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Lisa Sun-Hee Park

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PERPETUATION OF POVERTY THROUGH "PUBLIC CHARGE"

LISA SUN-HEE PARK

INTRODUCTION

A number of federal and state policies have had significant impacts on low-income, pregnant immigrant women living in California. This paper focuses on the issue of "Public Charge," in conjunction with the 1996 Welfare Reform[1] and the 1996 Immigration Act.[2] I argue that the social contexts that helped garner support for such anti-immigrant legislative measures created an environment that essentially criminalized motherhood for low-income immigrant women—whether they be undocumented or documented.

Public charge is a term used by the Immigration and Naturalization Service and the State Department to refer to immigrants who have or *will become* dependent on public benefits.[3] Interestingly, this term has been a part of U.S. immigration law for more than 100 years as grounds for inadmissibility and deportation.[4] However, it is with the passage of recent immigration and welfare reform laws that concerns regarding "public charge" have resurfaced. In particular, the vagueness of its definition and the standards with which this measure is applied generated considerable confusion regarding who is eligible for certain federal, state, or local public benefits and whether non-citizens may face adverse immigration consequences as a public charge for having received public benefits.

This concern prompted some non-citizens (including residents legally residing in the U.S.) and their families to avoid seeking public benefits for which they are eligible—including health care. Such is the case for many low-income, pregnant immigrant women seeking prenatal care. In April 1998, the National Health Law Program and the National Immigration Law Center found that "[t]hroughout the country, advocacy

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1. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, or PRWORA. Pub. L. No. 104-193, 110 Stat. 2105 (1997). Some call this the Personal Responsibility and Work Opportunity *Reform* Act of 1996. Yet, when I presented an earlier version of this paper, some scholars in attendance noted that the term, "Reform," is a misnomer. Rather, "Welfare Repeal" is more accurate in describing the policy changes.

2. The Illegal Immigration Reform and Immigration Responsibility Act of 1996, or IIRIRA, Pub. L. No. 104-208, 110 Stat. 3009-546 (1996).

3. *See generally* NATIONAL IMMIGRATION LAW CENTER, IMMIGRANTS AND PUBLIC CHARGE: RESOURCE BOOK 1998-99 (1998).

4. *See generally* U.S. Department of Justice, Immigration and Naturalization Service, *Fact Sheet: Public Charge 5/25/99, at* http://www.ins.usdoj.gov/graphics/publicaffairs/factsheet/publ_cfs.htm (last visited Feb. 23, 2001).

groups and healthcare providers are reporting that immigrants are medically 'on the run,' too afraid to obtain health care, even when they legally are entitled to it."[5]

As a result of this chilling effect, low-income, pregnant immigrant women in California are left with few options. On the whole, they either opt not to seek prenatal care, choose self-pay, or enroll in Medi-Cal[6] and take the risk of public charge.[7] Whichever option they choose, the threat of public charge sends a clear message: low-income immigrant women—documented and undocumented—are not welcome to use public benefits, including health care for which they are eligible. Immigrants, regardless of their documentation status, are not viewed as having the same rights and privileges as citizens. The recent passage of both the Welfare Reform Act and the Immigration Act of 1996, underscore the secondary status of immigrants and the popular assumption that they have a "natural" tendency for dependency.[8] In this way, public charge is used as a form of punishment and guarantee against further increases in the number of poor immigrants and their families.

This paper is part of a larger project investigating the impact of the welfare and immigration reforms on prenatal care providers and immigrant health advocates who serve low-income immigrant communities in California.[9] For this paper, I focus on low-income, pregnant immigrant Latinas' access to Medicaid. In the larger study, we interviewed ninety-nine key informants—government officials, safety-net prenatal care providers,[10] and immigrant advocates—who serve low-income, pregnant

5. Cynthia Schlosberg & Dinah Wiley, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care, at* http://www.healthlaw.org/pubs/19980522publiccharge.html (last visited Feb. 23, 2001). *See generally* Michael Fix & Jeffrey S. Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-1997, at* http://www.urban.org/immig/trends.html (last visited Feb. 10, 2001). They found that immigrants' use of benefits declined disproportionately after the 1996 Welfare Reform. *See generally* Wendy Zimmerman & Michael Fix, *Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County, at* http://www.urban.org/immig/lacounty.html (last visited Feb. 10, 2001).

