Entitled to Nothing
The Struggle for Immigrant Health Care in the Age of Welfare Reform
(Chapters 1, 2, 3)
CHAPTER 1

The Politics of Immigrant Reproduction

In 1998, twelve months after the birth of her twin girls, Sophia Chen traveled to China to introduce the girls to their grandparents. When she and the twins returned to the Los Angeles International Airport a few weeks later, anxious to go home, they were detained unexpectedly by the Immigration and Naturalization Service (INS, now ICE, Immigration Customs and Enforcement). Ms. Chen, who legally resides in the United States, was asked how she had paid for the delivery of her babies. When Ms. Chen stated that she had received Medicaid, she was sent to another office to speak with a state Department of Health Services (DHS) agent. After hours of shuttling from one room to another, Ms. Chen was notified that she was suspected of Medicaid fraud and was a "public charge"—meaning, a public burden—for using a public health insurance program to which she is legally entitled. She was given two options: either she could immediately repay $4,000 for the medical expenses she had incurred during her prenatal care and delivery; or she could take the next flight back to China and come back when she had sufficient funds to cover the medical bill. Startled, Ms. Chen protested that she had filled out all the proper application forms and was legally eligible for those benefits. The INS official responded that that did not matter and that there were no avenues for appeal.

In the end, after speaking with her husband, Ms. Chen chose the second option. They could not raise enough money right away. Devastated, Ms. Chen left the twins alone at the airport and boarded the next plane back.
to China. Her mother-in-law drove down from Oakland to pick up the twins, while her husband rushed to the restaurant where he works nights after his day courses at the local university. Overwhelmed by their circumstances, the Chens contacted a local immigrant advocacy organization. The community-based organization investigated the situation and found that the Chens were not alone. They found that Latina and Asian immigrant women of childbearing age were targeted for a new health insurance fraud detection program run by the federal INS and state DHS agencies at ports of entry, including the border of California and Mexico, the San Francisco International Airport, and the Los Angeles International Airport.

This program was in existence for five years until it was terminated on the basis of a state audit that found the DHS-initiated programs poorly administered, inadequately planned, and legally liable for overstepping the scope of their authority by attempting to influence federal INS decisions on whether to admit or deport immigrants as well as improperly sharing confidential medical information in the process. Despite its termination, I argue that this program is indicative of a significant historic moment in which notions of public charge were reinvigorated within the neoliberal ethos of the 1990s.

While these programs were initiated as an innovative approach to addressing health care fraud, the larger implications of the programs themselves and the way in which they were enacted require diligent investigation in light of the fact that these were not isolated events, but rather a concerted effort by various governmental and private entities that build upon the lessons of the past. This effort to control and discipline immigrants by targeting immigrant women’s reproduction as they attempt to pass through national boundaries is part of a larger social phenomenon that has long historical roots in our national ideology. Debates regarding who should have access to public services such as health care (and how much, if at all) are important avenues for understanding the shifting boundaries of social belonging, legal entitlement, and the political implications of the welfare state today.

This book looks at the politics of access to prenatal care by low-income Latina and Asian immigrant women during a recent moment of dramatic federal and state policy changes regarding welfare, immigration, and health care. In 1996, President Clinton signed into law the "Personal Responsibility and Work Opportunity Reconciliation Act" (i.e., PRWORA or Welfare Reform), which fundamentally altered the nation's welfare state by ending public benefits as an entitlement. One month later, the immigration reform bill, "Illegal Immigration Reform and Immigrant Responsibility Act" (i.e., IIRIRA or Immigration Reform) was also enacted, further restricting immigrant access to public services. These major federal legislations, in addition to the Anti-Terrorism and Effective Death Penalty Act—all passed in 1996—which significantly increased surveillance of both documented and undocumented immigrants, marked the reconfiguration of immigration policy under neoliberal governance. The discourse surrounding these policies isolated low-income immigrants as burdensome outsiders by reducing their presence to the sole result of U.S. charitable generosity and therefore contributing nothing to the everyday workings of the nation-state.

This framing, which placed immigrants clearly outside the national boundaries of social membership, was crucial to allowing for a neoliberal calculation of the value of immigrants as exclusively market-driven—the cheaper the better. The constant public fixation on their purported costs reached a fever pitch by the 1990s. The state of California took advantage of this political environment to revive the concept of a public charge to illegally force immigrant mothers to “repay” reproductive health care costs for which they were legally eligible. This state initiative was part of an intense, ongoing battle over the boundaries of citizenship, nation, and the substance of social rights.

These far-reaching federal laws, coupled with persistent state measures limiting health care access by people of low income, will indelibly touch the lives of immigrant families living in the United States for years to come. This book argues that this moment marks the formal return of the immigrant as a public charge—meaning, a burden upon the state.

Immigrant Women as Public Charge

Public charge is a political classification used to exclude or deport those immigrants perceived to be or to have the possibility of becoming a burden on the state. The latest U.S. Citizenship and Immigration Services’ (CIS) definition, refined in 1999, is as follows: “public charge' means an individual who is likely to become primarily dependent on the government for subsistence,
as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense.6 Public charge has been a part of U.S. immigration law for over a hundred years, used inconsistently to render "[a]n alien who is likely at any time to become a public charge [as] inadmissible and ineligible to become a legal permanent resident of the United States."6 During its long existence, public charge was largely undefined and left vague in its applicability. Arguably, it is this vagueness that made this administrative law so flexible and therefore so useful in excluding immigrants over the years. As this study will show, it was only after the 1996 immigration and welfare reforms that the federal government attempted an actual definition with guidelines to clarify which public benefits are applicable for public charge determinations. Unfortunately, as this study will also show, this bureaucratic "clarification" did little to lessen immigrants' confusion and fear of using social services. What has been fairly clear over the life of this law, however, is its special concern about pregnant low-income immigrant women.

Pregnancy has long been categorized as a public burden with respect to low-income immigrant women. Scholars consider this designation as part of a continuing tradition of "selective immigration" that began in 1875.6 When the Immigration Law of 1891 solidified the institutional mechanism for federal officials to inspect and exclude immigrants on the basis of public charge, Public Health Service agents were required to inspect and issue a medical certificate to all incoming immigrants for "loathsome or a dangerous contagious disease," including pregnancy.9 According to historian Martha Gardner, "Between 1880 and 1924, 'likely to become public charge' (LPC) provided a catch-all category of exclusion through which vast numbers of women found themselves deported as potential paupers for moral, marital, physical, and economic deficiencies."9 Gardner points out that while laws against poverty were usually applied to both men and women immigrants, LPC singled women out because the social mores of the early twentieth century linked immorality to indigence and, subsequently, poverty alleviation policies increasingly focused on women's morality and their "proper" role within the family. She writes, "LPC stigmatized women's work outside the home by dismissing the ability of single women, divorced women, or widows to support themselves and their families. Poverty, in essence, was a gendered disease."9 Between 1895 and 1915, LPC designations accounted for two-thirds of all exclusions.9 After the massive wave of migration during the turn of the twentieth century, public charge designations largely disappeared from the federal immigration agency's exclusionary repertoire. Then, in the mid-1990s, it reappeared on account of new health care fraud detection programs in California.9 In particular, access to and utilization of prenatal care by low-income immigrant women were targeted.

Governor Pete Wilson repeatedly and explicitly targeted prenatal care access in his efforts to halt immigration. In 1996, when a federal judge ruled in favor of Wilson's petition, arguing that the new federal welfare reform law allowed the state to end prenatal care for seventy thousand pregnant undocumented women, the governor was apparently "jubilant."9 Wilson saw this judgment as a victory towards surreptitiously implementing a key component of the earlier anti-immigrant state measure, Proposition 187, which was legally stricken as unconstitutional. Despite evidence to the contrary, the governor insisted that prenatal care was "an incentive for immigration" and created great numbers of public charges who disproportionately drained state funds.9 Regardless of the fact that studies have repeatedly shown that just a small fraction of America's health care spending is used to provide care to undocumented immigrants, Wilson and other anti-immigrant proponents continued to attack health care for immigrants (both documented and undocumented).9

In fact, immigrants are generally healthier than native-born Americans and have lower rates of health care use. A 2006 study of immigrant health care use found that a large number of foreign-born residents of Los Angeles County had had no contact with the formal health care system.6 In particular, prenatal care is consistently cited as cost effective.6 One study reported an annual cost savings of $320 per mother.6 Another study, conducted by the National Commission to Prevent Infant Mortality, estimated the cost of lifetime custodial care of low-birthweight children to be as much as $500,000 per child. The authors argued that since approximately 80 percent of mothers at high risk for low-birthweight babies can be identified in the first prenatal visit, prenatal care could potentially prevent long-term health problems and its accompanying costs.6

More importantly, prenatal care serves as the entry point for access to public health insurance (Medicaid) and other social services that can address underlying social inequalities. Writing in JAMA, Dawn Misra and Bernard Gayer point out, "Social factors also have strong influences, and it may be that changes in the woman's environment and resources are more
important than medical services provided through prenatal care." They add, "The stressful and impoverished environment in which many minority and low-income women live may be a fundamental factor that influences pregnancy outcomes but cannot be overcome easily with narrowly targeted interventions." For low-income immigrant women, prenatal care can serve an important role in connecting them to valuable social services and resources for which they are eligible, in addition to the actual medical services. This policy implication is cause for much chagrin for those who, like Wilson, want to limit the social rights of immigrants.

There are three basic methods that underlie how the United States has attempted to control the number and behavior of immigrants in the United States: first, by controlling initial immigration numbers through specific immigration and refugee policies, based largely upon U.S. domestic labor demands; second, by controlling the reproduction of those immigrants already in the United States; and third, by deterring future emigrants through punitive policies that limit access to social safety nets (such as health care access, public education, and welfare benefits) that are understood as basic rights of membership of U.S. society-making clear their second-class, temporary status. Pregnant immigrant women, then, embody a walking target for the expression of a number of national anxieties regarding the quantity and quality of our citizenry. Consequently, services geared toward these women are deeply political and require careful critical analysis. As such, dissecting the social and historical implications of access to prenatal care goes beyond understanding the importance of health care per se, to the larger social meaning of this form of health care.

The recent (re)application of the public charge law upon immigrant mothers who utilize prenatal care encompasses all three methods of immigration control noted above. Legal scholar Dorothy Roberts argues that restrictions on who may give birth to citizens highlight the schism between the theory and practice of our civic nationalism. She argues that while we would like to believe that social citizenship is based upon shared political institutions and values, it is, in reality, defined by race. Here, Roberts joins the work of other critical legal scholars who demonstrate that, since the founding of the nation, definitions of who belongs within the boundaries of American citizenship have been based on the simultaneous denial of citizenship of others living within its borders. One’s inclusion is relational to another’s exclusion.

Medicaid access is central to this issue of social inclusion and exclusion. A landmark achievement of the Kennedy-Johnson administrations, Medicaid is one of the largest and most established entitlement programs today. This publicly funded health insurance for low-income families is a vital component of ensuring early and continuous use of prenatal care by women who would otherwise be uninsured for this care. Regardless of individual health risks, the U.S. Public Health Service recommends a minimum standard of eight visits starting no later than the second month of pregnancy for all pregnant women and the American College of Obstetricians and Gynecologists recommends fourteen visits starting no later than the third month. During these visits women are screened for potential complications arising from their pregnancy, which can require additional visits, especially in the latter months of pregnancy. Low-income women, including immigrant women, have relied on Medicaid for these services. Both the federal and state governments fund California’s Medicaid program, Medi-Cal.

Studies show that uninsured women are less likely to make the recommended number of prenatal care visits, and they experience poorer birth outcomes than women with Medicaid. Furthermore, foreign-born women are generally more likely than U.S.-born women to be uninsured for prenatal care, and are less likely to follow the recommended schedule of prenatal care visits. When, in 1996, federal welfare and immigration reform legislation was passed, another barrier to access arose for low-income immigrant women by instituting greater restrictions on Medicaid for legal immigrants. Welfare reform restricted immigrants’ access to health care by more narrowly defining the immigrant populations eligible for federal Medicaid funding, and immigration reform made it harder for more recent immigrants to establish income eligibility for Medicaid.

In California, legal challenges to the implementation of welfare and immigration reforms and the use of state general funds ensured the eligibility of low-income immigrants for Medi-Cal coverage of prenatal care and other pregnancy-related services. The problem, however, is that the implementation of the federal welfare and immigration reforms, in addition to state health care fraud detection programs, produces a chilling effect that discourages the use of Medicaid by immigrants who are legally eligible in California. There is concern that this decline in Medi-Cal enrollment will lead to lower prenatal care utilization among low-income pregnant
immigrant women. This raises significant questions regarding the way in which federal and state policies collaborate to destabilize social safety net programs that were once viewed as fundamental to our national membership and identity. With the continued disintegration of the welfare state, a new relationship is apparent between the state and its members that goes beyond any distinction of citizenship status. Safety net protections are now more narrowly defined for all vulnerable people. What this study shows is that immigrants, particularly those who are low-income and women, function as easy markers to test the boundaries of this changing relationship, given their vulnerable gender, race, and class status. And the political economy of California in the 1990s provided a convenient opportunity for this test.

Reconfiguring the Burden in Neoliberalism

As immigrant women’s labor became more central to everyday life, their presence was increasingly destabilized and marginalized as burdensome. While the notion of immigrants as public burdens is not new, a reassertion of formal, state determinations of public charge signals a critical political moment that highlights the role of immigrants. In this latest iteration in the 1990s, public charge reappears to test the rights of migrants within transnational free market governance.22

In the context of the current global economy, the surge in demand for service sector labor has by and large replaced the manufacturing industry in the United States. Unlike traditional manufacturing industries in the United States, the service sector employs large numbers of women, thereby increasing the global demand for women’s labor. At the same time, economic globalization has increasingly feminized the workforce as multinational firms enter global South nations to establish assembly plants and take advantage of their low-wage labor.23 Douglas Massey describes the creation of a socially and economically uprooted population in this way:

The insertion of foreign factories into peripheral regions undermines traditional economies in other ways: by producing goods that compete with those made locally; by feminizing the workforce without providing sufficient factory-based employment for men; and by socializing women for industrial work and modern consumption without providing a lifetime career capable of meeting these needs.24

The end result is a “migration prone” workforce composed of both men and women, with an accompanying demand for their low-wage labor. In addition, immigrant women are essential to providing care work (child care, domestic service, home health care, and so on) and continue to labor in the agricultural industry. The dilemma of the role of low-income immigrant women is highlighted as they become pregnant. What makes women’s labor attractive in the global economy is its devalue (i.e., low cost) on the basis of their gender. However, when an immigrant woman uses her body for her own reproductive purposes, she is viewed as an irrational worker and punished for doing so. The bodily control that is necessary for the rationality and self-discipline of modern liberal subjects is denied to pregnant immigrant women workers. Global capitalist logic, which designates having babies and other forms of familial care-taking as inefficient for low-income migrant workers, becomes the basis for determining the rationality, and subsequently the deservingness of particular individuals. In this way, having babies is indicative of a lack of self-control.

In many respects, the timing appeared perfect. As Sanford Schram observed, even before the passage of major welfare and immigration reforms in 1996, there was “an ongoing ‘privatization of public assistance’—a retrenchment of public welfare programs and the corresponding elaboration of a network of substitute services, often in the form of private aid.”25 Rather than entitlements or rights, publicly funded programs including welfare and health care were increasingly privatized and refashioned into a humiliating form of individual charity. The consequences are considerable. As Schram26 predicted, we are seeing greater fragmentation and less accessibility, visibility, and effectiveness in the provision of social services, diminishing what little protection existed from structural issues that cause poverty including declining wages and eroding worker protections, racism and the dismantling of civil rights, unaffordable and inadequate childcare, underfunded public schools, and greater barriers to higher education.27 Instead, poverty is individualized as personal moral failings so that the solution centers on disciplining non-normative bodies to perform in “responsible” and “entrepreneurial” ways.
This logic allows for the justification of discipline of women in poverty by defining dependency as a pathological disease indicative of those with weak moral constitutions who are unable to self-regulate and make the "right" choices. In their analysis, Alejandra Marchevsky and Jeanne Theoharis assess, "To confess one's dependencies is to forfeit one's individuality and rights in the American state." As an example, they write,

If we looked into most homes in America, we might find this same tangled mess of socks, jeans, and sweaters on the sofa, and perhaps a pile of dirty dishes in the sink. But, in Myrna's case, a messy home or an empty refrigerator could cost her her children because Myrna is on welfare. Twice, in fact, the government has inspected her home, checking for food in the refrigerator and men's clothing in the closet. There are only three populations in the United States whose privacy is not protected under "probable cause" rules: prisoners, undocumented immigrants, and welfare recipients.

Dependency, then, is understood as indicative of whether or not one is deserving of rights necessary for social citizenship and almost entirely separated from actual need. Nancy Fraser and Linda Gordon note how this designation of deservingness is marked by specific economic, gender, and racial discriminations:

What in preindustrial society had been a normal and unstigmatized condition became deviant and stigmatized. More precisely, certain dependencies became shameful while others were deemed natural and proper. In particular, as eighteenth and nineteenth century political culture intensified gender difference, new, specifically gendered senses of dependency appeared—states considered proper for women but degrading for men. Likewise, emergent racial constructions made some forms of dependency appropriate for the "dark races" but intolerable for "whites."

By the 1980s, a decade after key western states enacted neoliberal policies, Ricky Solinger argues that the "core, essential attribute of a person in the state of dependency" was solidified as "the absence of the capacity to make sensible choices." She writes that dependency and choice become fixed in an antithetical relationship with each other, creating the necessary justification for greater restrictions on women's behavior. By this time, neoliberal interests had successfully usurped and redefined the discourse of "choice"—long championed by the women's reproductive rights movement. By the 1990s, low-income immigrant women were firmly circumscribed as dependent public burdens. For Asian and Latino immigrants, their purported dependency as a public charge was used to criminalize particular legal behavior as "illegal," regardless of their actual citizenship status. This was the case for Sophia Chen, whose story began this book, and many other immigrant women who received publicly funded prenatal care.

Reproductive Control versus Reproductive Freedom

The contradiction between choice and dependency is thoroughly embedded in feminist discourse regarding women's reproduction. The linchpin issue in the struggle for women's rights remains reproductive freedom, and the composition and delineation of this issue continues to spark serious debate. Dorothy Roberts argues that the Supreme Court's Roe v. Wade decision is restrictive in its narrow understanding of reproductive rights as "the freedom to decide, without active government interference, whether to use contraceptives and whether to terminate a pregnancy." Roberts argues for a broader definition:

A woman's reproductive life is clearly implicated in more than just the decision to use contraceptives and to have an abortion. Reproduction encompasses a range of events and conditions from the ability to bear children, to conception, to carrying a fetus, to abortion, to delivering a baby, to caring for a child. Each stage in turn involves myriad decisions that the woman must make; her decisions at each stage may be affected by numerous factors—economic, environmental, legal, political, emotional, ethical.

