asylum seekers are survivors of childhood trauma. For individual therapy, clinicians are encouraged to incorporate the robust body of research regarding the diagnosis and treatment of traumatic reactions to violence perpetrated during critical developmental time periods by caregivers and community (e.g., Foster, 2013). To address the intersection of the nonverbal aspects of trauma, particularly child trauma, and the needs of English language learners, nonverbal (e.g., eye movement desensitization and reprocessing; Shapiro, 2001) and body-based approaches (e.g. Levine, 1997; Ogden, Pain, & Minton, 2006), art or music therapy may be more appropriate than models rooted in verbal expression (e.g. narrative exposure therapy; Schauer, Neuner, & Elbert, 2011). Moreover, group therapy models focused on rebuilding and healing relationships with self, others, and community, such as dialectical behavior therapy (Linehan, 1993) and mindfulness-based stress reduction (Kabat-Zinn, 2013), may best leverage the unique resilience and address the nuanced vulnerabilities of LGBT asylum seekers. Several torture treatment programs facilitate capacity building with United States Customs and Immigration Services (e.g., asylum officers). The capacity-building efforts include specific mandated trainings for refugee and asylum officers on the

experiences of survivors of torture, particularly LGBT survivors and unaccompanied minors. This work begins to address the organizational and policy gaps in the United States and the social justice aspects of LGBT asylum seekers, experience.

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Note

1. In this article, "asylum seeker" refers to immigrants who have fled their home country due to fear of persecution and are seeking safety in the United States without the grant of legal status and the public benefits (e.g., Social Security, work authorization, housing) accorded to refugees by the United Nations and United States prior to entering the country. They may or may not have applied for asylum or have a valid visa; thus they may or may not be documented.

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