6. Medi-Cal is California's Medicaid program.

7. As self-payers, women become more likely to "shop around" for cheaper care. Choosing the lowest price provider to reduce their out-of-pocket expenses generally leads to less comprehensive prenatal care packages, delays in the start of prenatal care and/or a decline in the continuity of care. *See generally* Lisa Sun-Hee Park et al., *Impact of Recent Welfare and Immigration Reforms on Use of Medicaid for Prenatal Care by Immigrants in California,* 2 J. IMMIGRANT HEALTH 16 (2000).

8. A number of scholars and activists have asserted that immigrants migrate for work rather than welfare. For instance, in their testimony before the House of Representatives Ways and Means Committee, Michael Fix, Jeffrey S. Passel, and Wendy Zimmerman stated that immigrants' overall use of welfare is roughly the same rate as natives. In regard to the dependency question, they stated that "most immigrants *are* self-sufficient: 94 percent of immigrants in the U.S. do not receive welfare benefits" (emphasis in original). *See generally* Fix & Passel, *supra* note 5.

9. *See generally* Park, *supra* note 7.

10. Safety-net providers are county and community hospitals and clinics.

Asian and Latina immigrants at the national, state, or local levels. We focused on four regions in California where seventy-seven percent of new immigrants are concentrated: Los Angeles, San Diego, San Francisco Bay Area, and Central Valley.[11] Safety-net health care providers and advocates who work with low-income immigrant Latinas repeatedly and consistently reported a "chilling" environment in which women are afraid to access Medicaid to cover their prenatal care. We found that three factors contributed to this "chilling" environment: (1) the sharing of information between the California Department of Health Services and the federal Immigration and Naturalization Service, (2) the slow and confusing implementation of the reforms, and (3) the intimidating Medicaid eligibility process.[12]

Drawing on data from this project, I discuss how these barriers to health care punish Latinas and their children. I argue that this punishment comes in the form of criminalizing the status of being low-income immigrant, Latina, and of childbearing age. This was evident in a number of Medicaid fraud detection programs established at the Mexico-U.S. border, and later at the Los Angeles and San Francisco International Airports. As Nancy Ehrenreich points out, women's reproduction and the meaning of motherhood are power struggles,[13] wherein the state (i.e., courts, or in this case, federal and state legislatures) determines those who are "good" or "deserving" mothers and those who are "bad" or "dependent" mothers. I also argue that the consequences of this criminalization are significant, in that low-income immigrant women are treated as deviants for giving birth to yet another unwanted "immigrant" and this in turn helps to maintain their subjugated status. In other words, rather than assistance towards upward mobility, recent retrenchments in welfare benefits and stringent immigration policies have helped to perpetuate the continued poverty of low-income immigrant women and their families.

Part I critiques the feminization of poverty model and discusses its limitations as an explanatory instrument for immigrant Latinas. Part II discusses how these legislative policies have worked to perpetuate the poverty among low-income immigrant communities in California. Part II.A briefly outlines particular provisions in the 1996 Welfare and Immigration policies that are relevant to immigrant women's health. Then, Part II.B and II.C present a case study of how public charge determinations (long dormant until these recent legislative reforms) and point of entry detection programs maintain the poverty of low-income Latina immigrants by criminalizing their motherhood. Finally, I conclude with a

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11. This is for the years 1990 to 1994. Source: National Immigration and Law Center; Los Angeles, CA.

12. For more detail, see Park, *supra* note 7.

13. *See generally* Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492 (1993).

discussion of the larger social context of anti-immigrant policies and their implications on women's poverty.

I. THE FEMINIZATION OF POVERTY MODEL: A CRITIQUE

The issue of public charge highlights a number of criticisms raised by Athena Mutua in response to the relevance of the feminization of poverty as a descriptive or analytic tool.[14] Its utility is certainly questionable in the case of low-income immigrant women. In line with earlier critiques, the feminization of poverty model does not adequately address the various conditions of poverty for immigrant families. This section will outline four specific assumptions that contradict the experiences of low-income immigrant women.

First, the model's assumption that women are "falling into" poverty is incorrect in this case.[15] Most of these women and their families in this public charge dilemma were already living below the poverty line and have been their entire lives. Instead of asking how they fell into a state of poverty, a more relevant question is: how is their poverty maintained and what are their everyday experiences and strategies in dealing with these barriers to mobility?