Reproductive freedom, then, would include access to health care, particularly prenatal care. This expansive idea of reproductive freedom also takes into consideration the experiences of low-income and other women deemed "undeserving" who were never allowed the opportunity to make "choices" regarding their reproduction. Solinger writes, "when choice was associated with poor women, it became a symbol of illegitimacy. Poor
women had not earned the right to choose. . . . As dependents they were categorically excluded from good choice making.46 Implicit in this assumption is a particular morality-based understanding of poverty in which people cause their own poverty as a result of bad decision making and consequently should not be allowed to make greater mistakes (i.e., to have children) that will produce yet another generation of burden upon the state. There appears to be a fundamental contradiction in this concept of "choice" in which there is only one correct decision and only those who "choose" that particular "choice" are allowed to do so. "Choice," then, is derived from self-control, which is, in turn, indicative of personal freedom.

Political theorist Lealle Ruhl addresses this philosophical dilemma of "choice" in the concept of "control," which is central to understanding the current politics surrounding women's reproduction.47 She locates contemporary debates regarding birth control and fertility, which emphasize self-control, as a by-product of modern liberalism.48 Seminal feminist theorists such as Simone de Beauvoir defined rationality and self-discipline as the central elements of liberal subjectivity.49 However, Ruhl points out that "Modern liberalism relies implicitly on the capacity and willingness of its citizens to self-regulate."50 Citing Mariana Valverde's4 work on liberal governance, Ruhl argues that liberal citizens are "granted" the freedom to make choices only when they can be trusted to make the "right" decision. Meaning, "To act responsibly means to conform to an essentially middle-class, educated, and scientifically oriented worldview."51 This definition of freedom appears oxymoronic given that an individual's decision is represented as one derived of freedom only if the "choice" represents a particular worldview. Any decision that is counter to that endorsed by the normative worldview, then, is understood as being against one's will and is dealt with accordingly. Under these circumstances, modern rationality is equated with conformity and the potentially exploitative powers of this logic appear great. Ruhl cites Margaret Sanger's use of eugenic arguments to promote birth control as one such example of punitive consequences for women who fail to prove their status as responsible citizens by controlling their fertility.

The subjectivity of low-income immigrant women in a modern liberal state deepens the complexity of this dilemma. Contemporary arguments for women's reproductive rights remain prone to such discursive practices in their use of the concept of control, which in the end does not truly encompass reproductive freedom but, quite possibly, the opposite. Ruhl asserts that "a fundamental challenge for feminists is to maintain a commitment to complexity of reproductive freedom while remaining alert to the possible misuses of a rhetoric of control."53

At a fundamental level, capitalist logic cannot form the basis for a feminist approach to women's reproductive rights. This is certainly made clear in the case of low-income immigrant women in which a "choice" to become a good mother marks her as a bad immigrant (i.e., a bad worker). True reproductive freedom must encompass the "choice" of low-income immigrant women workers to have children and not be punished with barriers to prenatal care for doing so. Only after such a broad understanding of reproductive freedom has been incorporated does it seem plausible to argue for reproductive control. A case in point is Rosalind Petchesky's fascinating contention for a "feminist revision of the body as property."54 Petchesky argues for an alternative perspective to "rethink the meanings of ownership and thereby reclaim both a feminist idea of bodily integrity and a radical conception of property at large."55 Citing African slave women's experiences as property and the consequent significance of "self propriety" as a powerful form of resistance, she writes that "we are better off thinking about property as a right—or . . . a relationship—that a thing, and about private, exclusive property as a historically and culturally circumscribed form of owning."56 While the idea of self propriety is powerful, I am wary of this call for a revision of ownership as a form of feminist resistance, given the potential pitfalls in the use of this capitalist rhetoric and its accompanying logic with respect to racial minorities. First, the racialization of people of color as having no will, or antiwill, miscalculates their role in the marketplace. Patricia Williams writes,

[O]ne of the things passed on from slavery, which continues in the oppression of people of color, is a belief structure rooted in a concept of black (or brown or red) antiwill, the antithetical embodiment of pure will. We live in a society where the closest equivalent of nobility is the display of unremittingly controlled willfulness. To be perceived as unremittingly without will is to be imbued with an almost lethal trait.57

"Thus," she explains, "while blacks had an indubitable generative force in the marketplace, their presence could not be called activity; they had no active role in the market."58 Racialized initially as having no will, people of color are already irrational, making them illegible as economic actors. Consequently,
their "contribution" or participation in the market is discounted, since they never made the "choice" to do so. Instead they are viewed as charity cases, without equal recognition of mutual humanity. This helps explain why low-income immigrants are not accorded social citizenship rights despite their strong labor market participation. The notion of self-propriety requires acknowledgment of will, which remains elusive for racialized immigrants.

Second, conveying bodies as property, whether it is a self-owned right or a privately owned thing, is a slippery slope. As a historically and culturally constructed concept, self-propriety may shift from one owner to another but, more important, it remains an entity in need of control/ownership. Instead, I see a more fruitful direction in expanding notions of freedom rather than control. It is a move away from privatization, which I believe is in line with black feminist theories regarding communal mothering. For instance, the works of Patricia Hill Collins, Linda Burton, and Carol Stack describe alternative family structures, including a network of fictive kin, that diffuses the responsibilities for familial care among "bloodmothers" and "othermothers."39

Here, Collins makes an important point in stressing that within these woman-centered kin units, the centrality of mothers is not predicated on male powerlessness. These diffused networks do not adhere to mutually exclusive and hierarchical gendering. In fact, they function in direct contradiction to privatized notions of responsibility in which a single person or household "owns" the child and the responsibility to support them. By documenting the existence of communal care networks in the face of structural adversity, these studies provide significant theoretical and practical insights to better understanding the potential paradox of choice/control and freedom. Without romanticizing the harsh realities of poverty, these approaches are worth revisiting for what it can tell us about the neoliberal conditions under which women must mother today.

The Deportability of Immigrant Women's Labor

The formal resurfacing of public charge was achieved by simultaneously capitalizing on the modes of racialization and gendering that already existed within state institutions while at the same time utilizing new forms of fear and anxiety associated with immigrants in the "War on Terror."40 The purpose of this manufactured and enforced dependency is to preserve the political and economic vulnerability of immigrants during a time of unimpeded demand for their labor. Public charge policy is a technology41 of what Nicholas De Genova calls "deportability." Writing about Mexican immigrants specifically, De Genova states, "It is deportability, and not deportation as such, that has historically rendered Mexican labor to be a distinctly disposable commodity."42 He argues that U.S. immigration authorities do not actually intend to deport all undocumented migrants. On the contrary, it is deportability—a liminal state of perpetual insecurity—that ensures that some are deported in order that most may remain in the United States as vulnerable workers to ensure that U.S. citizens enjoy low food costs and home care. Similarly, the possibility of deportation through public charge maintains the vulnerable social location of immigrants (regardless of their legal citizenship status) and strictly disciplines their behavior.

In the end, neoliberalism promises that less government and more privatization will lead to greater individual freedom. This assertion raises a crucial question: "For whom?" In the case of many immigrants who are part of the growing population of the working poor, less government in the form of fewer state services has led instead to greater state surveillance (a different but continued government presence) and a diminution of individual rights and freedoms.43 In his astute analysis, Matthew Sparke points out that although neoliberalism trumpets deregulation, in practice it is a form of reregulation. He writes that whether it is at the macro level of government policy (in the form of free trade, financial deregulation, welfare reform, and the like) or at the micro level of governmentality (audits, performance assessments, cultural cultivation of self-policing entrepreneurial individualism), "all these innovations in governmental policy and practice represent transformed patterns of state-making and rule."44 This reconfigured governance produces a multitiered state in which the freedoms and rights of some are maintained by the reciprocal restriction of the same freedoms and rights of others.

Rather than greater rights in return for greater "personal responsibility," low-income immigrants must allow increased government surveillance of their movements as proof that they are in fact making the right "choices" and taking "personal responsibility." The assumption here is that immigrants are not doing these things and instead are "naturally" inclined to be burdensome. A fundamental contradiction underlying this assertion is the fact that most immigrants work. In fact, their rates of employment
are higher than those native-born and yet, their social contributions are repeatedly questioned. This conflicts with the near obsessive focus of welfare reform on work as the sole route to self-control and making the "right" choices. As Iris Marion Young notes,

When welfare rhetoric invokes self-sufficiency today, it doesn’t mean being literally independent from engagement with others to meet one’s needs. It means only having a job and therefore, according to the terms of the welfare state, no longer being dependent on public funds. Even though many jobs do not pay enough to meet one’s needs, are only part time, are very insecure, and make a person highly dependent on employers and co-workers, these facts are obscured by the language of self-sufficiency.

Young is skeptical of paid employment as the primary means of achieving social citizenship. The case of low-income immigrant workers supports Young’s skepticism, given their diminished level of rights regardless of how many hours they labor. Instead, dependency of a different sort—to private employers—is expected. Relatedly, Marchevsky and Theoharis point to another contradiction in the construction of immigrants as public burdens. They note that immigrant women’s domestic labor in their own homes is characterized as oppressive, while this same labor is viewed as an act of independence when performed in other people’s homes. They call attention to the convenient timing: “Calls for immigrant women to liberate themselves from their culturally defined gender roles . . . conveniently corresponded to the nation’s growing demand for immigrant domestic labor.” Evidently, the value and meaning of labor changes depending on where you perform it and for whom. What is considered pathological dependency in one context is viewed as libratory independence in another.

In tracing the genealogy of dependency, Fraser and Gordon point out that women historically have had to negotiate how to be “just dependent enough.” This has always been a difficult balance given how easy it is to “tip over into excess in either direction.” Patricia Hill Collins provides a powerful example in the case of controlling images of black women as “mammy” (too dependent) and “matriarch” (too independent). Both stereotypes depict the black female body as ever-deficient and in need of discipline. Black women are placed in a racist dilemma, in which those “who must work are labeled mammies, then are stigmatized again as matriarchs for being strong figures in their own homes.” Collins writes, “While the mammy typifies the Black mother figure in white homes, the matriarch symbolizes the mother figure in Black homes.” Similarly, low-income immigrant women and the labor they produce are valuable only in specific circumstances (i.e., cheap labor for other homes/businesses) within neoliberalism and disciplinary images of public burdens function to maintain this market value. And, as this book will show, this maintenance requires continuous, deliberate care in presenting low-income immigrant women as either too much or not enough—excessive either way and in need of discipline in order to make the right choices. This paternalism supplants rights with charity, which in turn produces greater inequality among members of society as the giver receives moral credit while the taker is increasingly stigmatized. Charity, as a unilateral “gift” provided by a donor (who has no obligation) to a recipient (who has no claim), is a profound expression of power inequality. Charity extracts significant costs for the recipient. However, the neoliberal framing of this exchange facilitates an altruistic, sentimental image of individual generosity while obscuring the fact that social entitlements are actually being taken away.

David Harvey observes that neoliberalism is “a failed utopian rhetoric masking a successful project for the restoration of ruling-class power.” This “masking” appears to play a key function in that the restoration of ruling class power requires the erasure of racism and sexism upon which it is based. Its discourse of individual choice and rational market actors absolves it from such “irrationalities” as racism and sexism. It seems imperative, then, for critics of neoliberalism to unmask this relationship and clearly articulate neoliberalism as a racist and sexist ideology, which is enforced by the state with such laws as public charge. Without an explicit challenge, market logic will continue to conceal the vast inequalities created for capital accumulation and our understanding of the complexities of migration will never advance beyond a mere debate about financial costs and benefits.

Racial Politics of Immigrant Births, 1990s Style

As it stands, one of the central arguments for the restriction of prenatal care for immigrants is the accusation that poor immigrants have a propensity for fraud and will abuse the generosity of the U.S. health care system. The core rationale of this position is that any use of the health care
system by low-income immigrants is fraudulent and abusive. And more specifically, access to prenatal care, which may imply the encouragement of greater numbers of immigrants or their children of color, is understood as a special privilege which they do not deserve.

Respondents I interviewed across the state of California highlighted how recent federal and state immigration and welfare policies have contributed to a sense of fear among immigrants using Medi-Cal (California's Medicaid program), a legal entitlement. Beginning in 1998, my research team and I interviewed almost two hundred safety net health care providers, immigrant health advocates, government officials, and low-income immigrant women in specific regions of California, including San Diego County, the San Francisco Bay Area, Los Angeles, and the Central Valley. My objective was to assess the impact of federal welfare and immigration policy changes on access to prenatal care.

The consistency of the responses was striking. The social workers and health care providers repeatedly described their patients' dual fear of the consequences of negative immigration status for applying for Medi-Cal coverage, on the one hand, and the cost of obtaining prenatal care without Medi-Cal, on the other. At the heart of this fear are changes in health, welfare, and immigration legislation that have altered the implications of using Medi-Cal–funded health care benefits for the future immigration status of women and their families. They were afraid that using health care would harm their chances of attaining legal citizenship or permanent residency status. On the other hand, the women are faced with the increasingly high cost of health care if they are to pay for it out-of-pocket.

There is fear on both sides of this heated exchange. The fear expressed by those advocating greater restrictions upon immigrants focuses on the growing population of immigrants and interprets that flow as an "invasion." The only solution to such threats is control, in its various forms. Consequently, pregnant immigrant women find themselves in the midst of an intense political debate over not only state control of women's reproduction but also immigration control. Within this predicament, the deeply racialized nature of immigrant women's reproduction is evident. For low-income immigrant women of color, having children is considered a selfish act, given their national role as temporary workers. This is in stark contrast to understanding the infertility of middle-class white women as a "tragedy," as expressed by many middle-class policy makers and politicians.

Arguments that immigrant women abuse health care and have babies in order to obtain U.S. citizenship question the motive of low-income women in having children. These arguments are distinctly similar to the public obsession with the black "welfare queen." Like the "welfare queen," low-income immigrant mothers are viewed as "working" the system by having children and therefore undeserving of social services for themselves or their children. Within this framework, new policies are introduced in order to deter such selfish behavior. These racist and classist assumptions preclude low-income immigrant births from any sense of protection derived from an understanding of mothering as "sacred" (as flawed as this understanding is). From this perspective, immigrant women giving birth to any children at all is too much and therefore indicative of an out-of-control fertility. Consequently, any low-income immigrant woman of childbearing age is a potential public burden—in other words, a public charge.

For those who believe that the United States is threatened—economically, culturally, or racially—by immigration, control and discipline are the primary mechanisms to detect and deter the movement of immigrants. Technologies of control and discipline require that individuals have constant contact with the state. The Port of Entry Fraud Detection (PED) Program and the Medi-Cal eligibility process are just two examples of this technology. Women who are "dependent" on state institutions are more closely monitored and controlled than those who are not. It appears that the dependency of immigrants on the state is enforced in policy, at the same time as it is decried in the public rhetoric.

The Politics of Immigrant Health Care Access in California

California is home to one-third of all immigrants living in the United States. One-fourth of the state's population was born outside the United States, making California the state with the highest concentration of immigrants. Asians and Latinos comprise the vast majority of immigrants to the United States. These two diverse ethnic/racial groups account for 80 percent of all incoming immigrants in the 1990s. Their individual and collective impact on the political, economic, and social landscape of
California is profound. In this regard, how California responds to these significant demographic changes is understood as the bellwether for the future of the entire nation. Further, an investigation of the politics of immigrant health care access shows that immigration is indeed a pressing civil rights and racial justice issue in the United States.

As part of this investigation, I found that despite the stark differences among the various immigrant communities, there are salient and strategic moments of interconnection that highlight some of the long-term consequences of federal policies and programs. In assessing the impact of the 1996 welfare reform on immigrant women, stereotypes of uncontrolled fertility—particularly Latina—played strongly into overall anti-immigrant sentiments. In his study of the politics surrounding Latina reproduction, Leo Chavez states, "Latinas exist and ‘reproduction’ exists, but ‘Latina reproduction’ as an object of a discourse produces a limited range of meanings, with an emphasis on ‘over’-reproduction and on fertility and sexuality depicted as ‘out of control’ in relation to the supposed social norm.” Negative perceptions of motherhood and mothering by ethnic immigrant minorities played a considerable role in swaying California residents to restrict immigrant care in the 1990s. The growing presence of ethnic minorities was used to justify claims that immigrants in general overuse public health services and education, and take jobs from American citizens. The overwhelming passage of California’s Proposition 187 in 1994, which restricted access to all publicly funded programs—including health care and education—for undocumented immigrants, clearly articulated this message. Lynn Fujikawa writes,

Proposition 187 reflects fears that undocumented immigrants were over utilizing public resources such as health care, education, and economic assistance at the expense of poor working-class “Americans.” Racial-gendered images of migrant women crossing the border to have their children and receive medical care through state-funded health care services played on working- and middle-class voters’ resentments against “non-Americans” who allegedly received benefits from their tax dollars.

Such sentiments are not uncommon. For instance, the San Diego Union-Tribune devoted significant resources to highlighting immigrants’ use of health benefits in 1993 (a year before the passage of Prop. 187). The newspaper ran a five-part series entitled “Medi-Cal: The New Gold Rush,” which focused on Mexican immigrants’ use of health care in the United States. The first installment began with this subheading: “California’s health program to treat the state’s poor—Medi-Cal—has created a new gold rush as people from around the globe flood the Golden State to grab a share of the unsurpassed medical care available here. Who pays for all this? You do.” The series reiterates many U.S. residents’ misconception that immigrants migrate to the United States for welfare and health benefits and that immigrants do not contribute to this society (in taxes or otherwise). The imagery of California’s gold rush of the 1800s that brought so many Chinese workers, as well as other immigrants, is also noteworthy. As the gold rush came to a close in the Sierra Nevada Foothills, Chinese immigrants experienced extreme hostility that resulted in the Chinese Exclusion Act of 1882. In fact, during this historical era, Chinese (along with Syrians and Greeks) were explicitly targeted in the medicalization and militarization of the U.S. border, as they tried to enter the United States as Mexicans.

Also, a few months prior to this newspaper series in 1993, State Senator William Craven, chairman of the Senate Special Committee on Border Issues, was quoted as saying, “It seems rather strange that we go out of our way to take care of the rights of these individuals who are perhaps on the lower scale of our humanity, for one reason or another.” The separation of Latinos into an “undesirable” or “undeserving” category is clear; and so are the racist undertones that helped garner support for subsequent anti-immigrant legislation.