Second, the model minimizes the role of race as a cause of poverty among immigrants. The issue of race is prominent in understanding the experiences of immigrants, and as such, immigration policy is justly viewed through a "racial" lens. This is true historically and contemporarily. For instance, the Chinese Exclusion law of 1882 was a racist immigration policy directed towards Chinese immigrant workers who were viewed as immoral interlopers.[16] Today, Latinos comprise forty percent of the incoming immigrants and Asians comprise another forty percent.[17] This dramatic change in racial composition has stirred the emotions of nationalistic and ethnocentric political forces opposed on principle to a sizable foreign-born population.

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14. *See generally* Athena Mutua, *Why Retire the Feminization of Poverty Construct*, 78 DENV. U. L. REV. 1171 (2001).

15. SUSAN L. THOMAS, GENDER AND POVERTY 65 (1994).

16. *See generally* PAUL SIU, THE CHINESE LAUNDRYMAN (1987); Thomas Espenshade and Katherine Hempstead, *Contemporary American Attitudes Toward U.S. Immigration*, 30 INT'L MIGRATION REV. 535 (1996).

17. *See generally* B. Lindsay Lowell, *Immigrant Integration and Pending Legislation: Observations on Empirical Projections*, *in* IMMIGRATION AND THE FAMILY 271 (Alan Booth et al. eds., 1997). This is a profound change in the racial make-up of the immigration flow. It is noteworthy to point out that this was an unexpected result of the 1965 Immigration Act that eliminated what was viewed as a racist national quota for immigration.

These sentiments were solidified with the passage of California's Proposition 187.[18] Lynn H. Fujiwara writes:

> Proposition 187 reflected fears that undocumented immigrants were overutilizing 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 "nonAmericans" who allegedly received benefits from their tax dollars.[19]

Similar sentiments also apply to the 1996 Welfare and Immigration reforms. Anti-immigration proponents successfully linked immigrants with crime, welfare, and illegality. Fujiwara states, "The imagery that drove anti-Latino sentiments traded on stereotypes of Latina fertility. These sentiments gained momentum from claims that Latinos overuse public health services and education and take jobs from "American citizens."[20]

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18. Proposition 187 was a state initiative that barred undocumented immigrants from receiving public benefits including health care (except emergency medical care) and education. Passed in 1994, this initiative was a response to the surge in immigration to California during the 1980s and early 1990s. In a study of Latina immigrant women's perspectives on Prop. 187, researchers found that Latinas perceived Proposition 187 as discriminatory and directed primarily at Latinos. The study also found that Latina immigrant women were reluctant to seek medical care as a result of this initiative. *See generally* Nancy Moss et al., *Perspectives of Latina Immigrant Women on Proposition 187*, 51 J. AM. MED. WOMEN'S ASS'N, 161 (1996). This reluctance to seek health care occurred despite that fact that the law was never enacted. Immediately after its passage, legal advocates questioned its constitutionality in a number of lawsuits.

19. Lynn H. Fujiwara, *The Impact of Welfare Reform on Asian Immigrant Communities*, 25 SOC. JUST. 82 (1998).

20. Fujiwara, *supra* note 19. These anti-Latina images were apparent in various forms throughout California, but perhaps none so egregiously as in San Diego. For example, The San Diego Union-Tribune devoted significant resources in highlighting immigrants' use of health benefits. In 1993 (a year before the passage of Prop. 187), they ran a five-part series entitled, "Medi-Cal: The New Gold Rush" that 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." Rex Dalton, *Medi-Cal: The New Gold Rush*, SAN DIEGO UNION-TRIB., Apr. 11, 1993, at A1. The series helped to solidify many U.S. residents' misinformed notion that immigrants migrate for welfare/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 sojourners, as well as many other immigrants, is also noteworthy.

Also, a few months prior to this series, state Sen. 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." Jeffrey J. Rose, *Migrants A Burden to Local Budgets?*, SAN DIEGO UNION-TRIB., Feb. 6, 1993, at B1. 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 also ran an "exposé" entitled "Born in the USA" that targeted Latina immigrant's fertility using what is by now familiar anti-

In looking at the case of low-income immigrant Latinas, it is clear that their immigration status contributes to their race, gender, and class experience (and vice versa). To highlight simply their gendered status misinforms the context of their experiences.

Third, the feminization of poverty model is criticized for mistakenly treating all women as members of an oppressed group or class equally vulnerable to poverty.[21] This criticism is related to the earlier statement regarding the secondary or "epiphenomenal" treatment of race.[22] Here, the lessons learned through the work of feminist scholars of color in regard to "rethinking" theories of racial-ethnic families appear appropriate. More specifically, the understanding of family patterns as "relational" applies here.[23] Evelyn Nakano Glenn writes that "[r]elational means that race/gender categories are positioned and that they gain meaning in relation to each other."[24] Another scholar has added that examining race, class, and gender allows us to better understand the world where some people's privilege depends on oppressing and exploitating others.[25]

Simply focusing on the gendered aspect of poverty obscures the fact that some women are privileged by the oppression and continued poverty of other women. In this way, women can be oppressors as well as the oppressed, depending upon their race, class, and immigration status (sexuality and disability are, of course, other possible sources of privilege and oppression). Perhaps the strongest evidence is presented in studies of domestic labor in the United States, wherein middle-class white women benefit from the subjugated status of low-income immigrant women.[26]

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immigrant rhetoric. The headlines read: *Births to Illegal Immigrants on the Rise: California Taxpayers Finance Soaring Number of Foreigners' Babies*, Rex Dalton, *Birth to Illegal Immigrants on the Rise: California Taxpayers Finance Soaring Number of Foreigners' Babies*, SAN DIEGO UNION-TRIB., Feb. 20, 1994, at A1, and *Border Baby with Medical Problem costs $2.7 million*, Rex Dalton, *Border Baby with Medical Problem costs $2.7 million*, SAN DIEGO UNION-TRIB., Feb. 20, 1994, at A22.

21. *See generally* THOMAS, *supra* note 15, at 65.

22. *See generally* Patricia Zavella, *The Problematic Relationship of Feminism and Chicana Studies*, 17 WOMEN'S STUD. 25 (1989).

23. *See generally* Maxine Baca Zinn, *Feminist Rethinking from Racial-Ethnic Families*, *in* WOMEN OF COLOR IN U.S. SOCIETY, 303 (Maxine Baca Zinn & Bonnie Thornton Dill eds., 1994).

24. Evelyn Nakano Glenn, *From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor*, 18 SIGNS 1 (1992).

25. Zinn, *supra* note 23.

26. *See generally* EVELYN NAKANO GLENN, ISSEI, NISEI, WARBRIDE: THREE GENERATIONS OF JAPANESE AMERICAN WOMEN IN DOMESTIC SERVICE (1986); JUDITH ROLLINS, BETWEEN WOMEN: DOMESTICS AND THEIR EMPLOYERS (1985); MARY ROMERO, MAID IN THE U.S.A. (1992); Vicki L. Ruiz, *By the Day or the Week: Mexicana Domestic Workers in El Paso*, *in* WOMEN IN THE U.S. MEXICO BORDER, (Vicki L. Ruiz & Susan Tiano eds., 1998).

Fourth, the feminization of poverty model ignores "the role of the capitalist economy in creating and perpetuating poverty."[27] For immigrant communities, the larger capitalist or global economy is central to understanding their experiences. The next section will address this fourth point in more detail to illustrate the deep connections between the larger capitalist economy and the state of low-income immigrant communities.

The increasing global nature of capital, in conjunction with recent welfare and immigration reforms, has helped contribute to the continuing presence of poverty within immigrant communities. Many low-income immigrant women, the vast majority of whom migrate as workers, experience a double-edged sword in that they enter the U.S. as a result of growing transnational markets while at the same time, face anti-immigrant legislation that punishes their arrival. While immigrant women's cheap labor is in demand in the United States, the basic needs of workers and their families are denied.[28]

Despite recent efforts to restrict the flow of immigrants, the creation of global capital, military, and economic linkages continue to foster large-scale immigration to the United States.[29] The growing prominence