Finally, in February 1994, the San Diego Union-Tribune ran an “exposé” entitled “Born in the USA” which targeted Latina immigrants’ fertility using what is by now familiar anti-immigrant rhetoric. The headlines read: “Births to Illegal Immigrants on the Rise,” “California Taxpayers Finance Soaring Number of Foreigners’ Babies,” and “Border Baby with Medical Problem Costs $2.7 million.” Such claims are in direct contradiction with numerous studies that have shown that individuals do not migrate to the United States for health or other social services. Immigrants’ overall use of welfare services and benefits is roughly the same rate as those of native-born persons. However, in 1994, immigrant women accounted for 60 percent of all publicly funded births (via Medi-Cal). This high rate is attributed to a number of issues, including the disproportionately large number of immigrants who live in poverty, improvements in access to health care for immigrant women during the 1980s and early 1990s in California,
amnesty granted through the Immigration Reform and Control Act of 1986, and liberalization of the family reunification policy.  

Historically, nativist concerns have a tendency to expand to encompass other vulnerable minorities under certain political and economic conditions. The Port of Entry Detection (PED) program, for instance, highlights the links among immigrants from Latin America and Asia. In this case, Latinas (particularly Mexicans) were the initial test, and once deemed successful, the program expanded from the U.S.-Mexico border to international airports to target Asian immigrants. The intersection of various policies exposes the ways in which different racial/ethnic populations are intertwined. At certain historical moments, particular ethnic groups rotate as convenient test cases to push the boundaries of citizenship rights. For instance, legal scholar Bill Ong Hing writes that the legislative attacks on Asians in the late 1800s served as a model for the exclusion of eastern and southern Europeans. Today, immigrants from Latin America are the most visibly attacked, both verbally and physically, for their use of public benefits. However, as the Port of Entry fraud detection program attests, the target can easily shift to others deemed foreign—including those presumed to be model minorities.

Another pressing concern in this investigation into the politics of access to immigrant health care is the unprecedented sharing of what was once considered private individual information across both state and federal agencies. While immigrant access to health services such as prenatal care was increasingly hindered, governmental access to individual information greatly expanded during this time. Five years prior to the September 11, 2001 attacks and the subsequent passage of the federal USA Patriot Act, immigrants in California experienced firsthand the effects of a new, intensified level of state surveillance of private information.

California's Proposition 187

Preparation for the collaboration and sharing of information between the state DHS and the federal INS departments in California was evident in 1994 with the passage of Proposition 187 and the creation of the PED programs. It was a sign of things to come for immigrants in the United States.

The passage of Proposition 187 conveyed the message to immigrants that they were not welcome in the state's publicly funded schools, clinics, and hospitals. This initiative, created by a coalition of nativist Californians and spearheaded by then-governor Pete Wilson (formerly the mayor of San Diego), was particularly punitive, given that undocumented immigrants were already denied health and welfare benefits. In Ono and Sloop's study of the political rhetoric during this time, they note:

For many, the policy conjured up memories of the racialized "alien" land law restrictions against Japanese Americans; legislation severely limiting Asian immigration; the incarceration of Japanese Americans during World War II; the 1930s repatriation campaigns to force Mexicans in the United States and their children to move back to Mexico; and the 1954 "Operation Wetback," in which more than a million Mexican migrant workers were forcibly deported from the United States to Mexico.

Immediately after the passage of Proposition 187, a number of legal advocates filed legal injunctions questioning its constitutionality and successfully prevented it from being implemented. Despite the fact that this initiative was never enacted, the initial passage of this state legislation with overwhelming voter support sent a clear message to immigrants—both undocumented and documented—that they are viewed as a burden on the state and therefore unwanted. One of our respondents, a community clinic administrator, described the situation at that time as follows:

After [Proposition] 187 passed, there was a lot of fear. Then we went back and forth as people were trying to get legalized. They did not want to apply for any kind of services that might jeopardize their applications. So some people wouldn't apply for Medi-Cal and we had to encourage and push them to apply for Medi-Cal because, let's face it, if you don't apply for Medi-Cal and you do not have the money, you're facing a $5,000 bill, at least—between prenatal care and the hospital. We basically sat down with them and said, "If you don't apply for Medi-Cal this is what your bill is going to be." And you know, when you look at what the bill is going to be, most of them... a few of them wouldn't, but most of them would apply. If not for their prenatal care, at least for their delivery.
These initiatives, along with the subsequent passage of federal legislation on welfare and immigration reform in 1996, reinforced the message of a severely restricted entitlement to publicly funded programs. In a study of Latina immigrant women's perspectives on Proposition 187, researchers found that Latinas perceived this initiative as discriminatory and directed primarily at their community. The study also found that Latinas were reluctant to seek medical care as a result of this initiative.6 This finding was supported by another study conducted by the Urban Institute that showed a significant decline in applications for Medi-Cal and welfare benefits by immigrants in Los Angeles County. Apparently, immigrant access and utilization of key public benefits declined immediately after the passage of this anti-immigrant proposition, reflecting a pervasive fear in these communities.

Federal Welfare Reform and Immigration Reform of 1996

Such hostile perceptions and treatment of immigrant women were further solidified in 1996 with the passage of the federal welfare reform bill (PRWORA—Personal Responsibility and Opportunity for Work Reform Act—PL 104-193) and the federal immigration legislation (IIRIRA—Illegal Immigration Reform and Immigrant Responsibility Act—PL 104-208). The welfare reform restricted immigrants' access to health care by more narrowly defining which immigrant populations were eligible for federal Medicaid funding. Federal Immigration and Welfare legislation explicitly linked immigration status to eligibility for public benefits by creating new categories of exclusion: "pre-enactment" and "postenactment."7 For those immigrants who arrived (legally) after August 22, 1996, this legislation ended their eligibility for federal means-tested entitlements, including federal cash assistance, food stamps, and Medicaid. Along with a five-year lifetime limit on cash benefits and new work requirements imposed on all welfare beneficiaries, the PRWORA implemented additional restrictions on legal immigrants.8 Remarkably, restrictions on immigrant benefits alone accounted for almost half of the total federal savings.9 Ostensibly a budgetary measure, the savings from eliminating almost the entire safety net for immigrants came from denying benefits to legal—not "illegal"—immigrants. Undocumented immigrants are already ineligible for most major means-tested entitlement benefits.

A year later, some food stamps and Supplemental Security Income benefits were restored to a narrowly defined group of immigrants through the Balanced Budget Act. States were also given the option to determine immigrants' eligibility for Medicaid and state cash assistance programs. California opted to continue Medi-Cal coverage to legal immigrants irrespective of their date of entry to the United States. However, state and local government agencies continued to require documentation of immigration status from applicants for means-tested programs.

At the same time, the federal immigration reform made it more difficult for more recent immigrants to establish income eligibility for Medicaid by requiring sponsors of new immigrants to sign legal affidavits that they had incomes greater than 125 percent of the federal poverty level. This legislation also required that the income and assets of sponsors be considered when determining Medicaid eligibility for a new immigrant (i.e., "deeming"). This deeming provision created another barrier to health care access because the addition of the sponsor's income and assets significantly decreased the number of new immigrants eligible for Medi-Cal. This was in addition to the other major provisions in this legislation that affected both documented and undocumented immigrants, including new legal affidavits by family unification sponsors, nearly doubling the number of Border Patrol agents, increased civil and criminal penalties for illegal entry, greater restriction on asylum admittance, and limitations on possible challenges to deportation rulings.100

The passage of these two laws also facilitated the exchange of information regarding immigration status and the receipt of Medicaid-funded services between states and the federal INS (now Immigration and Customs Enforcement—ICE).101 For instance, PRWORA explicitly prohibits the use of federal funds for Medicaid benefits other than emergency care for specific groups of immigrants. Therefore, unless they have a specific, verifiable immigration status, immigrants are only allowed coverage for emergency care. States must now verify the immigration status of a foreign-born Medicaid applicant with the INS if the person applies for a Medicaid benefit that includes federal financial participation.102 This is a departure from previous policies in California wherein verification of immigration status was only required for those seeking full-scale benefits and, when required, a social security card or birth certificate was sufficient to establish legal immigration status. Consequently, an immigrant was eligible for emergency and pregnancy-related
services without any documentation of immigration status. Chapter 3 will illustrate this issue further, using as a case study a class action suit against the California Department of Health Services.

Moreover, these federal policies have prohibited state and local governments from restricting communication between state and local agencies and the INS regarding the immigration status of benefits applicants. This information link between the INS and DHS can occur through local Medi-Cal eligibility offices. When immigrants apply for Medi-Cal, the information they provide about their income, assets, and the information in documents they used to establish their California residency can now be turned over legally to the INS. This institutionalized sharing of what was once private information is a public health issue, given that the increased level of fear may deter immigrants from using preventive health care such as prenatal care. The disciplinary, governmental reach of INS/ICE continues to expand into other entities, often to the detriment of these organizations. Thus, the mission of safety net health care hospitals and clinics to care for their underserved and vulnerable populations is jeopardized as they become increasingly intertwined with immigration enforcement. For instance, public hospitals seeking federal reimbursement for emergency services provided to nonqualified aliens are required to follow federal procedures regarding verification of immigration status. In this way, public hospitals are forced to verify their patients’ immigration status in order to be compensated for their care. Verification of immigration status is central to federal Medicaid eligibility requirements.

Currently in California, legal challenges to the implementation of welfare and immigration reforms and the use of state general funds have ensured the eligibility of low-income immigrants for Medi-Cal coverage of prenatal care and other pregnancy-related services. The problem, however, is that the policy implementations of the welfare and immigration reforms have created a chilling effect that has discouraged use of Medicaid by immigrants who are legally eligible in California. There is concern that this fear may have long-term health consequences for low-income pregnant immigrant women.

Since the passage of the 1996 laws, information concerning people who apply for and receive Medi-Cal has been provided on an ongoing basis to the state DHS office by local Medi-Cal eligibility agencies. Prior to the INS clarification, the issue at stake was whether Medicaid, a non-cash public benefit, fell within the domain of public charge since the benefit is not cash assistance, but health care coverage.

Surprisingly, the official clarification of public charge in 1999—stating that Medi-Cal use alone cannot be used to determine public charge—did little to diminish the initial fears created by the federal and state policies. The trust required to deliver quality preventive health care such as prenatal care to immigrant communities was badly damaged as a result of a history of anti-immigrant sentiment. The 1996 policies helped to solidify this distrust of government programs. The power of the INS to arbitrarily prevent an immigrant they judge to be a potential public charge from obtaining legal permanent residency helped to create this antagonistic relationship. In addition, the INS can refuse readmission to immigrants who leave the United States for more than 180 days, and are judged likely to become a public charge upon their return. And the ever-present threat of deportation as a public charge (while rarely done) has created an intensely hostile environment for low-income immigrant women in need of prenatal care. Again, the message is that low-income immigrant women do not have the same freedom as middle-class native-born women, to have healthy children. The threat of deportation is severe.

It appears that what California began with Proposition 187 in 1994 was enacted de facto across the nation with the Immigration and Welfare Reform Acts of 1996. The restrictions to public services enforced by the state Prop. 187, which were deemed unconstitutional and never legally enacted, were in effect reinstated by federal policies two years later. The chilling effects initiated by Prop. 187 were further solidified nationally through these federal legislations that reinforced the stereotype of immigrants as public burdens.

Methods

For this project, 196 participants were interviewed in two stages from September 1998 to December 2001. Using qualitative methods, key respondents were interviewed to document the impact of recent immigration and welfare reforms on health care access for low-income pregnant immigrant women in California. Initially, we focused on four areas of the state that together comprise more than 75 percent of California’s foreign-born
population: San Diego, Los Angeles, the San Francisco Bay Area, and the Central Valley. In this first stage, we selected a purposive sample of 101 respondents from 76 different organizations knowledgeable about immigrant health care in California since 1994. These respondents were from three different types of organizations, thus revealing the multiple dimensions of immigrant women's experiences with health services: safety net health care providers, immigrant organizations, and government agencies.

A little over a year later, I returned to my respondents and interviewed them once again to document any changes in access to health care since our first interview. This time, I limited my sample size to three geographical areas to provide greater depth: the San Francisco Bay Area, Fresno County, and San Diego County. The San Francisco Bay Area remained the northern California sample, Fresno the rural, Central Valley sample, and San Diego the southern California sample. However, during our return visit, we found a high turnover rate in these positions, making it difficult to locate the same individual we had interviewed earlier. Consequently, whenever possible we spoke with the newly hired replacements of those we had interviewed earlier, holding the same positions. In some instances, the positions had been eliminated altogether. We interviewed a total of 95 key informants in this second stage.

My objective, in this second phase of data collection, was to document whether the women and their health care providers had experienced less confusion after a number of key attempts were initiated to clarify federal and state policies regarding health care for immigrants. I paid particular attention to federal policy clarifications regarding public charge, which was intended to alleviate the fear of the consequences of accessing health care. A more detailed description of my data collection methods is provided in Appendix A.

Outline of the Book

This book begins by framing the social context of immigrant women's reproduction within major welfare and immigration reforms in the 1990s. I first outline the history of "public charge" and its strategic political use to portray low-income immigrant women as burdens on the state. I discuss the contemporary neoliberal twist to this idea and how immigrant access to prenatal care pertains to and contributes to debates about immigration in California. In extending these arguments, I analyze the role of immigrants in what is left of today's welfare state in chapter 2. Here, I focus on pregnant immigrant women's experiences with the Medicaid eligibility process in California.

In chapter 3, I investigate the impact of public charge fears on low-income pregnant immigrant women's access to Medi-Cal, a publicly funded health insurance program for low-income Californians. Here, I begin with a more detailed discussion of the Medicaid fraud detection programs established at the Mexico-U.S. border, and later at the Los Angeles and San Francisco International airports to illustrate the extensive and complex influence of policy on an everyday level. Of particular significance is the impact—or lack thereof—of government efforts to backtrack or "clarify" their mistakes (i.e., unintended consequences). As data, I provide two key case studies. First, I use documents and interviews relating to a lawsuit brought against the State Department of Health Services regarding its handling of fraud detection programs at the border. This lawsuit brought to light largely secretive initiatives to deter low-income immigrants from accessing health care and to illegally collect funds from immigrants who had already done so. Second, I analyze a remarkable state audit of a specific fraud detection program aimed at documented, low-income immigrants re-entering the United States through border crossings in San Diego County and the international airports in Los Angeles and San Francisco. These cases show that federal policies have little room for error, given these policies' actual consequences on people's everyday lives.

Chapter 4 focuses on the role of social workers in ensuring the necessary level of community trust in sustaining medical safety nets. I show how these social workers play a pivotal role in holding up the fraying health care safety net. To do this, I analyze the clarification of public charge policy in 1999 and its impact on community-based safety net organizations. In chapter 5, I pay attention to San Diego as a constructed "illegal" space where local and national anxieties about immigration come together to push (seemingly) new initiatives to dismantle health care for low-income immigrant workers. The U.S./Mexico border allows for an extranational space of experimentation to see how far rules and regulations can be bent in keeping with the ebb and flow of global financial investment, national
security fears, and political capital. I look particularly at two health care clinics in San Diego County who care for indigent residents. These clinics are indicative of the last frontier of immigrant health care.

I conclude, in chapter 6, with a summary of how the notion of public charge promotes a neoliberal ideology of personal responsibility and criminal dependency. The criminalization of low-income Asian and Latino immigrants in the 1990s as public burdens recast their legal behavior as "illegal," regardless of their actual citizenship status. In response, various health care clinics, hospitals, and organizations developed innovative strategies to alleviate some of the chilling effects of public charge allegations on low-income immigrant families. These innovations are essential, given the grave consequences of these federal and state policies. By simultaneously capitalizing on the modes of racialization and gendering that already existed within these government institutions, understandings of burden and citizenship are reframed by neoliberal logic to the detriment of all people—both immigrant and native-born.
Especially since the 1970s, the norms of good citizenship in advanced liberal democracies have shifted from an emphasis on duties and obligations to the nation to a stress on becoming autonomous, responsible choice-making subjects who can serve the nation best by becoming "entrepreneurs of the self."
——Ahwa Ong’

Creating “Entrepreneurs of the Self”

The massive economic restructuring of the 1970s was pivotal to the development of global capitalism. This economic transformation, driven by a ferocious faith in a global market free of barriers to facilitate the flow of capital, fueled a parallel demand for transnational labor migration. In fact, Saskia Sassen argues that immigration is largely a result of the economic, political, and social conditions of the receiving country. She states, “Immigration flows may take a while to adjust to changes in levels of labor demand or to saturation of opportunities, but eventually they always have tended to adjust to the conditions in receiving counties, even if these adjustments are imperfect.” At the same time, the Hart-Celler Act of 1965 not only rearranged which and how many persons could enter the United States but also the entire process by which these decisions were made. The new category of “family unification” helped to alter the composition
of the immigrant population to comprise approximately 40 percent from Latin America and another 40 percent from Asia. In a stunning turn-around, European admissions fell to less than 20 percent during the 1970s. Thus, the 1970s brought in a new wave of large-scale immigration from what were, at the time, nontraditional sending nations. Subsequently, the number of Latino/as surpassed the African American population to become the largest racial minority group in the United States today. In addition, Asian immigrant communities also experienced significant population increases—so much so that Asian Americans became the fastest growing minority group.

The decade of the 1970s was also an historic era of civil rights legislation. Consequently, particular forms of discrimination, including racism, were legally prohibited. Here, we see the impact of the civil rights movement in opening access to welfare benefits to African Americans. In 1939, when AFDC was created (Aid to Families with Dependent Children), the major welfare program for poor families, 89 percent of the recipients were white and 61 percent were widows.6 These numbers began to change in the 1960s as black women and other welfare rights advocates collectively won greater access to AFDC by contesting the exclusion of certain industries from coverage under the programs and discriminatory practices of state agencies that administered the programs.7 However, by the mid-1970s, re-trenchment of the welfare state was institutionalized through a concerted political attack on the acceptability of entitlement. Teresa Amott describes this coordinated process as follows:

Starting in California, a movement to limit state taxes was able to mobilize the concerns of moderate income citizens over their stagnating earnings. Fundamentalist Christians focused on the erosion of “family values” and the rise in divorce and out-of-wedlock births. Corporations facing falling profit rates sought to impose labor discipline through cutbacks in government programs, sophisticated anti-union campaigns, and demands for deregulation. At the state level, these movements combined to sharply limit the never-strong political support for AFDC.8

As the U.S. economy began to stagnate in the 1970s and neoliberal political and economic doctrines took root, the concept of entitlement underwent severe scrutiny as age-old moral fitness arguments were reinstated to question the “deservingness” of Black mothers. Gwendolyn Mink observes that welfare, as a maternalist innovation, was once understood as a “Mother’s pension,” but it became “discursively transformed into a ‘way of life’ by the late 1960s, and the worth and rights of single mothers were displaced by the icon of the Black ‘welfare mother.’”9 Mink describes today’s postmaternalist welfare policy as pathologizing women’s dependency to justify punishing mothers who do not conform to legislated morality—a “shape-up-in-the-home or ship-out-to-work” principle: “Today’s welfare reform . . . rejects the idea that the poverty of mothers and children is a social concern and seeks to privatize economic uplift: hence the notion of coercive work requirements.”