27. THOMAS, *supra* note 15. While I find Thomas' outline of some of the central complaints against the feminization of poverty model useful, I find the author's responses to these criticisms largely unconvincing. For instance, she states that "[w]hile I support the idea that women's and men's poverty is exacerbated by the workings of a capitalist economy, I am unsympathetic to the left's notion that gender is an irrelevant consideration when analyzing poverty." *Id.* at 65. This statement underestimates the role of a capitalist economy in not only "exacerbating" women's and men's poverty but creating and maintaining poverty. In addition, from Thomas' analysis, it is unclear as to who these "Leftists" are and I remain unconvinced that those who critique this model for its ignorance of the larger capitalist economy find gender irrelevant. Also, on the issue of race as a cause of women's poverty, Thomas acknowledges the feminization of poverty approach as lacking. However, she adds, "I do not agree that race and class are *more important* than gender in causing women's poverty. . . . I would suggest that until women *as* women know what their similarities are they cannot understand their differences . . . race, class and gender are interwoven in complex ways, each contributing to women's pauperization. This book focuses on the role that gender plays in causing women's poverty while acknowledging that race and class also play roles in creating and perpetuating women's poverty." *Id.* at 66. In these statements, Thomas misunderstands the work of feminist scholars of color who have theorized about the concept of "race, class, and gender" and "difference" as an analytic tool in understanding the experiences of women of color. For some women of color at certain times (as evidenced in the lives of immigrant women of color), one's racial status can supersede one's gender or class status in defining that particular moment or experience. At other times, gender or class may take precedence. To simply set aside race and class by "acknowledging" its existence is inadequate and inexcusable in analyzing women's poverty. *See generally* PATRICIA HILL COLLINS, BLACK FEMINIST THOUGHT (1990); Trinh T. Minh-Ha, *Not You/Like You: Post-Colonial Women and the Interlocking Questions of Identity and Difference*, *in* MAKING FACE, MAKING SOUL 371 (Gloria Anzaldúa ed., 1990); Zinn, *supra* note 23. The responses presented by Thomas exemplify a middle-class, white bias that work to discredit her analysis rather than bolster it.

28. Statistics show that immigrants (both documented and undocumented) have high employment rates. *See generally* David E. Hayes-Bautista & Gregory Rodriguez, *Immigrant Use of Public Programs in the U.S., 1996*, *in* REPORT FOR THE CENTER FOR THE STUDY OF LATINO HEALTH (UCLA School of Medicine 1997).

29. *See generally* SASKIA SASSEN, GLOBALIZATION AND ITS DISCONTENTS (1998).

of established immigrant enclaves in major urban cities, along with globalization of production, decline of manufacturing, and the growth of the service sector have expanded the supply of low-wage jobs, including temporary and part-time jobs. And this in turn, helps fuel continued migration.

The increased movement of goods and services brings with it an increased movement of people.[30] In this way, immigration is a form of labor mobility, sustained by interpersonal networks bridging points of origin and points of destination.[31] The decline of the traditional industrial work force and the rise of new industries based on immigrant labor occurred as the relative power between workers and management shifted through the substitution of low-wage, unorganized workers for high-wage, organized labor.[32] Immigrants from Asia, the Caribbean, and Latin America played an important role in this transition.[33] While the use of Asian and Mexican immigrants who are easily disposable (i.e., reserve labor) is not new, the circumstances leading to migration as well as the gender composition of immigrants have changed.

Perhaps one of the most significant effects of foreign investment in export production is the uprooting of people from traditional modes of existence. In export manufacturing, the catalyst for the disruption of traditional work structures is the massive recruitment of young women into jobs in the new industrial zones.[34] Young women comprise the vast majority of the workers in these export processing industrial zones. The most obvious reason is their cheap labor, but in addition, young women in patriarchal societies are seen by foreign employers as obedient and

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30. *See generally* GEORGE J. BORJAS, FRIENDS OR STRANGERS: THE IMPACT OF IMMIGRANTS ON THE U.S. ECONOMY (1990).

31. *See generally* Maria Patricia Fernandez Kelly & Richard Schauffler, *Divided Fates: Immigrant Children in a Restructured U.S. Economy*, 28 INT'L MIGRATION REV. 662, 689 (1994).

32. *See generally* PETER KWONG, THE NEW CHINATOWN (1987).

33. However, this is not to say that the use of immigrant workers as cheap labor is a new phenomenon. Since the mid-1800s, Asian workers helped build the Transcontinental railroad, worked in mines, planted some of the first crops in California's Central Valley, developed fishing industries and canneries along the West Coast, and labored in sewing factories, laundries, and restaurants. And after the exclusion of Chinese in 1882 and Japanese immigrant workers in 1924, Mexican laborers were used as replacements to fill the need for low-wage, disposable labor.

Mexican labor was particularly in demand in the United States during the labor shortages of WWI and WWII. With WWII, the Bracero program was created. This program, lasting from 1942 to 1964, provided Mexicans with temporary work visas and helped to institutionalize the role of Mexican workers as a reserve army of labor. They were available to be drawn into the labor force at low wages whenever shortages threatened to raise wages, but always remained vulnerable to expulsion when the economy contracted or when other sources of cheap labor appeared. Even though the program was allegedly enacted to ease war-time labor shortages, agricultural growers and other employers obtained renewal of the program for decades thereafter. *See generally* TERESA AMOTT & JULIE MATTHAEI, RACE, GENDER, AND WORK (1996).