By 1990, Linda Gordon writes,

In two generations the meaning of “welfare” has reversed itself. What once meant well-being now means ill-being. What once meant prosperity, good health, and good spirits now implies poverty, bad health, and fatalism. A word that once evoked images of pastoral contentment now connotes slums, depressed single mothers and neglected children, even crime. Today “welfare” means grudging aid to the poor, when once it referred to a vision of a good life.10

As access to social services included more people of color, the service itself became defined as morally questionable. The few publicly funded programs of assistance to the very poor were so despised that even self-defined liberal progressive organizations did not want to touch the matter. For instance, the National Organization for Women (NOW)’s Legal Defense and Education Fund tried to appeal for financial support for an economic justice litigator through direct mail but its request was met with so much hate mail that it stopped mailing any literature mentioning welfare issues.11 Gordon provides this bleak assessment of the state of welfare in 1994:

“Welfare” is hated by the prosperous and the poor, by the women who receive it and by those who feel they are paying for it. It stigmatizes its recipients, not least because they are so often suspected of cheating, claiming “welfare” when they could be working or paying their own way. It humiliates its recipients by subjecting them to demeaning supervision
and invasions of privacy. Yet it does nothing to move poor women and their children out of poverty and often places obstacles in the paths of women's own attempts to do so.13

By 1996, women who accessed welfare were openly treated as "reckless breeders who bear children to avoid work."14

While the drive for reform is not surprising, given such assessments, the extent and depth of the 1996 welfare legislation's long-term effects on low-income immigrant families and its implications for our national identity is profound. These policies describe a retrenchment or retraction of the welfare state itself. One of the most remarkable elements in this legislation is the disproportionate focus on immigrants. In the initial form passed, almost 50 percent of the overall welfare cuts were directed at the limited services for immigrants. Clearly, the focus of national anxiety over welfare use highlighted immigrants.

Given this vitriolic reaction to anything defined as "welfare," health care activists advocated for prenatal services for low-income immigrants by framing prenatal care as a form of preventive care that was relatively cheap compared to emergency care and by defining the patients as deserving, self-sufficient people who valued their children. Linking cost effectiveness and morality, good mothering was evoked to distance their patients from the negative imagery of "welfare mothers." However, this argument was to little avail as the political climate toward immigrants increasingly chilled to a point where even immunization for infant children of immigrant mothers was viewed as asking for too much.15 Ironically, by focusing their arguments on costs, morality, and mothering, public health efforts may have functioned to further solidify the negative stereotype of welfare mothers as real. Rather than dispute the representations themselves as false, harmful, and racist, public health advocates may have missed an opportunity by presenting certain immigrant women as "model minorities," in opposition to others who fall into this stereotype.

There is another pitfall with this representation, in that strong, independent women are problematic in a welfare system in which recipients must show "neediness." The welfare state's role as disciplinarian is well established. From Mimi Abramovitz's historical analysis of welfare policy as a systemic way to regulate women's lives to Michel Foucault's theory of governmentality,16 studies have illustrated how the state utilizes a discourse of "needs" to justify institutional social control. What has changed is the degree to which discipline was meted out during the neoliberal era of the 1990s.17

Despite the rhetoric of low-income immigrant women as public burdens, real independence is troublesome for the nation-state in its current drive to control the border and the immigrants within it. Ironically, the nation-state requires a certain level of subservience or dependency from these women and the welfare system enforces this. The eligibility process to gain access to the system, for example, enforces a strict code of behavior, as do most forms of charity. The move toward privatization through personal responsibility has diminished what were once state entitlements to almost complete dependence on individual charity. This is particularly the case for low-income immigrant women who are seen as public burdens. For immigrants, the consequences are considerable. The following section of this chapter outlines in greater detail the ritual—that is, the procedures and performance—of enforced dependency that many low-income women encounter as they try to access prenatal care for which they are eligible. I will also discuss the impact of intergovernmental collaboration as a persistent barrier that contributes to this ritual. Then, I will conclude by examining the political quandary of motherhood for low-income immigrant women who need prenatal care. Many of these women are trapped between being viewed as either too dependent or too independent of the state, both of which are deemed irresponsible subject positions.

With the "enforced and induced compliance"18 of the individualistic logic of neoliberal capitalist discipline, the existence of the welfare state is treated as an eyesore. And the anxieties regarding immigrants and immigration have contributed to the latest, near-fatal blow to the welfare state. What images of the "welfare queen" crippled, the "immigrant public charge" has decimated, perhaps even nailing the coffin shut.

Rituals of Enforced Dependency

The Medi-Cal Eligibility Process

Medi-Cal—California's Medicaid program—provides health care coverage for over 5.1 million low-income families and individuals who lack health insurance. Both the federal and state governments fund Medi-Cal. It is
administered by the Department of Health Services (DHS) at the state level, and by the Department of Social Services (DSS) at the county level. It is at the county level that “Medi-Cal eligibility workers” determine eligibility. These eligibility workers are based in welfare offices and in some health care hospitals and clinics.  

However, Medi-Cal does not cover everyone who is poor. One must meet a number of property, income, institutional status, residence, and citizenship requirements to qualify. In 1998, there were 107 categories or “aid codes” for eligibility. The welfare and immigration legislative changes after 1996 made what was already a complicated Medi-Cal eligibility process even more intimidating for immigrants. The Medi-Cal eligibility process is commonly described as a “hassle.” The complicated income and residency requirements and intimidating investigators all contribute to the barriers that surround access to Medi-Cal. A community clinic director explained:

[It is very difficult for people to understand all the eligibility categories. My professional eligibility staff—it is a miracle that they understand all that. Understanding all these little rules. It is just such an incredible waste of wealth as well as a deterrent to care. I think that is the real impact of how this comes together. And it is with such concentration, particularly aimed at immigrant families. It is sort of academic whether or not you are eligible under these certain circumstances. Overall message is you are really not welcome, you are really not eligible.

Respondents in each region stated that even though immigrants may want health care, the lengthy paperwork involved in signing up for Medi-Cal deters them from enrolling. The time spent on completing the application and then getting approval for the services is a lengthy and time-consuming task that has discouraged some immigrants from enrolling in Medi-Cal. A health care provider in San Diego illustrates the level of frustration that characterizes this process by saying:

There’s absolutely no assistance in completing an absolutely monstrous application. Most of the clients we are dealing with are really not in a position to complete application forms. . . . So if you’ve got a huge document this thick, what’s the likelihood of having tremendous miscommunication? Massive.

The inability to fully complete an application may mean that it will be months before an individual is eligible for Medi-Cal, resulting in delay in seeking and receiving the needed health care. A San Diego health care provider describes the problems that can surface with the completion of these applications as follows:

People have to apply two or three times because they don’t get the paperwork done. They’re not actually denying a person because it’s actual ineligibility, they just don’t have either what they want or what they need to determine that eligibility. So I think it’s becoming more and more clear that all of our clients really need help in completing the actual applications so that when the eligibility technicians get the forms, they can actually determine eligibility and then go ahead and grant, or deny if in fact they are ineligible.

These difficulties involved in Medi-Cal access are also evident in the income and residency requirements of these applications.

Income Requirements

As part of the Medi-Cal application process, an applicant’s household income must be assessed. For some immigrant applicants, this is no easy task. Many immigrants, particularly the undocumented, work in the “informal economy” where there is no written record of their labor or the wages they receive. As a community clinic outreach worker explained:

One of the major problems they have here is that a lot of them do work under the table—for instance gardening work—and they get paid in cash and when they go to apply for Medi-Cal; well, Medi-Cal says, “we need proof of income” and they go back to that person and they say, “you know, can you give me a receipt or a little ledger that says that I worked here and I made $40 today.” People refuse to do that because they know that they are hiring an illegal and they don’t want to be involved. And they deny that the person has worked there. So they go back to the Medi-Cal worker and say, “you know, I cannot provide this because this person doesn’t want to give me this,” and then this is the end of the story.
The outreach worker described a number of cases in which her patients experienced a series of disruptions in her prenatal care as they and/or their partners jumped from one "informal" job to another. Even those who are initially enrolled in Medi-Cal find themselves in difficult situations regarding their employment. The informality of this labor force creates problems for Medi-Cal recipients when they file mandatory quarterly reports declaring their income and assets. As they go from one job to the next, there is no guarantee that their current employer will provide the necessary documentation for the quarterly Medi-Cal form. Those patients who are unable to provide proof of income may be cut from the program. Due to the stricter eligibility requirements and immigrants' inability to provide sufficient documents, providers have reported growing numbers of denials for Pregnancy Only Medi-Cal applicants.

In these situations, immigrant health care advocates are essential for minimizing or eliminating the disruptions in prenatal care. One outreach worker related the following experience of one of her patients who needed prenatal care:

She was five months pregnant, had a stack of [medical] bills, and the employer refused to sign the [form] because he did not want to be in trouble for hiring somebody knowing that they have a fake social security number. He did not want anything to come back to him. So, that is why I called the social worker and I just gave her the situation. I said, "What can she do, her employer doesn't want to sign this form. They have already closed her case, her Medi-Cal case."

In the meantime, this outreach worker ensured temporary access to prenatal care through presumptive eligibility so that her patient could have at least another sixty days to disentangle her enrollment problems. The outreach worker also made some phone calls and found that there was a supplemental form she could use to explain her employment situation. The eligibility worker did not inform the patient that this supplemental form could replace the original income eligibility requirement.

Immigrants working in the agricultural industry also find themselves in difficult situations as their employment is not year-round but seasonal. They follow the agricultural cycle and work nine months out of the year. While most immigrant agricultural workers' gross annual incomes fall well below the federal poverty guidelines, health care providers in these areas find that during the peak harvest season—when all the household members are working overtime—families make more than the designated income eligibility level (at or below 200 percent of the federal poverty level) for Medi-Cal. Some also earn more than the limit imposed by alternative payment programs that were established by individual safety net providers for immigrants unwilling to apply for Medi-Cal. A community clinic outreach worker explained:

We offer a sliding fee scale—but sometimes they don't qualify because they were at that peak season where they made a lot of money, you know, overtime hours with her husband and herself, then it would be too high for them to pay on a cash basis. Sometimes they'll hold off and not apply until the season's over.

Medi-Cal policies do not allow for the unique difficulties that seasonal workers face. This is one of many hurdles some immigrants confront when trying to access basic care for which they are eligible.

Residency Requirements

Residency requirements can also prove to be an obstacle for some immigrants. A director of women's services at a safety net hospital said that her immigrant patients experienced difficulties in providing a seemingly simple requirement, namely, proof of residency. This is particularly so for those who work in the informal agricultural sector. The director said:

With Medi-Cal you have to have an address, you have to previously live here. We have a lot of migrant farm workers up here that work in the fields. They have no way of proving, of giving an address. So they are unable to sign up for Medi-Cal for that reason.

Residency requirements may be difficult to fulfill for low-income immigrants living in metropolitan areas as well. A coordinator of a home-visiting program for high-risk infants born to immigrant mothers explained that many of the families with whom she worked lived in small one-bedroom apartments with several other families. The high cost of living,
particularly for rent, had forced many low-income immigrant families to share the cost of housing. However, this has led to problems in establishing who legally resides in a particular household. Not all occupants are listed in the lease or on an electricity bill, making the proof of residency requirement difficult to fulfill.

An immigrant advocate and social worker in the Bay Area discussed the recent barriers constructed for the undocumented to establish their residency as follows:

They ask them for a utility bill in their name. And before, they could bring the brother or sister-in-law’s utility bill with a letter from the person saying she lives here. But now they can’t do that. There has to be something with their name. So, they go back and forth, back and forth, and they have this form from the state saying specific items that they need for them to bring to apply for Medi-Cal. And one is a California ID. And they cannot get California ID because in order for them to get California ID, they need to get a social security number, and they are undocumented so they cannot get social security. So there is no way around. And so they go and get fraudulent papers; and then they get caught. It is really difficult. A lot of women go through pregnancy with no Medi-Cal, and after the baby is born, then they try to figure out how they are going to pay, or Medi-Cal will send them papers to come and apply, but it is a hassle to just go back and forth, back and forth, to try to get the papers that they require for Medi-Cal to get prenatal care.

To make matters worse, in San Diego, an invasive investigation is conducted for those whose Medi-Cal applications are in “pending” status. In that county, if there are questions regarding an applicant’s residency requirement, an investigation is launched wherein DHS peace officers, armed with guns and badges, appear at the applicant’s door. In these circumstances, people have no option but to let the officers in and give them permission to search their home. A local community clinic coordinator explained that, if immigrants did not let the DHS officers into their house: “Then [DHS] will say there is not enough information and they will reject [the application]. So, it is very, very intimidating.”

Another clinic outreach worker in San Diego reported:

Many times, if there is a question about someone’s eligibility, an investigator is sent to their home to check to see if they really live there. They show up in uniform and armed with a gun. It’s really intimidating. They go inside and look through everything, including their underwear drawers to see if they actually live there. They count the underwear. Lots of times, they’ll go during the workday when no one’s home. If no one answers the door, then, they’re denied Medi-Cal. It’s invasive and you feel like a criminal.

The Medi-Cal Eligibility Worker

Stricter income and residency requirements, combined with intimidating eligibility investigators, have created greater barriers to care. One of the most common complaints expressed during my research team’s interviews concerned the disrespectful treatment of immigrant Medi-Cal applicants by eligibility workers. The problem arises from the fact that there is little or no trust between the applicant and the local Department of Social Services (DSS), whose job it is to determine their eligibility for Medi-Cal benefits. While trust is imperative in alleviating fear among low-income immigrant communities, it is difficult to achieve in an environment where there is high turnover and burnout rate among DSS workers.

Many outreach and social workers who work with low-income pregnant immigrant women described a hostile environment at the eligibility office, where there is no sense of comfort or safety. However, there are some women who enjoy a good relationship with their eligibility officer, and have developed a level of trust where the social worker and/or the immigrant applicant feels free to ask questions regarding eligibility requirements and, more importantly, is confident about the reliability of the response. Having DSS workers “outstationed” at the clinic site has helped to regenerate some trust. A clinic coordinator in San Diego said:

One thing we do is, we have DSS workers who come on site and do the eligibility determinations right here. So people can avoid going to the DSS offices entirely. And that is a benefit for our patients, because they are very intimidated by the DSS offices.
As one outreach worker in Santa Clara County told us, “They [immigrant women] just want to be treated like human beings.” Respondents described many DSS investigators as frustrated, disrespectful, and poorly trained. According to outreach workers we interviewed, the job turnover rate is so great among Medi-Cal eligibility workers that there is very little consistency and the workers themselves are ill-informed about policy changes. Participants discussed how a single uninformed eligibility worker could damage trust in the system and prevent many immigrants from accessing the services they need and are entitled to. “Many are scared off,” stated one administrator at a Fresno health clinic. “There are negative connotations, but also large [amounts of] paperwork and dealing with incidents with eligibility workers being rude or insensitive that turns them off from applying.”

A health educator in Fresno described some of her interactions with Medi-Cal eligibility workers as follows:

Sometimes [immigrant patients] are treated with very little respect… [Eligibility workers] are overworked and you call the Department of Human Resources and you leave 20 messages and you won’t ever get a response. So it’s hard. I’ve tried to call myself from the office and leave messages, talk to supervisors and you usually come to a wall. You’re banging yourself against this wall.

A Medi-Cal eligibility worker’s lack of sensitivity or knowledge can seriously affect an immigrant’s trust and heighten the fear of government programs. One statewide advocate said:

Medi-Cal is a great program… Unfortunately, it doesn’t take many eligibility workers to wreck it for everybody. If you don’t have the advocacy component to get in there and fix those problems, you don’t get the trust back.

In San Diego, focus group participants repeatedly stated that the health care eligibility workers consistently and purposely tried to prevent immigrants from obtaining Medi-Cal. Medi-Cal fraud is an important focus in San Diego County due to a powerful conservative constituency (similar to that of many border towns) and media attention surrounding a relatively small number of immigrants who inappropriately obtained Medi-Cal and health services. As a result, eligibility workers have focused their efforts on detecting fraud at the expense of authorizing needed health care services. In other words, the job becomes one of fraud detection rather than public service provision. A program manager from San Diego stated:

[It’s fraud prevention that they are more concerned about…] [I]n this county, we don’t have a county hospital, we don’t have anyplace for these poor people to go except for the community clinics and other kinds of places along that line. … In a sense, they are saying that unless you are a citizen, you don’t deserve it. And it’s a subtlety; they won’t say it to your face, but that’s really what they mean.

Moreover, there is an attitude that permeates the work of eligibility workers. One San Diego health care provider said:

[As] long as the attitude at the top is that, “we don’t want to increase our case load, we really aren’t interested in helping these people, they really ought to go home,” and all of those other kinds of things, the attitudes of the workers are not going to change and even when you get a bright, fresh, new employee that comes in and starts working and really wants to help, after a few years of being beaten down, you give up or you leave.

The Medi-Cal Eligibility Office

The sharing of DHS information between local health and human service departments and the INS is also evident in DSS offices in San Diego where women go to apply for Medi-Cal eligibility. The San Diego County Board of Supervisors directed its County Health Department staff to provide INS information regarding documentation status for any immigrants applying for TANF, Food Stamps, or General Relief. The county went so far as to place signs in the local social service offices where individuals apply for Medi-Cal. A San Diego legal advocate described the signs:
It said, "Please be aware that we can send any information you give us to INS" and went on to state that they may send information to the INS if you are applying for Cal Works or Food Stamps. Finally, the last paragraph stated: "We will not send information from people who are applying for Medi-Cal only."

The advocate noted that many people did not read past the intimidating introductory sentence down to the last paragraph that exempted Medi-Cal only applicants. These signs have had a reverberating impact in San Diego's immigrant community. A health care provider explained:

There was a lot of concern about the public charge issue and particularly in San Diego County, which is a very conservative county in which the board of supervisors interjected its policies . . . with the Department of Social Services. So, what we were seeing was that people were very much aware that information was being shared between the DSS and the INS. There were posters for a period of time in the Department of Social Services offices saying information will be shared with the INS and that just made people crazy. We had about 70 percent of our patients who were interviewed by the eligibility technician going on pending status. They would be investigated and many of them received visits by peace officers who—carrying weapons—would actually go into their homes and look at their underwear, look at their letters, look at their wallet, and use that to determine whether they were eligible. It was extremely, extremely intimidating for people.

A midwife at a safety net clinic in San Diego spoke about her patients' reactions to the signs:

[W]hat the women told me is that they feel threatened when they go in and they say that whatever you say here can be reported to immigration [INS] or something, so a lot of them, even if I tell them that they all have the right to go and apply because the law still provides for them to have Medi-Cal, they feel threatened. They say, no I don't think so. They say, they've heard stories that somebody got deported or something. And unfortunately, even though we gave out a pamphlet that says you have the right, even if you don't have papers, to apply for Medi-Cal, a lot of them when they go to the office and when they see that poster they turn around and they don't do it.

The perinatal manager of this clinic, which relies on Medi-Cal patients, reported a dramatic decline in the number of pregnant immigrant Latinas coming into their clinic. She has had to lay off one of her two providers and views the hostile Medi-Cal eligibility process as the culprit.

Intergovernmental Collaboration: Sharing of Personal Information

Before 1996, state government agencies did not formally share information with the federal Immigration and Naturalization Service (INS) about individuals' immigration status or use of public benefits. Provisions of the Social Security Act expressly prohibit the sharing of information in regard to individuals' receipt of public benefits with other government agencies. However, both the 1996 welfare and immigration reforms included new provisions that allow for the sharing of information between the state Department of Health Services (DHS), which is responsible for the state Medi-Cal program, and the federal INS (now called Immigration and Customs Enforcement or ICE, housed within the Department of Homeland Security).

Under the welfare reform legislation, states are now required to verify the immigration status of a foreign-born Medicaid applicant with ICE if the person applies for a Medicaid benefit that includes financial participation by the federal government. In the past, a social security card or birth certificate was sufficient to establish legal immigration status. Moreover, state and local governments are prohibited from restricting communication between state and local agencies and the Department of Homeland Security regarding the immigration status of benefits applicants. This information link between Homeland Security and DHS can occur through local county Medi-Cal eligibility offices. When immigrants apply for Medi-Cal, the information they provide about their income and assets, as well as the information in documents they used to establish their California residency, now can be turned over legally to the federal immigration authority.

In addition, public hospitals seeking federal reimbursement for emergency services provided to certain noncitizens designated "nonqualified" are now required to follow federal procedures regarding verification of immigration status. Public hospitals are now forced to verify their patients'
immigration status in order to be compensated for their care and verification of immigration status is now central to federal Medicaid eligibility requirements. This institutionalized sharing of information across state and federal government agencies created an unnerving precedent for many ethnic minorities regardless of their legal citizenship status. State surveillance powers increased dramatically with these new policies and many immigrants expressed fear in accessing even those social and health services for which they were eligible. The governmental interconnection institutionalized through these new policies delivered a blow to the hard-earned trust gained by community advocates who had successfully promoted preventive health care, such as prenatal care, in immigrant communities throughout California.

Unfortunately, these hostile welfare and immigration policies make health care access an excruciating choice for those with limited financial resources and legal protections. A Bay Area community clinic director described an incident involving a low-income mother of two young children, a three-year-old girl and a three-month-old baby, respectively. A month earlier, the older sibling had developed an alarming fever. The mother took her child to the emergency room and incurred a hospital bill in excess of $1,000. The clinic director continued:

So, the bill was sitting on the kitchen table and then the three-month-old baby starts choking. The mother is holding the baby and the mother is thinking, “OK, what do I do?” She is looking at this $1,000 bill and thinking, maybe I panicked that time; maybe I didn’t need to take her to the ER. So she is second-guessing herself, and ends up calling five different relatives and friends. On the 6th call, she calls the clinic, and the doctor goes, “What?! She’s choking? Get off the phone right now and call 911.” And she did but the baby died. The irony was the baby was three months old so technically was still covered under Medicaid for another three months after delivery.

For many immigrants, health insurance continues to be a luxury and even the prospect of utilizing emergency health care is a difficult decision that requires careful balancing of costs and benefits. Even in such life-or-death situations (or perhaps particularly in these situations), the decision to go to a hospital is not a simple one. The confusing and frequently humiliating health insurance eligibility process, hostile health care workers, possible negative ramifications for the individual and his or her family’s immigration status, in addition to the costs of the care are just some of the barriers that contribute to a situation in which health care is frequently out of reach. The confusion and hostility is, at times, so great that community rumors of prison time for not paying back Medi-Cal benefits are received as truth. Health care providers conclude that many immigrants simply do not get care until it is too late.

The Specter of Bad Mothers

Since overtly racist rationales for exclusion might be accompanied by the discomforting specter of eugenics, ideologically charged labels of “good” and “bad” mothers become a convenient cover for media and policy discourses on immigrant access to health care. As a legacy from the Victorian ideal of motherhood, the “good” mother is self-sacrificing, domestic, and instinctively attuned to her children’s needs, while the “bad” mother is deemed to fail on one or more of these measures. As part of this legacy, women’s place in the new nation was explicitly tied to “good” mothering. A self-sacrificing mother was the ideal citizen. Ladd-Taylor and Umansky write, “Women were formally excluded from most rights of citizens (such as voting), but they were assigned informal responsibility for the moral education of their citizen-sons.” This education was considered the foundation of a successful American democracy. Ladd-Taylor and Umansky note that in practice, the label of “bad” mother has fallen upon three general categories of people: “those who do not live in a ‘traditional’ nuclear family; those who would not or could not protect their children from harm; and those whose children went wrong.” Consequently, “bad” mothering does not actually denote particular practices, but rather implicates entire categories of people. During the late nineteenth century, the idea of a “scientific motherhood” provided a modernist twist for creating a hierarchy of “good” mothers. Proponents argued that evolutionary theory deemed Anglo-Saxon or northern European women as the true “good” mothers. Women of other races further down the evolutionary ladder inevitably produced inferior offspring.
In addition to the persistence of race in discussions of immigration and the use of motherhood as a strategic state ideology, a third characteristic is common in these eugenic arguments: the link between motherhood and childhood. On this last point, sociologist Evelyn Nakano Glenn points out that new notions of motherhood arose as industrialization propelled a new understanding of childhood as priceless. She writes, "Childhood came to be seen as a special and valued period of life, and children were depicted as innocent beings in need of prolonged protection and care." This new conception of childhood required a complementary conception of motherhood as a serious responsibility, one that required total and exclusive devotion. Here, we see the beginnings of the extraordinary mother as normative social convention. This new concept of childhood and accompanying motherhood placed many working-class immigrant women and women of color in a difficult position. The new "science" of eugenics defined them as bad mothers on the basis of their "inferior" racial stock, but at the same time the demand for their labor in the domestic sphere—as nannies and housekeepers—increased sharply.

Ladd-Taylor and Umansky note, "Although proslavery ideologues declared black women to be lacking in maternal feelings for their own children, they sentimentalized the mammy, always there to protect and care for her young white charges." Working-class immigrant women today find themselves in a similar dilemma. Glenn argues that these women are not expected or allowed to be "good" mothers. She states, "Because [women of color] were incorporated into the United States largely to take advantage of their labor, there was little interest in preserving family life or encouraging the cultural and economic development of people of color." Anti-immigrant policies that restrict access to prenatal care services construct low-income immigrants as social burdens and an uncontrollable internal threat to the nation's economic, cultural, and political stability.

As a social institution, motherhood is so taken-for-granted and pervasive in its idealized form that real women with children negotiating everyday life with its endless details are viewed as bizarre—so much so that extraordinary mothers are now the social norm. The cultural romanticization of motherhood has shifted the definition of a "good" mother to that of an extraordinary one. An extraordinary mother, then, is a miraculous woman who can provide for her family—emotionally and materially—beyond the resources available to her. As Ladd-Taylor and Umansky write, "To most Americans, 'bad' mothering is like obscenity: you know it when you see it." In practical terms, extraordinary mothers are those who can achieve particular outcomes without adequate resources to do so. This includes women who work outside the home who can accomplish as a parent what she would have accomplished had she stayed at home full-time. Consequently, the normative good mother is now an extraordinary one who can make the impossible happen, and at great cost to herself. In fact, it is this impossibility that makes motherhood "sacred." In her discussion of the cultural contradictions of motherhood, Sharon Hays writes, "Giving of oneself and one's resources freely is the appropriate code of maternal behavior, and any concern for maximizing personal profit is condemned." The sacred nature of mothering is the diametrical opposite of a rationalized market economy that encourages personal profit. A good mother must somehow participate in a capitalist system as a consumer and, for most women in the United States, as a worker, but she must eschew any personal benefit that may result from the system while at the same time meeting the many needs of her growing children. A bad mother, on the other hand, is one who cannot extract sufficient capital from the market economy and must depend, at least in part, upon public benefits to care for her family. Extracting the necessary services or cash assistance from the state to care for one's family is viewed with severe disdain and understood as a sign of selfishness.

Clearly, this idealized notion of motherhood has a class and racial bias. A good mother must exhibit adequate self-sacrifice and forgo personal profit but at the same time provide a comfortable, stable, and safe home for her children. This ideal is far more difficult to achieve for women with limited financial and social means than it is for middle- and upper-class women. Self-sacrifice entails an entirely different regimen for families whose basic needs are met and taken for granted. On the other hand, low-income immigrant women of color experience an essentially impossible proposition. They must provide all the trappings of a middle-class childhood for their children, but with far fewer resources and greater barriers to success. Access to basic, preventive health care is a prime example of this impossible situation. A basic level of healthfulness is essential, given that a sick child is symbolic of "bad" mothering. However, preventive prenatal care for immigrant women is a constant target for elimination.
among those in favor of anti-immigrant legislation, not to mention social conservatives pushing for traditional family values. Consequently, immigrant mothers are blamed for any negative health outcomes of their children while at the same time being restricted from accessing services that can prevent or minimize potential health problems.

Legal theorist Dorothy Roberts points out that mothers are primarily responsible for childrearing but many poor women of color are denied the compensation, power, and support they deserve and require to achieve that goal. Roberts contends that this scenario conveniently absolves the state of liability. She writes, "It pretends that poor minority children's deprivation is caused by maternal negligence and not by joblessness, deplorable housing, inadequate health care, and dilapidated schools." Evidently, it is far easier and politically more salient to police the behavior of low-income mothers than it is to address such complex structural inequalities as health care access.

The Good Mother versus the Good Immigrant

If motherhood, as a historical and social construct, is the link between the family and the nation, what then of immigrant mothers? Certainly within nativist narratives, low-income immigrant mothers of color are a threat to a "healthy," unified national identity. Beyond this eugenic notion of nation building, low-income immigrant mothers pose further ideological difficulties in upholding the nation as a family. This difficulty in inclusion stems from the fact that immigrant mothers are expected to silently exist outside the national family but at the same time uphold the ahistorical and fictive national narrative of "the American Family." This is evident in the construction of the ideology of the "good immigrant,"44 which functions in contrast to the "good mother." A good immigrant is one who provides particular kinds of necessary but generally denigrated labor at below market value and does not expect the same access, protections, or privileges as a full national member. Therefore, a good immigrant cannot be a mother—good or otherwise. Within this system, the children of today's largely Asian and Latin American immigrants are viewed as costs, given their contentious position within the national family. Studies of the second generation portray an ambiguous scenario in which their inclusion or adaptation as full citizens is far from certain. Even those misinterpreted as "model minorities" feel compelled to refute the persistent assumption of their "foreigner" status.45

And yet, the demand for immigrant women's labor remains unfettered. In defining a new "commodity frontier," Arlie Russell Hochschild writes that public and private resources for intimate or domestic care are declining at the same time that demands for longer work hours are increasing.46 In response, immigrant labor becomes an increasingly necessary component in meeting the average family's daily expectations. Immigrants are essential to ensuring that their employers adhere to the national ideology of family and in particular, that the "mother" be a good one. Immigrant women's labor as domestic and service workers becomes increasingly necessary for many families in the current 24/7 global economy. In fact, their labor is evidence that meeting the impossible goal of being a "good" mother in today's economy actually requires a second, silent mother. However, this silence is disturbed when immigrant women have their own children. It is discomfiting, to say the least, to know that one family is maintained at the expense of another. On the surface, transnational mothers who leave behind their own children and thereby externalize the cost of reproduction appear to embody a tidy solution. But even here, there are difficulties. In their study of Latina transnational motherhood, Hondagneu-Sotelo and Avila found that raising other people's children and taking care of other people's homes is a "radical break with deeply gendered spatial and temporal boundaries of family and work."47 These transnational mothers from Mexico and Central America redefine the good mother in ways that are at odds with the U.S. national narrative. They write,

The daily indignities of paid domestic work—low pay, subtle humiliations, not enough food to eat, invisibility—means that transnational mothers are not only stretching their U.S.-earned dollars further by sending the money back home but also, by leaving the children behind, they are providing special protection from the discrimination the children might receive in the United States.48

Counter to nativist assumptions of the "American Dream," these immigrant women feel the need to protect their children from the United States in an effort to be good mothers. In addition, long-term separations for employment are understood to be a part of being a good mother. These
definitions fall outside the established narrative of motherhood that acts as a normalizing tool to link familial hierarchies to national inequalities. At their core, strong and independent immigrant mothers are a problematic necessity in upholding the ideal American family.

While the rhetoric of public charge positions poor immigrant women as problematic on account of their "dependency" on the state, it seems that independent poor immigrant women pose an even greater problem. As the nation becomes increasingly dependent upon immigrant women, independent immigrant women who define their identity as mothers apart from the U.S. national ideology are viewed as a growing threat. Consequently, such women are forced to be dependent on the state. This is evident in the technology of the state bureaucracy, which actually enforces dependency among low-income immigrants as a mechanism for detecting and limiting their movement within the United States. This enforced dependency also reinforces the "natural" national narrative wherein women are appropriately dependent upon the (male) head of state, mirroring their rightful subordination to the male head of the family. This paradox is evident in prenatal care policy and rhetoric. The growing restrictions on access to prenatal care for which immigrant women are eligible come largely in the form of greater bureaucratic hurdles that allow increased state surveillance, despite the state's repeated emphasis on "individual responsibility."

Historically, the national anxiety regarding the number of immigrants and their economic and social influence has reached hysterical proportions every few decades. Common within these anxious moments are arguments regarding one's "deservingness" to not only participate in social programs open to the "public" but also their "deservingness" to labor in the United States. The nativist core of these arguments views immigrants from global South countries—especially women with limited financial means—first and foremost as public burdens, regardless of any economic and social contributions they may make. The fact that low-income immigrant women may give birth to racial minorities with rights of legal citizenship threatens the nation's sense of control of our national identity.47

A good immigrant is an invisible laborer who upholds the fictive imagery of the American family and gladly accepts his or her exclusion from that unit. A good mother, on the other hand, is an extraordinary, self-sacrificing woman who magically provides for the well-being of her children without adequate resources to do so. It appears that a good immigrant cannot be a good mother—since having children, particularly citizen children, interrupts her invisibility as a worker. Immigrant mothers are, by definition, a public burden, and are consequently bad mothers. Like the Eugenists of the late nineteenth century, this construction of the immigrant mother as threatening and burdensome solidifies her secondary citizenship status. Roberts writes, "One of the tests of privileges of inclusion in a community is the ability to contribute one's children to the next generation of citizens."48 Immigrant mothers find themselves in difficult circumstances in which they are necessarily included as laborers but are excluded from the most basic privilege of community membership—the right to have children.
CHAPTER 3

The Politics of Public Charge

The Department of Health Services (department) inadequately planned its port of entry fraud detection programs—Port of Entry Detection (PED) and California Airport Residency Review (CARR)—before launching them. It did not fully research essential legal aspects of the programs before it adopted guidelines and protocols. As a result, the department opened itself up to lawsuits charging that the department’s operation of the port of entry programs led to abuses.

—California State Auditor

The Eugenic Beginnings of Public Charge

It is no coincidence that the notion of a “public charge” was formalized during the height of mass migration and the subsequent popularity of eugenics in the early twentieth century. The prominence of the American eugenics movement occurred in part as a response to social anxieties about immigrant female sexuality and reproduction. In his seminal text, Backdoor to Eugenics, Troy Duster notes the importance of immigration to the development of scientific racism in the United States. During the early 1900s, the mass migration of poor European immigrants put into motion a number of efforts to distinguish this group as different and inferior to those Europeans who had immigrated earlier. Duster writes that scientific racism via eugenics was a central element in making this differentiation: “[T]he growth of a body of research showing that genetic disorders were distributed differently through different racial and ethnic groups [provided] empirical evidence that one group was more likely to have genetic disorders than another.” The fact that these genetic differences were produced socially through enforced patterns of mating did little to diminish the far-reaching usefulness of eugenics as a palatable (i.e., “scientific”) evidence of racial superiority and inferiority. The popularity of eugenics reached both sides of the political spectrum, including social radical Margaret Sanger and staunch conservative Madison Grant.

Sanger and other Progressive Era reformers embraced eugenics as a civilizing force that would further increase women’s rights. She and her contemporaries viewed eugenics as the advancement of an “objective” scientific tool to control reproduction rather than the moral rationale employed in the nineteenth century. On the other hand, Madison Grant, author of the bestseller The Passing of the Great Race, embraced eugenics as a way to limit immigrant rights by deterring births by immigrant women deemed sexually promiscuous. Historian Wendy Kline writes,

White middle-class authority and middle-class manhood both were in jeopardy because of social and economic changes that undermined established race and gender hierarchies. By regulating the sexuality of working-class and immigrant women, eugenics would reform the sexual behavior of “women adrift” and limit the procreation of the “less civilized”—that is, nonwhite and working-class—races. And by encouraging middle-class white women to return to full-time motherhood, eugenics would both prevent the new woman from succeeding in her “vain attempts to fill men’s places” and ensure that the white race once again would be healthy and prolific.

During this historical period, Kline argues that a nationalistic goal of “building a better race” brought strange bedfellows together to focus on immigrant reproductive decisions. The logic of eugenic ideology assumed that restricting the reproduction of “feebleminded” mothers would eliminate feeblemindedness in future generations. This logic solidified the notion of feeblemindedness or being a “moron” as the result of illicit sexual behavior by women. Across the political spectrum there was broad agreement that immigrant women and their innate propensity for reproduction posed a significant social problem.

Almost a century later, immigrant women’s reproduction remains central to national anxieties over race and class. However, this time the majority of immigrants are from Asia and Latin America. And while eugenics has fallen out of favor as the explicit operating logic governing immigration or reproductive policies, “it remains just beneath the surface.” Duster
outlines the general ebb and flow of this racist logic in U.S. history, citing 1900 to 1935 as the height of its popularity, followed by an abrupt disenchantment from 1940 to 1965, and a gradual resurgence beginning in 1970 and continuing into the 1990s.8 Not surprisingly, this latest resurgence coincided with the newest wave of mass migration.