34. *See generally* SASSEN, *supra* note 29.

disciplined workers, willing to do tedious, high-precision work and put up with working conditions that others would not tolerate.[35]

This mobilization of large numbers of women into wage labor disrupts the traditional, often non-wage work patterns. To make matters worse, this entry into wage labor is generally a one-way proposition, wherein as traditional economic opportunities in rural areas shrink, it becomes difficult, if not impossible, for workers to return home if they are laid off or unsuccessful in their job search. For workers in these situations, emigration is one of very few options available.[36]

Once here in the United States, social policies such as the 1996 Welfare Reform and Immigration Acts work to maintain immigrant families' poverty by creating barriers to social services such as health care. Low-income immigrants are forced to either pay out of pocket or forego care. In this way, many immigrants with little financial means find themselves with a substantial amount of debt. These legislative policies criminalize the use of health care. The fear of potential public charge determinations not only poses a significant barrier to adequate care but also serves as a tangible barrier between those who are valued in this society and those who are not. For many low-income immigrant women, their combined status as female, low-income, racial minority, and immigrant helps to define them as marginal or undeserving.

II. THE PERPETUATION OF POVERTY

A. *Welfare and Immigration Reform and Immigrant Women's Health Care*

In the final version of the 1996 Welfare Reform, restrictions on immigrant welfare accounted for almost half of the total federal savings.[37] This is despite the fact that only about eight percent of the U.S. population are foreign-born as of 1990, and undocumented immigrants comprise about one percent of the U.S. population, or thirteen percent of the foreign born population. Ostensibly a budgetary measure, all the savings from eliminating almost all of the safety nets for immigrants come from denying benefits to legal—not "illegal"—immigrants. Undocumented immigrants are already ineligible for most major means-tested entitlement benefits.

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35. *See generally id.*; Karen J. Hossfeld, *Hiring Immigrant Women: Silicon Valley's "Simple Formula," in* WOMEN OF COLOR IN U.S. SOCIETY (Maxine Baca Zinn & Bonnie Thornton Dill eds., 1994).

36. *See generally* SASSEN, *supra* note 29.

37. *See generally* T. MACURDY & M. O'BRIEN-STRAIN, REFORM REVERSED? THE RESTORATION OF WELFARE BENEFITS TO IMMIGRANTS IN CALIFORNIA (Public Policy Institute of California 1997).

Federal welfare and immigration reform legislation of 1996 added restrictions to the use of Medicaid by legal immigrants. The Personal Responsibility and Work Opportunity Reform Act of 1996 restricted immigrants' access to health care by more narrowly defining which immigrant populations were eligible for federal Medicaid funding. The Illegal Immigration Reform and Immigrant Responsibility Act of 1996 made it harder for more recent immigrants to establish income eligibility for Medicaid.

The PRWORA created two categories of immigrants with respect to Medicaid eligibility: pre- and post-enactment immigrants.[38] The distinction was based on the relationship of an immigrant's date of entry to the date of the legislative change; those entering after August 22, 1996, were classified as post-enactment immigrants. States had the option of providing Medicaid coverage for pre-enactment qualified immigrants. Coverage of non-emergency services for legal post-enactment immigrants would have to be state-funded for the first five years of the immigrant's stay in the country. California opted to continue Medi-Cal coverage to legal immigrants irrespective of their date of entry to the U.S. However, state and local government agencies continued to require documentation of immigration status from applicants for means-tested programs.

The passage of these two laws facilitated the exchange of information regarding immigration status and the receipt of Medicaid-funded services between states and the INS. 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 specified immigration status, immigrants are allowed only coverage for emergency care. 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 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 and assets, as well as the information in documents they used to establish their California residency, can now be turned over legally to the INS.

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

38. *See generally* ANN MORSE ET AL., AMERICA'S NEWCOMERS: MENDING THE SAFETY NET FOR IMMIGRANTS (1998).

Medicaid by immigrants who are *legally* eligible in California. There is concern that a decline in Medi-Cal enrollment, and consequently prenatal care utilization, is occurring among low-income pregnant immigrant women.

Studies have shown 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.[39] Furthermore, foreign-born women are 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.[40] A minimum standard of fourteen visits starting no later than the third month of pregnancy is recommended by the American College of Obstetricians and Gynecologists.[41] During these visits, women are screened for potential pregnancy complications, which can require additional visits, especially in the latter months of pregnancy. Medicaid coverage for prenatal care is important in ensuring early and continuous use of prenatal care by women who would otherwise be uninsured for the care.

B. *Impact of Public Charge*

Among the various forms of collaboration between the state DHS agency and the federal INS agency, the issue of public charge is perhaps the most alarming to immigrant communities and those who serve them. The issue at stake is whether Medicaid, a non-cash public benefit, falls within the public charge domain since the benefit is not cash assistance, but health care coverage.

The INS can prevent an immigrant they judge likely to become a public charge from obtaining legal permanent residency. In addition, the INS can refuse readmission to the United States to immigrants who leave the country for more than 180 days, whom, when they attempt to reenter, are judged likely to become a public charge. The INS can also deport a person found to be a public charge, though this is rarely done.

Since the 1996 enactments, information concerning people who apply for and receive Medi-Cal has been provided continuously to the state DHS office by local Medi-Cal eligibility agencies. In May of 1999, after

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39. *See generally* G. Alexander & M. Kotelchuck, *Quantifying the Adequacy of Prenatal Care: A Comparison of Indices*, 111 PUB. HEALTH REP. 408 (1996); Paula Braverman et al., *Validity of Insurance Information on California Birth Certificates*, 88 AM. J. PUB. HEALTH 813 (1998); Michael Kogan et al., *The Changing Pattern of Prenatal Care Utilization in the United States, 1981-1995, Using Different Prenatal Care Indices*, 279 JAMA 1623 (1998).

40. *See generally* S.J. Ventura & S.M. Taffel, *Childbearing Characteristics of U.S. and Foreign-Born Hispanic Mothers*, 100 PUB. HEALTH REP. 647 (1985). California Department of Health Services (CDHS), *Adequacy of Prenatal Care Utilization – California 1989-1994*, 45 MORBIDITY & MORTALITY WKLY. REV. 655 (1996).

41. *See generally* Milton Kotelchuck, *The Adequacy of Prenatal Care Utilization Index: Its U.S. Distribution and Association with Low Birthweight*. 84 AM. J. PUB. HEALTH 1486 (1994).

pressure from immigrant health advocates, the federal government further clarified public charge criterion to exclude non-cash benefits, such as Medicaid and special-purpose cash benefits that are not intended for income maintenance.[42] However, the failure of the federal government to provide clarification on the potential impact of the use of non-cash benefits on future immigration status, almost three years after the passage of the legislation, had a significant impact on immigrant communities.

Since 1994, the INS and state DHS officials have made public charge determinations based solely on the use of Medi-Cal.[43] This practice was in conflict with a written policy stating that public charge determinations should be made on the basis of the individual's total circumstances, including age, health, family status, assets, resources, financial status, education, and skills. One community health care clinic director told us of an incident in which she received a phone call from a family member of someone who was having a heart attack. They had called to ask how much an ambulance would cost for a full fee, cash paying patient. Despite the fact that they were documented immigrants, they expressed fear of a public charge determination for using an ambulance as a public benefit. In another case, an immigrant woman in the Bay Area scalded herself badly in the bathtub. The clinic director described the situation:

> [H]er family were all documented citizens and working in one of the suburbs. And she was so afraid of ...getting her family in trouble, or getting herself in jeopardy that she didn't show up in the emergency room for 30 days after having scalded herself, and by then she was so infected that she was not able to survive. She died.[44]

C. *Port of Entry Detection Programs*

In California, the sharing of information between Medi-Cal and the INS around issues of public charge became institutionalized through the Port of Entry Fraud Detection programs. There were two such programs: the first was the Port of Entry Detection (PED) at the border of Mexico, and the second one expanded this program to include the Los Angeles International Airport and the San Francisco International Airport. This later program was called the California Airport Residency Program (CARR).

The first Port of Entry Detection Program started in 1994. Under this program, INS officials shared information with DHS staff regarding non-citizen entrants they suspected might have illegally received Medi-Cal

42. *See generally* U.S. Department of Justice, *supra* note 4.
43. *See generally* Schlosberg & Wiley, *supra* note 5.
44. Interview with clinic director (Oct. 1998) (on file with author).

benefits. DHS staff used the INS assistance to identify potential cases of Medi-Cal fraud, especially with regard to California residency.