However, the use of the term eugenics was considered socially distasteful. Instead, other forms of discourse were used, with differing levels of success. In the late 1960s and early 1970s, the rhetoric of overpopulation and welfare dependency gained greater currency in discussions of “the immigrant problem.” This was evident in the massive sterilization campaigns directed at poor women of color during that time. In her study of coerced sterilization in Los Angeles County, Elena Gutiérrez argues that the rhetoric of overpopulation, rising welfare rolls, increasing Mexican immigration, and the perception that the costs of delivering immigrant children were excessive made Mexican immigrant women a prime target for forced sterilization in the 1960s and 1970s.9 Here again, there was collaboration across the political spectrum. This time, environmentalists (generally understood as politically left-leaning) encouraged sterilization as a way to reduce the ecological strain of population growth on the earth’s resources.10 And conservative nativists remained consistent in their belief that childbearing was part of a plot to recolonize the United States.11 These concerns by both the political left and right converged to define low-income immigrant women’s reproduction as a significant public threat.

The constant surveillance of immigrant mothers, whether from below or above the surface, is a result of their delicate position in the broader Western idea of the nation as “family.” Anne McClintock argues that since the mid-nineteenth century the trope of family has functioned as the organizing rationale for the social hierarchies within Western nations. She writes, “Because the subordination of woman to man and child to adult was deemed a natural fact, hierarchies within the nation could be depicted in familial terms to guarantee social difference as a category of nature.”12 She goes on to note the fallacy of this rationale, in that the family—a metaphor for a unified national narrative—is actually an institution devoid of history and excluded from national power.13 In other words, notions of the family, as an ahistorical and largely politically powerless entity, strictly limit the role of women. The mother, then, functions as a central metaphorical figure in national narratives as a “naturally” dependent and subordinate member.

While all wage-earning mothers have the potential to disrupt this national narrative of dependence, low-income immigrant women, like most working-class racial/ethnic minorities, are not “protected” or bound by traditional notions of the family. Rather, many of these women were employed as maids and nannies to uphold the ideal family for white, middle- and upper-class women.14 This is not to say that the national trope of the family did not affect these immigrant and working-class women. Rather, the powerful ideology of the family functioned to enforce dependency in order to control their movements without even the possibility of subordinate membership of the national family. The family trope facilitated the “disappearance” of their necessary roles in maintaining the larger social hierarchy. Their continued invisibility is perpetuated through intense governmental surveillance and negative public scrutiny of their illegitimate (i.e., “illegal”) presence, which enforces their silence. At the same time, they must endure the controlling, disciplinary tactics of the state. In the end, low-income immigrant women are forced into a dependent relationship with the state, largely for the benefit of the state, and are simultaneously punished for this dependency.

Public Charge, 1990s

Legal policy scholar Kitty Calavita convincingly argues that public charge provisions are one of the most important ways in which the United States tries to resolve the contradiction whereby immigrants are desirable as a source of cheap labor for the growth of capitalist markets while being disavowed as public burdens for allegedly causing overall wages to stagnate and incurring high social welfare costs.15 While I would agree that these provisions are important venues to interrogate the oppositional positioning of immigrants, I would add that rather than resolving this contradiction, public charge provisions actually maintain it by preserving a counterbalance between the two approaches. Public charge provisions function
to heighten the supposed social costs of immigrants to offset their labor benefit/value. In reality, the desirability and disavowal of immigrants are two sides of the same coin. What makes immigrant labor desirable is their cut-rate wages, which follow from their disparaged social position as a noncitizen racial minority. Both approaches work together to reinforce capital growth through racial subordination.

Public charge—in policy and sentiment—has existed just beneath the surface of U.S. immigration policy since its inception in the late 1800s, and has reared its head at key historical moments. Apparently, moments of high demand for immigrant labor allow for public charge determinations to become a feasible, formal state response. Public charge tempers the desirability of immigrant labor by clearly positioning immigrants as dependent and undeserving/irresponsible burdens upon citizens and the state. In this way, “desirability” can be more broadly construed to include an increasing sense that their presence is “normal,” which consequently leads them to have a greater potential for political influence. The mid-1990s, which saw the passage of major welfare, immigration, and health legislative reforms at the state and federal level, were one of these “corrective” moments in which the labor and political desirability of immigrants was counterbalanced by heightened public policy disavowal.

In California, the formal return of the immigrant as public charge is evidenced through the state’s Port of Entry Fraud Detection (PED) programs. In this chapter, I discuss in greater detail the process and significance of this health care fraud program, run by the California Department of Health Services at transnational border sites. I then highlight the intricate strategies of state-level immigrant health policy advocates, each of whom was identified as instrumental in responding to the resurfacing of public charge policy, and analyze their generally pragmatic assessments of their own efforts. The advocates’ experiences provide a parallel narrative alongside the state’s documents in articulating not only the purpose of these particular health care access programs but also the (ir)responsibility and (il)legality of the state in their relationship with immigrants. These data support my argument that immigration policies produce a double reinforcement of the desire for cheap immigrant labor and the social subordination of these populations in that the PED is an instrument that serves to mark immigrants as populations in need of surveillance and control.

**Port of Entry Detection Programs**

The Port of Entry Detection (PED) programs were part of the effort by the California Department of Health Services (DHS) to discourage the fraudulent use of health care. The first Port of Entry Detection program officially began in 1994, in the midst of and strategically under the radar of the intense battle over Proposition 187. The pilot PED program in 1994 combined two specific tactics to root out Medicaid fraud: first, prevent fraud before it happens, and second, target documented immigrants/noncitizens trying to return to the United States through ports of entry. The PED programs were part of a larger state effort to cut Medicaid costs by targeting individual access to health care. By increasing the number of investigations of people suspected of inaccurate or fraudulent reporting of income, property, residence, or household composition, DHS was able to proudly tout a 55 percent denial rate on applications for public health insurance for low-income, disabled, and elderly residents, resulting in “substantial cost savings.” The program’s success was particularly noted in San Diego County. In addition, these suspicions were given top priority from the DHS Investigations Branch and processed within seven days, and the findings were reported back within ten days of receipt of the referral—a significant feat of lightening speed relative to most state bureaucratic procedures.

The PED programs assumed that immigrant health care use was suspicious from the start and required the greatest level of surveillance to prove otherwise. In effect, this program institutionalized greater restrictions on health care access for immigrants, without initiating the far more cumbersome (and democratic) process of legislative reform. In addition, the state specifically targeted immigrant women’s use of prenatal care. With the strong support of then Governor Pete Wilson and the tidal wave of anti-immigrant sentiment that passed the landmark state Proposition 187, DHS and INS viewed the PED program as an exciting collaborative effort that would lead to greater sharing of information across government agencies. Watched with growing interest by neighboring states, PED increasingly pushed the boundaries of immigrant rights, health care access, and constitutional due process.

There were two PED programs. The first was located at the three U.S./Mexico ports of entry: San Ysidro, Tecate, and Calexico. As these three
sites brought in more and more revenue, the program quickly expanded to include the Los Angeles International Airport a few months later, and then the San Francisco International Airport in 1996. The later program located at the Los Angeles and San Francisco airports was called the California Airport Residency Review (CARR). In these programs, immigrants and noncitizens returning to the United States through these border checkpoints were asked about their use of Medi-Cal.9 Women who had legally received health insurance coverage for prenatal care and delivery in the past five years were told to repay the benefits before reentering the country. This was the dilemma that Sophia Chen confronted upon her return to the United States from a family visit to China (see chapter 1). The assumption was that immigrants without permanent residency status (i.e., green cards) are nonresidents and therefore do not meet state residency eligibility requirements for Medi-Cal.24 However, it is also the case that nonimmigrant and qualified aliens are indeed eligible for state-only funded Medi-Cal emergency and nonemergency pregnancy-related services.25 This logistical conundrum led to disparate accounts about the mission and administration of these programs. The different narratives illustrate differing understandings of the states' responsibility to immigrants, and vice versa.

For instance, according to an official of the DHS office of Audits and Investigations I interviewed, the mission of these programs is to stop the illegal use of health care. The administration of this goal was reportedly fairly straightforward.26 The DHS official explained that INS officials first identified potential fraudulent beneficiaries and referred them to DHS for further investigation. The referral decision was reportedly made solely by the Immigration and/or Customs official and was separate from DHS's jurisdiction. In a separate office, DHS officials asked for proof of California residency and determined if the individuals had or were receiving AFDC (Aid to Families with Dependent Children) or Medi-Cal, using the Medi-Cal Eligibility Data System (MEDS). This was estimated to take twenty to thirty minutes. If they suspected residency fraud, DHS then referred them back to the INS, with information about the results of their initial review, and wrote a “notice of action” to the DHS field office to determine residency status and money owed for medical care or AFDC.27 The DHS official I interviewed stated that while they received many referrals from the INS, they only followed up and collected money on a few cases. He noted that this procedure was relatively new—they used to determine fraud at the initial meeting at the airport or port of entry rather than refer the case to field offices (e.g., county welfare offices) for an independent review. A process for appeal and a hotline to report inappropriate treatment during the investigation were also new features of the program.28

One of our respondents, a Bay Area community health clinic director, had an opportunity to visit the California Airport Residency Review (CARR) site in San Francisco in November 1997. During an interview, she provided a detailed account of the program's administration. She became concerned about the program after half a dozen of her clients, who were documented immigrants, reported having problems trying to reenter the country. The health clinic director was able to set up a meeting with DHS and INS officials to find out how the program operated.29 One of her first questions was how they chose particular people to interview. She learned that flights from Asia and Latin America, principally Mexico, and women of childbearing age were targeted. She described the extra screening conducted near the customs checkpoint in this way:

They are looking at women of Asian and Latino origin. [particularly] if they had little children with them or they were somewhere between the ages of 20 and 45. Then, [they were] asked a series of light interview questions. And in those light interview questions, [if] either determined that they had children within a certain period, then they would ask, who paid for it? What kind of insurance did you have? Who was your health care provider? ... [A]nd if someone ended up showing their Medi-Cal card, then they were totally in the next realm of interview.

Interviewees were then sent to a second level of screening. The director went on to explain:

There were three levels of interview, and if you got to the third level, you were basically brought into a small cubicle, way inside, and at this point you have been detained several hours. And then, by the end of that, they had determined that you ... were either a potential public charge or that you should not have gotten services. It was purely arbitrary as far as we could see.
Here, she describes a complex administrative process where an individual is physically moved from one space to another, deeper into a bureaucratic maze, and is made to wait for hours as a judgment is passed as to whether she will be able to leave the airport and join her family. From the clinic director’s point of view, these judgments appeared to be made randomly, given that the women in question had received their medical care legally. She described the process further:

[T]hey are basically convincing you that you should consider paying back the money that Medicaid had paid for your health services. They would have someone from DHS stationed there with a computer. . . . And they say, “Well, when it got down to it, you could have been eligible under DHS criteria, but the INS could be taking a different interpretation. . . . of public charge.”

The clinic director portrays a complicated interplay between the federal INS official and the state DHS representative. Rather than a clear determination of Medi-Cal fraud, the state health care representative used innuendos of public charge to persuade the individual to “voluntarily” repay the state for health services delivered. The exchange played on the fear clearly associated with public charge. The clinic director explained that the DHS and INS officials coordinated a “good cop/bad cop” script. While the INS agent questioned the woman, the DHS official sat quietly, letting the INS play “bad cop.” The INS agent would raise questions as to whether she was truly eligible for Medi-Cal and advise her to consider paying back the benefits to avoid being sent to court for an eligibility determination, or the more severe penalty of possible deportation and permanent denial of future entry. After creating these doubts and fears, the woman was advised of the costs of the services she had received and “provided the opportunity” to repay DHS. The clinic director said:

[T]he DHS person knows that it is against the law for them to demand money back, repayment of services that under their guidelines the person was eligible for. So they will sit there and say, sign this letter that you are voluntarily asking how much it cost. And if they sign the letter, it supposedly cleared DHS [of] any culpability of going out of their bounds. They look up in the computer, and go, it was $4,000, you had a cesarean section. . . . And this was by admission of the DHS and INS people: that they were so grateful to be able to have the opportunity to pay this thing back rather than face the potential jeopardy of going to a court and then being deported and permanently banned from ever coming back into the United States.

At a certain point, they were doing this so much that there were lines, sort of like going to your check cashing, there were lines at the airport of people who were making payments for services that they had gotten under Medicaid.

Contrary to the account from the DHS official from the Office of Audits and Investigations, the clinic director’s narrative had little to do with actual health care or Medi-Cal fraud. Instead, the state officials functioned illegally in demanding repayment of legally utilized health care services. And the PED programs racially profiled and gender profiled specific immigrants of color from Latin America and Asia. While the DHS account emphasized a clear separation of the state Department of Health Services from the federal Immigration and Nationalization Service, the clinic director witnessed a far closer interaction between the two government entities. In fact, the state and federal agencies strategically preyed upon the dual vulnerabilities of health care access and immigration status experienced by low-income immigrants who want to ensure a healthy baby as well as permanent residency. Public charge appears to be the crux of the interaction between these two powerful government agencies. INS needs DHS and vice versa to make real the fear of consequences from a public charge determination.

Unfortunately for the DHS and INS, their actions in operating the PED programs were found to be outside the bounds of legality. A lawsuit and an audit led to this conclusion, which precipitated the program’s demise.

Rocio versus Belshe: Linking Health Care and Migration

Rocio v. Belshe was a pivotal lawsuit that fundamentally altered the administration of the PED program and forced the DHS to deal directly with public charge, which it had been avoiding by claiming that this was strictly within the purview of the INS. The DHS had feigned innocence regarding the INS’s use of health care information to make public charge
determinations. At the same time, the INS distanced itself from any culpability by defining the program as solely a DHS venture in which it was only peripherally involved because the programs happened to be located at the ports of entry.

The lawsuit, which was filed in March 1997 with the U.S. District Court of Southern California, serves as an informative case study of how public charge links together health care and immigration concerns. This class action suit alleged that the DHS went beyond its legal mandate and "routinely, knowingly, and deliberately" collected benefits lawfully paid to immigrants. The lawsuit went on to state,

This practice violates federal statutory and constitutional protections, including Federal Medicaid law which provides that states may not recover Medicaid benefits which are correctly paid, and regulatory, statutory, and constitutional due process provisions governing the procedure for collecting Medi-Cal overpayment.26

The central plaintiff of this lawsuit was Rocio R. She and her husband were documented residents living in San Diego County with their citizen children. Mrs. R had legally received Medi-Cal benefits for the births of her children and completed all the appropriate DHS paperwork. The family’s troubles began when Mrs. R applied to the INS to change her temporary immigration status to legal permanent resident (i.e., a green card holder). In response to her application, INS asked her to obtain a letter from Medi-Cal disclosing any debt owed by her to Medi-Cal. When she did this, Mrs. R received a letter from the DHS stating that she owed a debt of over $6,000 for "illegal receipt of Medi-Cal benefits." This was the first time she had ever heard from the DHS that she owed any money or that she was ineligible for the health care that she received. When she contacted the DHS’s Audits and Investigations office for an explanation, she was told that she "had to pay all of the money 'owed' or Mrs. R would not receive her legal permanent resident status from the INS."27 Given that Mrs. R was approved for the health care benefits by the same state government agency that later deemed it an "illegal" "debt," the question arises as to how and when the benefit became "illegal." It seems that legal access and use of health care can become illegal when they coincide with another request upon

the state—in this case, legal permanent residence. Here, a clear connection is made between the use of health care and one’s ability to become a permanent resident of the United States. For low-income immigrants, health care of any kind—legal or otherwise—is punishable as irresponsible and burdensome.

When Mrs. and Mr. R received the DHS letter, they contacted Sofia Immigration Services,28 a nonprofit immigrant advocacy organization, for legal representation. Sofia then contacted Mrs. R's Medi-Cal eligibility worker at the County Department of Social Services and the department worker confirmed that Medi-Cal benefits were appropriately accessed and the costs were correctly reimbursed to the clinic that cared for Mrs. R. However, the DHS continued to refuse to provide a letter clearing Mrs. R of any debt. This stalemate not only delayed Mrs. R's application for change in immigration status, but also led to Mrs. and Mr. R's decision to withdraw their citizen children's Medi-Cal benefits, for which they were eligible, for fear that their use would further hinder Mrs. R's immigration status and potentially lead to her deportation and the rest of the family's as well. These fears were not unreasonable or illogical, given Mrs. R's extra-legal treatment. Mrs. R was not afforded the legal protections guaranteed to others by the state. What basis did she have to expect that the state would act within the boundaries of its own rules and regulations?

This uncertainty is institutionalized in the vagueness of policy and the secrecy with which the policy is administered. Rocio R's predicament was part of the DHS's larger "Border Project" (which includes the PED program) and the lawsuit points to the lack of information about DHS health care fraud detection initiatives: "Most of the rules governing the procedures are secret, are not made available to Medi-Cal recipients or the public, have not been published for notice and comment as required by the State Administrative Procedure Act."29 This, coupled with the overall vagueness of the definition of public charge (e.g., "immigrants who have or will become dependent on public benefits"),30 have allowed for wide variations in its interpretation of fraudulent behavior, health care access, and public burden. The fact that the DHS issued form letters notifying Medi-Cal recipients that they owed a debt to the state for benefits received without any determination as to whether or not the benefits were correctly paid assumes that all use of health care is fraudulent for immigrants. And this initiative
clearly targeted low-income immigrants by tying a "release" letter from the DHS as a condition of having their immigration application approved by the INS.

The *Rocio v. Belshe* lawsuit based its complaint on four main statutory infringements: first, restricting access to state Medicaid programs; second, lack of protection of personal information, including health and immigration status; third, recovery of medical costs correctly paid to beneficiaries; and fourth, absence of due process. On May 4, 1998, a settlement was reached between the plaintiffs and Kimberly Belshe, Director of the California Department of Health Services, and the DHS. And while the final settlement agreement was sealed, the subsequent actions by the DHS in response to this lawsuit make clear that the plaintiffs "won" the argument. An All County Welfare Directors Letter dated March 14, 2000 directly addressed the settlement and advised all DHS county workers to:

1. Stop seeking repayment of Medi-Cal benefits that were legitimately received;
2. Stop advising Medi-Cal applicants or beneficiaries on the interpretation or application of immigration and Naturalization Service (INS) rules or regulations, or the effect that receipt of Medi-Cal may have on a person's immigration status;
3. Review new clarification of public charge determination rules;
4. Send notification to all affected that DHS had incorrectly acted in claiming Medi-Cal benefits as a debt that required repayment; and
5. Refund any money paid to DHS since March 19, 1996.

In fact, these five directives met almost all the demands of the lawsuit. The class action had insisted that DHS stop:

1. Collecting Medi-Cal benefits correctly paid;
2. Issuing overpayment notices which do not advise recipients of due process and statutory rights to a fair hearing;
3. Coercing Medi-Cal recipients into cancelling or repaying their Medi-Cal benefits, by reporting or threatening to report them to the INS;
4. The "Border Project" unless and until procedures are formally adopted as regulations and made available to the public; and
5. Providing Medi-Cal recipients and applicants with incorrect or misleading information regarding the effect of Medi-Cal receipt on their immigration status.

As part of the settlement, it seems defendants were asked to not only notify all class members of the DHS's wrongdoing but also to refund the amount paid. In accordance with this demand, the DHS issued a refund notice with instructions, a two-page flyer from INS on the most recent clarification of public charge policy, and a claim form on two separate occasions. The second notice was part of a modified settlement agreement made in light of the fact that the first notice was written only in English and so few had filed a claim requesting a refund. This second notice also included a Spanish, Vietnamese, Cantonese, Tagalog, Korean, Hmong, and Cambodian translation. Class members were given until March 15, 2003 to postmark their claim form.

In both notices, all questions by potential claimants were directed to the plaintiff's counsel. In these "All County" letters, welfare offices were strictly forbidden from assisting anyone with questions regarding the refund or broader public charge questions. Claimants were instead directed to the counsel and/or they were simply told to read the two-page INS Fact Sheet on public charge (written only in English and Spanish) that was enclosed with the refund notice. While the official number of refund requests is unclear, health care advocates I interviewed reported that the numbers were low on account of the continued lack of trust of government agencies and the clear directive made to welfare offices to not discuss public charge issues with their clients, which limited efforts to disseminate the significant public policy changes in health care access for immigrants. The burden of notifying immigrants regarding the public charge clarifications that arose due to this lawsuit and the PED programs was entirely privatized to individual hospitals, clinics, and nonprofit organizations that clearly lacked the resources to do so.

This lawsuit greatly affected the administration of PED programs and was a crucial factor in dismantling the programs. *Rocio v. Belshe* altered the repayment collection procedure by forcing the DHS to actually take into consideration whether the health care was legitimately received through Medi-Cal, and if it was, to stop "asking" the Medi-Cal recipients to repay these benefits. These administrative changes resulted in most of the
cases being referred back to the INS with the understanding that no fraud was suspected. Ultimately, the cost of running these programs became greater than the recovery of funds.

**PED Audit: "Unjustified," "Poorly Administered," and "Abusive"**

In April 1999, the DHS terminated all the Port of Entry Fraud Detection programs. A few days later, both the state assembly and senate budget subcommittees formally defunded the programs. These actions followed a particularly negative review of the programs by the Bureau of State Audits, declaring both Port of Entry Medi-Cal Fraud Detection programs "unjustified." The audit cited operational and administrative deficiencies and found that the department was no longer recovering sufficient fraudulent Medi-Cal payments to justify its investment in these programs. The settlement required the state DHS to return at least $3 million to immigrants who were "improperly ordered to return Medi-Cal benefits" to the PED programs. State auditors documented intimidation by way of threatened imprisonment or reduced chances for citizenship, and demands for repayments higher than the actual cost of the Medi-Cal benefits received. Approximately fifteen hundred families were eligible for refunds under this settlement. As of April 1999, only one-third of these families had filed for a refund.

In their assessment, the auditors reviewed DHS policies regarding the two fraud detection programs, written communications between the state DHS, federal Department of Health and Human Services, and the federal Health Care Financing Administration, as well as a memoranda of agreement between the DHS and INS and another MOA between the DHS and San Diego and Imperial counties. They also researched state laws that governed Medi-Cal, and federal laws that governed the relevant immigration issues. They also reviewed lawsuits filed against the PED programs and interviewed opponents of the programs. This was in addition to reviewing 440 case files of individuals investigated by the programs. Their conclusions overwhelmingly supported the administrative process described by the community health clinic director and other immigrant health advocates I interviewed.

According to the auditor's report, using Medi-Cal was especially onerous for women. Of the 440 case files, the audit team found that 97 percent of all the individuals investigated by the Port of Entry programs were women and the type of health care coverage most frequently identified was pregnancy-related. This was despite the fact that women accounted for only 50 percent of people eligible for Medi-Cal benefits.

The profiles of people investigated by the PED and CARR programs contrasted sharply with the general profile of people eligible for Medi-Cal benefits. For example, just under 20 percent of people eligible for Medi-Cal in July 1998 were between the ages of 21 and 40, yet this age group represented over 80 percent of the individuals investigated by both programs. And in 1997, nonimmigrants and undocumented aliens living in California represented just 7 percent of the eligible Medi-Cal population. However, they accounted for at least 80 percent of the investigations for the programs. These individuals were not "illegal" immigrants; they held some form of documentation—including a temporary border pass, U.S. tourist visa, student visa, or a temporary visa. And as noted in my earlier interview with the community health clinic director, there appears to be a targeting of particular nationalities at specific ports of entry. Most of the people detained at the U.S./Mexico border were Latinas and more than half of those detained in San Francisco were Asian.

### Table 3.1

<table>
<thead>
<tr>
<th>Profile of Individuals Investigated at PED and CARR (N = 440 case files)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: 97% Women (430 cases)</td>
<td></td>
</tr>
<tr>
<td>Age*: 86% 21–60 years old</td>
<td></td>
</tr>
<tr>
<td>Documentation status: 80% nonimmigrant aliens living in CA and eligible only for pregnancy and emergency services</td>
<td></td>
</tr>
<tr>
<td>Families with children: 89%</td>
<td></td>
</tr>
<tr>
<td>Nationalities/PED: 98% Mexico</td>
<td></td>
</tr>
<tr>
<td>Nationalities/CARR@LAX: 40% Mexico, El Salvador, Guatemala, Honduras</td>
<td></td>
</tr>
<tr>
<td>Nationalities/CARR@PED: 19% Mexico</td>
<td></td>
</tr>
<tr>
<td>Nationalities/PED: 51% Philippines, Korea, China</td>
<td></td>
</tr>
<tr>
<td>Nationalities/PED: 30% unknown</td>
<td></td>
</tr>
</tbody>
</table>

*Average age range was from 29 to 35 yrs old.

Source: California State Auditor 1999.
The audit's central criticism was that there was poor planning, which led to poor administration and, consequently, to lawsuits against the abuses. The report describes a rush by the DHS to discontinue or deny Medi-Cal benefits by changing eligibility procedures without requesting appropriate changes in state regulations. And, as the Rocio lawsuit contended, the auditor found that the DHS routinely demanded repayment of Medi-Cal benefits without actually determining whether recipients were indeed ineligible. Also, the report documented evidence that the DHS went "beyond the scope of their employment by trying to influence the federal Immigration and Naturalization Service's (INS) decisions on whether to admit immigrants and visitors at ports of entry." Here, the fear of public charge—an administrative law within the purview of INS—was used by DHS for its own purposes. The report states, "Upon reviewing the minutes of 1996 meetings of the PED program, we found repeated discussion of the link between repayment and improvement in immigration status." They found similar problems at the international airport sites (CARR):

According to a discussion we had with a CARR program investigator, investigators sometimes led subjects to believe that repayment, or an expressed willingness to repay, might improve their chances of admission to the United States. In addition, according to the minutes of meetings and correspondence we reviewed, investigators solicited repayment of Medi-Cal benefits in exchange for the release of passports INS held. Nevertheless, the department characterized repayments made under these circumstances as voluntary.

This mischaracterization of repayments as "voluntary" was used as cover for the state to circumvent legal protections including due process: "[T]he department believed that the subjects voluntarily repaid benefits; therefore, it was not necessary to notify them of their rights to a hearing." The audit's report took pains to explicitly lay out the laws and legal procedures that pertained to these programs. The administrators appeared to have strayed so far from legal bounds that a reminder was necessary. For instance, the report clarifies what the DHS already knew but had conveniently overlooked:

The department was aware prior to 1997 that individuals may possess nonimmigrant documentation and still be eligible for public assistance, if sufficient additional evidence indicated they were also residents of California. Federal statutes in 1986 extended Medicaid benefits for emergency medical assistance, including labor and delivery, to undocumented and nonimmigrant alien residents. These individuals often possess nonimmigrant documentation but reside in California. Thus, the department's change in the eligibility regulations made such individuals automatically ineligible for Medi-Cal benefits in California, in spite of federal law.

By automatically denying eligibility for emergency health care to nonimmigrants, the DHS had essentially instituted a new policy without complying with state requirements to do so. To properly adopt a new regulation, government agencies were required to seek public comment and forward the proposed regulation to the State's Office of Administrative Law for review. The report makes clear that the contention that repayment was the low-income immigrants' "choice" and technically not required did not absolve the DHS of responsibility for its actions.

In addition, the auditor documented an increasing level of harassment and threats in the letters suggesting "voluntary" repayment. By the time the last port of entry site—CARR at San Francisco International Airport—was established in November 1998, DHS investigators were sending letters making unsubstantiated accusations of criminal violation and threatening imprisonment. The report takes particular issue with a letter that inaccurately stated that the person's use of health care through Medi-Cal constituted three felonies and that a conviction would lead to state prison. This letter was sent prior to the department's investigation of whether the person was actually ineligible. There were also numerous accounts of CARR investigators making demands for random amounts of funds. The auditor wrote:

We reviewed one such letter, which demanded a repayment of over $33,000 even though actual Medi-Cal payments totaled just $3,200. Another letter requested a $12,000 repayment for Medi-Cal services. It was followed two days later by a second letter requesting repayment of $8,700 for the same services.

These letters indicate an increasing level of desperation on the DHS's part. By the end of 1998, the return on the state's investment in these programs
began to truly plummet, especially at the airports. Table 3.2 shows a significant drop in return from $8.06 to $0.44 for every $1 in cost, in just one year at the CARR sites.

The effect of modifying the operations of these programs in 1998, as a result of lawsuits and concerns from the federal Health Care Financing Administration (HCFA), was dramatic. When they no longer demanded repayment from detained Medi-Cal beneficiaries until a thorough investigation was completed, their return on their investment was significantly lower than before. In fact, after these modifications, the programs were no longer financially viable. In other words, the only reason these fraud programs were "successful" was due to illegal procedures that exploited low-income immigrant women with children.

In the end, the audit highlighted three major conclusions: first, due to significant operational and administrative deficiencies, continuation of the programs was no longer justified; second, the cost-effectiveness of the programs diminished after the department modified its operational procedures; and third, the state and the Medi-Cal program would be better served if the department redirected its funds to other fraud detection programs.

The report also added that despite the improvements to the PED and CARR operations since the lawsuits, the programs continued to share confidential information about beneficiaries of Medi-Cal and other public assistance programs with the INS even though the DHS has not met the legal requirements allowing this. The PED investigators provided three kinds of information: first, recipients’ names, birth dates, social security numbers, and addresses; second, names and birth dates of family members receiving benefits on the same case; and third, the type of benefits received. This was done with the understanding that the INS would, in turn, supply the DHS with useful information about the person’s residency, income, work history, and immigration status to help in the investigation. According to the auditor’s report, the INS had never reciprocated and the DHS had never followed up and asked why. The auditor concluded: "[I]t does not appear that the department’s disclosure of confidential information has contributed to its investigation of Medi-Cal fraud." However, the DHS continued to contend that these PED programs were a separate issue from public charge since they were primarily concerned with benefit fraud and not whether an immigrant was or would become dependent on public benefits. But, in reality, it appears that public charge was a concern for the INS and when the DHS collaborated with the INS, immigrants were screened for both benefit fraud and public charge within a single program. For most immigrants, the differences between the two were academic, if not insignificant. For them, the message was clear: using Medi-Cal can be detrimental to your immigration status.

Overall, the PED Programs have had a profound effect on immigrants throughout the state of California. The fact that documented immigrants who legitimately used health services could be asked to repay their Medicaid expenses, be denied reentry, or even be deported by an arbitrary process of public charge determinations is a frightening proposition for all immigrants. One health care provider I interviewed in San Francisco put it this way: "People don’t trust the government. They will see what the government gives them and wonder what the government will take away from them. They will always have that fear." The women and children (many of whom were citizens) were forced through an invasive and humiliating system that reinforced their perception that they were unwanted and that the U.S. government was a hostile authority.

Clarifying Policy: Key Role of Policy Advocates

In the midst of all this policy confusion on the part not only of Medi-Cal recipients but also those administering state programs, there are important
policy advocates who monitor the slippery slope of policy enforcement to ensure at least minimal health care access for immigrants. The following section analyzes the role of five key players, who work in nonprofit organizations on behalf of low-income immigrants in California. These advocates, whom I interviewed on multiple occasions, were women who functioned as mediators between the state and the on-the-ground legal practitioners and health care providers who cared for immigrant communities. As the California State Auditor's report illustrates, convenient interpretations or misreadings of legal provisions, particularly in times of significant policy change, can lead to questionable practices that have serious ramifications for vulnerable populations. These interviews with state-level policy advocates provided another level of understanding of how intricate the policies governing immigration and welfare are and how this intersection impacts access to health care for low-income immigrants. The advocates' intense behind-the-scenes efforts to combat the formal reintroduction of public charge determinations outline these intersections and their implications.

Calling the Port of Entry Fraud Detection program a "witch hunt" that was a "scandalous misuse of state power," a strong network of key immigration advocates successfully worked to undermine the PED programs. They approached these programs as a "very challenging, high-stakes issue" because they understood that the underlying concerns of public charge and its implications within PED went far beyond the specific programs at hand. The detrimental effects of a wide-reaching public charge policy could have grave consequences for not only low-income immigrants but for the general constitutional protections of due process and equal rights for all U.S. residents.

As the confusion regarding public charge reached their doorstep, California state-level legal advocates worked with agencies and advocates at the federal level to clarify the legal boundaries of public charge determinations. They were able to convince the Department of Justice and the INS to issue new field guidance regarding the regulation of public charge in response to the growing confusion surrounding its definition and the standards by which this measure was applied. In May 1999, it was clarified that noncash benefits, such as Medicaid, and special-purpose benefits that were not intended for income maintenance were not subject to public charge consideration.38 In other words, the use of Medi-Cal or other health services alone would not affect immigration status unless these and other
government funds were used to pay for long-term care (i.e., nursing home or other institutionalized care). In addition, the use of food stamps, WIC, public housing, or other noncash programs was protected from public charge consideration. However, receipt of cash welfare, including SSI, TANF, or general assistance could affect one's immigration status.

An advocate described their efforts to clarify public charge as "a classic textbook example of policy change." A grassroots mobilization of policy makers, a media campaign, and the assistance of strategic community (i.e., minority) members in positions of power within the federal government pushed the INS to more clearly define public charge and the ways in which state agencies could apply this rule. This effort was initiated as reports about the PED program spread to immigrant communities, their health care providers, and to legal advocates for immigrants. A staff attorney at an immigrant advocacy center who worked closely with federal officials to develop the clarification of public charge applications said, "People across the country were reporting to us about the abuses, in particular in the health care arena and in California, where people were inappropriately being asked to repay benefits as a condition [for] coming back to the country." She described the effort in this way:

We helped, along with many, many other organizations, to document the abuses. When it got to a critical point and health care providers were saying that this was just making it impossible for them to deliver health care to their communities, our D.C. office compiled the stories and submitted them to federal agencies. At the same time, county and state officials who noticed the impact of the public charge simultaneously wrote to public officials asking for clarification. At some point the federal agencies got together and decided to do it.

According to this attorney, the severe misapplication of this law occurred with the passage of welfare reform in 1996. She explained: "The main thing that happened was that across the country there were a lot of abuses of existing law. The clarification was merely a clarification of existing law. But after the welfare law passed there was a lot of misinformation about whether the law had changed." Given the intense nativist sentiments in the 1990s that helped bring about Prop. 187 in California, and the federal welfare and immigration laws, the clarification—which stated that
Medi-Cal use alone could not be used to determine public charge—was viewed as a significant win.

Crucial to this win was a broad-based mobilization that convincingly appropriated a social justice frame. An advocate explained, “It was relentless, high quality, and well-informed.” She said,

The facts were well-documented. It got to the heart of health access and social justice. There were people unquestionably eligible for benefits who were playing by all the rules. It was just the INS and state Medicaid agencies and food stamp agencies that were misapplying the law, either due to confusion or ignorance or whatever. Clearly the communities were right on this. It was a powerful moment.

However, in assessing their overall efforts, the advocates were pragmatic about their short-term gains and more than a little ambivalent about the long-term impact. One advocate said, “I don’t think any of us wants to minimize the impact of that [clarification] victory, but at the same time the difficulty is, when we look at the 1996 welfare reform, the impact of the law was so devastating that I don’t think we’ll ever be able to get back to the point where we can finally say things are safe.”

In their successful challenge of public charge determinations, immigrant advocates effectively combined two crucial strategies. First, advocates at various levels worked to intervene and insert an alternative understanding of the effects of public charge applications and essentially flipped the standard script of the legislations’ intent. Second, it took a broad network of advocates—of various racial/ethnic backgrounds and citizenship status—to create a systemic approach to disseminate this alternative narrative.

**Flipping the Script**

The first strategy required that the issue be understood in broad-based terms to bring together the stakeholders or participants who were affected and that the response be specific. Advocates and community constituents developed a system of gathering solid, accurate information in response to state discourse, which was largely silent if not misleading on the issue of public charge. As one advocate explained, we have to figure out “what it takes to educate everyone in the system at the appropriate junctures.” An up-to-date networking structure was imperative in this systemic approach that linked together a wide spectrum of knowledge and could flow from one end to the other. The formal two-page clarification of public charge from the INS only came after years of concentrated pressure that was strategically organized by these advocates.

During this time, thousands of Californians were detained and threatened with severe immigration sanctions that would forever alter their family’s futures. And a far greater number of people altered their health and social services utilization as news spread through word-of-mouth—some of which was accurate and much of it not—that the Migra® had yet another plan to round up community members. The length of time it took to clarify confusing policies varied greatly but all the advocates agreed on the necessity to get and disseminate good, solid information as soon as possible.

By doing so, community health workers were able to document the effects of this misapplication by governmental agencies and “flip” the “personal responsibility” trope on its head and place the responsibility for clearing up the confusion on the state. The power of these stories, in addition to the shaky legal grounds on which this program stood, pushed the federal government to more clearly limit the reach of public charge.

The second strategy required the meticulous reading of policies (particularly when new laws were introduced) in order to ascertain the most effective way to insert the alternative narratives of policy impact. These personal stories relayed by community clinics and organizations were used as powerful correctives to government narratives. An advocate based in San Francisco explained, “[W]e always have to be monitoring and vigilant. Bureaucracies make mistakes, either unintentionally or willfully, so we have to pay attention…. Getting people networked and hooked up to the same kind of educational and information-sharing systems is a huge challenge.” It was a tedious but necessary foundation for their advocacy. These immigrant rights advocates were part of a loosely-structured coalition of nonprofit organizations, who, in effect, functioned as a regulatory body keeping government actions in check. Their jobs required that they know not only the language of the state and regulation but their intersection with other policies and how it was actually experienced by people.
Continuing Consequences of Public Charge

As important as clarification was from a policy standpoint, it did not resolve all public charge issues, nor did it increase immigrant families’ overall sense of freedom or security. One advocate recalled her disappointment from “[j]ust peeling off one layer of issues [to find] that there were other issues that remained.” Perhaps the biggest source of continued confusion for immigrant families was that public charge still existed, though in more prescribed terms. The advocate explained, “[T]he public charge test is still in operation, so somebody who is low-income who is sick, who is elderly, or who has other factors that make them likely to become a public charge will have to worry about public charge. We can’t guarantee the person they’re going to get their green card.” For example, the clarification did not quell concerns regarding sponsor liability. Sponsor liability became a new, pressing concern with the passage of welfare reform and immigration reform in 1996. A San Francisco-based advocate said,

The next day [after public charge clarification] we started getting tons of calls on sponsor liability. . . . We don’t know what to tell folks. You will find that a lot of folks who are on the new affidavits of support are eligible for Medi-Cal but not accessing it because they or their sponsors are worried that their sponsors are going to be sued to pay back those benefits. It’s a legitimate fear.

These new federal laws created a new requirement that all family-sponsored immigrants who applied for an immigrant visa or adjustment of status on or after December 19, 1997 must have an affidavit of support (INS Form 1-864) from a qualifying sponsor. Without this form, he or she would be found inadmissible as a public charge. The main statutory requirement to be a sponsor was an annual income of more than 125 percent of the federal poverty level. This affidavit of support was a legally binding promise that the sponsor would provide support and assistance to the immigrant if necessary. The sponsor also agreed to repay the government if the immigrant used certain benefits and the government requested repayment. The sponsor’s obligation under the legal affidavit lasted until the immigrant became naturalized, had logged in 40 fiscal quarters of work (this usually took ten consecutive years), left the United States permanently, or died.

Interestingly, if the sponsor died, the sponsor’s estate was still required to repay any obligations accrued before the sponsor’s death.

Pressing questions remained regarding what kinds of benefits sponsors were obligated to repay and what, if any, avenues of appeal or legal waivers were possible. There remained considerable opportunity for greater clarity on public charge determinations resulting from sponsor liability issues. However, a policy analyst cautioned against rushing into a situation that would make things worse for those for whom they are advocating. Peeling back all layers of a policy at once may not be the best strategy. The analyst explained, “[T]he policy that was passed in 1996 is so horrible that quite frankly we don’t know what a clarification would look like and whether or not the government would come out with something that again would scare people away from accessing things they’re entitled to.” The analyst’s caution demonstrated the fickle nature of policy making. This was also present in this person’s approach to the audit: “Quite frankly, until we all knew what the situation really was out there and what the state was doing and what the community’s involvement was, we weren’t sure we wanted an audit.” The audit was a final step in a two-year strategy that required a close study of immigrant rights and the public benefits for the community.

Interpretations of law are open to the influence of the larger social, political, and economic mores of that historical moment. Consequently, a systemic understanding of policy change and the constant vigilance of bureaucratic maneuverings sharpened the focus of policy advocates as they carefully peeled one layer of issues away to expose another. An interviewee put it this way:

Did we learn a lot? Yes . . . [but] it’s not like you can pull any of this stuff off the shelf. It’s important background, and it saves you a lot of time on some of the basics, but what government does is invent a new strategy. I may sound a little too cynical. I don’t mean to be a conspiracy theorist but how it plays out is that the next political spin on this will be some kind of variation on the theme. I can’t predict what that will be.

Perhaps one of the most profound lessons learned from this effort was how difficult it is to regain the trust of immigrant communities once it is broken. Many public health workers, community clinics, and safety net hospitals in California have worked diligently for years to ensure that they
achieve their mandate of serving the health care needs of their community. Given the high concentration of foreign-born populations in California, immigrants comprise a significant portion of potential constituents for many health care providers. In addition, many safety net health care providers depend upon Medi-Cal reimbursements from caring for low-income residents. This has meant that many health care facilities have worked very hard to reach out to these communities and develop bonds of trust. The public charge test deeply debilitated this trust between immigrants and their health care provider. Since immigrants were initially told that it was safe to use publicly funded health care, the public charge scare questioned the reliability of the doctor’s reassurance and raised the possibility that prenatal care was another “trap” for immigrants. One advocate said, “The main lesson is that once you destroy the community’s trust, people are not going to give it back to you easily. You have to work to get it back. You misinformed them in the past. People aren’t stupid.”

Trust is a hard-earned sentiment, given the level of reticence and the fear of accessing public benefits experienced by immigrants. Given the political climate of growing nativism, many immigrants reported enduring a sense of siege and preferring to avoid undue scrutiny. Those areas that reported a strong sense of trust despite these fears were ones where people felt the clinic staff had deep knowledge and expertise relating to their community. However, even these clinics found themselves in a very difficult situation trying to retain a meaningful level of trust with their immigrant patients following the 1996 welfare and immigration reforms. A policy analyst working with a strong immigrant collaborative on issues of welfare and health care noted the following reaction from immigrant communities they worked with:

As soon as we got the clarification, we were all very excited. We thought, “This is great. This will address a lot of the fear and confusion that’s been in our communities for very legitimate reasons.” We immediately started to do outreach, presentations, work with other providers. What we noticed was, when we would tell the providers or advocates or attorneys, they would think, “Oh, that’s great news.” But there was a total disconnect between folks who work with the community and with people who are directly affected.

This stark disconnect was perfectly illustrated at a community event to disseminate news regarding the clarification of public charge:

The day after the clarification, some of our L.A. partners pulled together a press conference to announce the public charge clarification as a way to get a word in the community that it’s no longer a problem. People should feel safe to access benefits. They invited a woman community member who herself had been in the position of not enrolling her kids or herself in any health care programs because she thought it would be an issue. They talked to her several times beforehand and invited her to speak. She was great. She really spoke to the impact the policy had had prior to the clarification. The funny thing is, afterwards, some of our folks said, “Thanks for speaking at the press conference. Are you going to enroll in health programs now?” She said, “No, no way.”

While the community member intellectually understood the importance of health insurance and encouraged others to access Medi-Cal, the fear of future punitive government action kept her away. Dissemination of public policy change in this political environment posed a formidable challenge. Compounding the problems posed by this challenge, Governor Gray Davis took office in January 1999 in the midst of the public charge clarification and the PED audit investigation, and took what advocates viewed as a very unfortunate reading of the government’s responsibility in clarifying public charge.

An advocate explained, “They’ve interpreted the settlement agreement in Rocio v. Belshe much more broadly than attorneys on the case interpret it, telling counties not to conduct public charge outreach unless they were specifically approved. They sent out INS letters that actually conflicted with some of the local entities’ work with counties.” This advocate saw the Davis Administration’s move as a passive-aggressive act against immigrants: “The Davis administration tried to prevent money [from being] allocated specifically to public charge outreach and in general has thwarted any efforts to do outreach on public charge.” Immigrant advocates interpreted the administration’s inaction as deliberately sitting on the political fence on immigration, which did not strengthen its political stature in their perspective.
A state-level advocate took particular care to separate the successful public charge policy change from any actions by Gray Davis: "In the technical analysis, at the end of the day, technically it was this governor who agreed to a budget agreement that defunded the Port of Entry. But really I think that was just technical and administrative." Advocates argued that the appropriate response should have been more forceful and proactive. He should have said, "This is abhorrent to me, I'm going to eliminate it from my budget," according to this advocate. Instead, "He let the process play itself out. He made some members of the legislature prove that it was not cost-effective to the state and the system had run really amok before he acted. And then he didn't even publicize his action. He hoped it would go unnoticed." Following this line of analysis, the governor not only played little to no role in the policy change, but made a difficult situation worse by sitting on his hands for personal political reasons. In the end, the advocates viewed Davis, a Democrat, as hostile to immigrants—a deep disappointment for those who had struggled against the vicious anti-immigrant policies of former Republican governor Pete Wilson. A federal-level immigrant rights advocate based in California provided one reason for their disappointment:

> When the audit came out the program was disbanded. A couple of weeks later, Governor Davis somehow put in another request for funding to do some kind of fraud detection, but we were able to clarify that the focus was to be on health care providers rather than beneficiaries. There was some kind of attempt to refund it, even after that audit.

This statement reinforces the second lesson learned from this effort to clarify public charge policy—the need for constant vigilance of state practices, particularly with respect to immigrant populations, regardless of which political party held state office. This statement also reminds us of the persistent nature of public charge, which remains just beneath the surface. As another advocate retorted, "I would never underestimate the potential for that kind of thing to happen again if the politicians think it's in their interests, for whatever reason."

### Table 3.3

<table>
<thead>
<tr>
<th>Period</th>
<th>Total</th>
<th>L.P.C.*</th>
<th>% of Total Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1892–1900</td>
<td>22,515</td>
<td>15,070</td>
<td>67</td>
</tr>
<tr>
<td>1901–1910</td>
<td>108,211</td>
<td>63,311</td>
<td>59</td>
</tr>
<tr>
<td>1911–1920</td>
<td>178,109</td>
<td>90,045</td>
<td>51</td>
</tr>
<tr>
<td>1921–1930</td>
<td>189,307</td>
<td>37,175</td>
<td>20</td>
</tr>
<tr>
<td>1931–1940</td>
<td>68,217</td>
<td>12,019</td>
<td>18</td>
</tr>
<tr>
<td>1941–1950</td>
<td>30,263</td>
<td>1,072</td>
<td>4</td>
</tr>
<tr>
<td>1951–1960</td>
<td>20,553</td>
<td>149</td>
<td>&lt;1</td>
</tr>
<tr>
<td>1961–1970</td>
<td>4,833</td>
<td>27</td>
<td>&lt;1</td>
</tr>
<tr>
<td>1971–1980</td>
<td>8,455</td>
<td>31</td>
<td>&lt;1</td>
</tr>
<tr>
<td>1981–1990**</td>
<td>19,759</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

* L.P.C.: "Likely to Become a Public Charge"
** The INS Statistical Yearbook discontinued listing the number of L.P.C. exclusions in the mid-1980s.

### Public Charge, Redux

This latest surfacing of public charge tests will likely not be the last. This legal provision is a powerful tool in its strategic ambiguity and quiet location on the outskirts of public notice. As an administrative law, public charge is a statutory provision under the jurisdiction of nonjudicial staff within government and not subject to oversight by legislatures or courts. Since its inception in the late 1880s, this administrative law has undergone very little change. In her careful study of public charge, Patricia Evans argues that while other administrative laws evolved during the twentieth century, public charge determinations reached a stage of "arrested development" as they moved out of public view, limited largely to the confines of American consulates abroad. Writing in 1987, Evans states that public charge reached its "zenith" with a presidential directive in the 1930s to exclude as many immigrants as possible from Depression-stricken America. INS records illustrate a steep drop in its use after the Depression.

However, the ability to exclude or deport on the basis of someone potentially becoming a public burden was established as a powerful tool for social engineering purposes. And despite its disreputable history as a frequently used mechanism within the eugenics movement, it continues to
exist. This is due in part because public charge provisions allow for the contradictory social location of low-income immigrants in order to preserve their political and economic vulnerability. This arbitrarily administered immigration law not only lies in wait just underneath the surface of public notice, to arise at the appropriate moment, but it also serves as a constant threat of deportation and a reminder to immigrants that they are allowed to live in the United States only for the purposes of laboring for capital growth.

Debates about immigrants as public burdens also confines our understanding of immigration to calculations of costs and benefits. Regardless of which side of the argument one falls on, immigration and immigrant labor are misunderstood as purely market-driven phenomena. While immigrant labor is fundamental to the U.S. and global market economy, immigration law is a product of broad social and political factors during a particular historical moment. While the tightening labor market of the Depression helped to explain the utilization of public charge determinations in the 1930s, the more recent turn of events is the culmination of an historic anti-immigrant political climate in combination with dramatically changing racial demographics and the ever increasing speed and reach of global capitalism. Demographically, California officially became a majority minority state in the 1990s. The “browning” of America is evident in the numbers provided by the U.S. Census Bureau. From July 1, 1990 to July 1, 1999, the nation's Asian and Pacific Islander population grew 43 percent, and the Latino (or Hispanic, as defined by the Census Bureau) population grew 38.8 percent. California had the greatest numeric increase in both racial/ethnic groups. At the same time, the white population declined from 179 million in 1990 to 165 million in 1999, bringing down the percentage of whites to 49.8 percent of the total state population.

And while the contemporary number of exclusions based on public charge may not rival that of the early twentieth century, it is still a pressing concern. For many immigrants, public charge is yet another avenue for expulsion. If public charge is unavailable as a tool for nativism, there are always other options. For example, Operation Gatekeeper, a federal “control through deterrence” program initiated in 1994 (the same year as the passage of Prop. 187) funded the construction of fences and militarization of the U.S.-Mexico border and set the stage for the Anti-Terrorism and Effective Death Penalty Act of 1996. However, as the policy advocates learned in their fight against public charge threats targeting immigrant women’s use of Medi-Cal, each method of expulsion requires constant, careful vigilance and monitoring. There needs to be a systemic analytical approach to these policies to understand the various layers and interconnections between one regulation and another; with the goal of devising an effective challenge that will bring together the appropriate people with the necessary information. This is essential if we are to repair the trust required to ensure health care access. And, in the midst of all the many methods of deportation, public charge remains, quietly waiting in the wings, with the potential to resurface in various incarnations—some more egregious than others.

However, across the variations on a nativist theme, there has been consistency in the particular scrutiny paid to women in public charge investigations. Their propensity for pregnancy placed them just below those with “loathsome and dangerous” contagious diseases in the hierarchy of excludable offenses. This was certainly evident in the profile of individuals targeted for Medi-Cal fraud investigations at the Port of Entry Detection program. The federal INS and state DHS agencies collaborated in targeting immigrant women with children in an attempt to interrupt both the flow of immigration and the likelihood of more childbirths by low-income immigrant women. According to INS records, “alien removals” of women steadily increased in the 1990s. “Removal” of an “alien” from the United States is considered appropriate “when the presence of that alien is deemed inconsistent with the public welfare.” The INS has several possible removal procedures, including deportation, voluntary departure, and exclusion; however, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) significantly changed these procedures. Deportation and exclusion proceedings were consolidated and relabeled “removal” proceedings (with voluntary departure continuing as an option at the government’s convenience). But perhaps the most significant change was the new authority for expedited removals, in which an arriving immigrant is judged to be inadmissible due to improper documentation, fraud, or misrepresentation, and is removed without any further hearing or review unless a plea is made for asylum. In addition, there are significant penalties associated with a formal removal that include not only the removal but possible fines, imprisonment for up to ten years, and a bar to future legal entry (the bar is permanent for aggravated felonies and up to twenty years for other immigrants).
Between 1992 and 1995, women comprised approximately 6 percent of "alien removals." The proportion of women in this category rose to 12 percent in 1996, 16 percent in 1997, and 21 percent in 1998. Much of this increase is attributable to women from Mexico who attempted to cross the ports of entry into San Diego and Imperial counties. By the end of the 1990s, women constituted 39 percent of all expedited removals—an increase attributable to the PED program and the passage of IRIRA.76

However, recent immigration numbers show that these policies, including the welfare and immigration reforms of 1996, have not worked entirely as intended.77 Sassen explains that these reforms and others that have increasingly militarized the U.S.-Mexico border have not only failed to slow migration but have also increased other social problems. She writes, "The combination of such sanctions and a regularization program that excludes a large number of undocumented workers will contribute to the formation of an immigrant underclass that is legally as well as economically disadvantaged."78

These barriers to health care access increase the reluctance of immigrant women to receive prenatal care that may prevent potentially costly future health problems. Low-income immigrant families' already tenuous financial situation becomes more stressed as they try to find other means to cover a public benefit for which they are eligible. The recent 1996 welfare reform measure sends a clear message against the use of public benefits in the United States. Those who argue for stricter immigration laws view the use of public benefits as an indication of declining "quality" of immigrants admitted.79 This notion reinforces the idea that use of public benefits implies dependence and that dependence is a sign of weakness or moral deficiency.80

Ironically, many immigrants share the general "American dream" in which one should "pull themselves up by their bootstraps." In addition to the structural barriers to accessing Medi-Cal, health care providers who work with immigrants report that many immigrants are reluctant to access public benefits in the first place. One advocate said:

Many of our immigrant women, because of their cultural values, would prefer not to be on public benefits because they feel that it is not a good thing to do. They feel they should be on their own, depend on themselves. So, sometimes we need to work with them more; need to work with them for a longer time to tell them that, "[L]ook, this is what you need to do because it is OK. If you work in the future you will be paying into the government, therefore you are not getting a free ride."

Health care providers and advocates find that they must persuade their patients and clients to access Medi-Cal not only by addressing their fears of public charge, but also by enhancing their sense of themselves as productive members of society. This is despite the fact that low-income immigrants remain substantially less likely to use welfare than working-age U.S.-born people who are poor.81 A state policy analyst highlighted the particular vulnerability of pregnancy:

The point at which parents are willing to risk their concerns over public benefits or just their general reluctance to take something from the government is the point at which their children are most at risk, and there isn't a more important time than pregnancy for that kind of balancing. The state data bears that out. Most immigrant Latino women use the Medi-Cal program for the pregnancy-related programs and services.

Here, the analyst explains that the state strategically focuses on prenatal care and delivery, knowing that these are the kinds of health care for which immigrant women would be most willing to risk governmental surveillance and discipline.

It is apparent that within the contemporary social welfare discourse, welfare dependence, not poverty or unemployment, is viewed as the social ill that the state should target for remedial action.82 The focus on welfare dependency erroneously simplifies the source of the problem as the individual rather than the structural, institutional mechanisms that constrain the individual.83 It is always easier to blame the victim than to clean up the problem. The threat of public charge, or the potential dependence on welfare benefits, has made it clear that immigrant women and their children are undeserving and unwanted.

The following chapter focuses in more detail on the work of safety net health care providers and community outreach workers as they try to build a relationship with their patients in the midst of a broken sense of trust.