The second program, the California Airport Residency Program began at the Los Angeles International Airport in 1994 and expanded to the San Francisco International Airport in 1996. Under this program, nonresidents returning to the country through the Los Angeles and San Francisco Airports were asked about their use of Medi-Cal.[45] In many instances, immigrants who had received coverage legally in the past five years were required to repay the benefits before reentering the country. These demands for repayment were illegal, and in response to lawsuits and advocate pressures, a court injunction stopped this practice.[46] However, despite the injunction against forced repayments, the inspection process continued under stricter legal guidelines. DHS officials, unable to legally demand repayment for benefits consequently informed immigrants that they may "wish" to pay back claims paid by Medi-Cal for past health services.

During an interview, an official of the DHS office of Audits and Investigations explained that INS initially contacted DHS regarding beneficiary fraud by individuals entering the United States. DHS then created a pilot program in the San Diego Port. The INS officials first identified potential fraudulent beneficiaries and referred them to DHS for further investigation. In a separate office, DHS officials asked for proof of California residency and determined if the individuals had or were receiving AFDC or Medi-Cal. If they suspected residency fraud, then they 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. This additional measure of referral to the field office was a procedural change from the past when DHS used to determine fraud solely on the initial meeting at the airport or port of entry. More recently, DHS referred cases to their field offices for independent review. At this point, DHS and the INS conducted separate investigations. The DHS official explained that most of the people detained at these points of entry were not undocumented immigrants. They had a temporary border pass, a U.S. tourist visa, or a U.S. temporary visa.

One possible outcome of the DHS referral was the collection of repayments of potentially fraudulent claims paid by Medi-Cal in the past. Most of the cases were referred back to the INS with the understanding that no fraud was suspected. However, in some cases, immigrants were denied re-entry into the United States. A hotline was created for com-

45. *See generally Abuse by Officials at the Border*, L.A. TIMES, Dec. 23, 1997, at B6.

46. *See generally* California State Auditor, *Department of Health Services: Use of Its Port of Entry Fraud Detection Programs Is No Longer Justified, at* http://www.bsa.ca.gov/bsa/summaries/98026sum.html (last visited Feb. 19, 2001).

plaints of inappropriate treatment within the DHS investigation process. This was in response to past problems with DHS officials demonstrating a lack of respect toward immigrants in this program. The DHS official we interviewed acknowledged this problem and stated that these issues had been resolved.

In April 1999, the state Health and Human Services Agency terminated the two programs. A few days later, both the state assembly and senate budget subcommittees 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."[47] The audit cited operational and administrative deficiencies and found that the department was no longer recovering enough fraudulent Medi-Cal payments to justify its investment in these programs. In part, this was due to a class action challenging the California Department of Health Services' practice of colluding with the INS to demand repayment of Medicaid benefits received.[48] The settlement required the state DHS to return at least $3 million to immigrants who were improperly ordered to return Medi-Cal benefits at the port of entry fraud detection programs.[49] State auditors documented intimidation by way of threatened imprisonment or reduced chances for citizenship, and by demands for repayments higher than the actual cost of the Medi-Cal benefits received. About 1,500 families were eligible for refunds under this settlement.

DHS contends that these programs were a separate issue from public charge, since they were concerned with benefit fraud and not whether an immigrant is or will become dependent on public benefits. However, public charge is a concern for the INS. It appears that, in effect, immigrants were screened for both issues of benefit fraud and public charge by two different governmental agencies within the same program. For immigrants in general, the differences between the two are subtle, if not insignificant. For them, the message is clear: using Medi-Cal is dangerous.

According to the Auditor's report, using Medi-Cal was especially dangerous for immigrant women. After reviewing 440 case files, the audit team found that ninety-seven percent of all the individuals investigated by the Port of Entry Programs were women. Eighty-six percent were between twenty-one and forty years old, and eighty-nine percent of cases involved families with children. The report went on to add:

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47. *Id.*

48. *See generally* National Immigration Law Center, *Settlement Reached in Medi-Cal "Debt" Reimbursement Case*, 12 IMMIGRANTS' RTS. UPDATE (Sept. 16, 1998), *available at* http://www.nilc.org/immspbs/health/health003.htm.

49. *See generally* California State Auditor, *supra* note 46.

> 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. In addition, women accounted for 50 percent of the people eligible for Medi-Cal benefits but comprised over 97 percent of the PED and CARR program investigations. Finally, 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.[50]

A key informant, a Bay Area community clinic director, had an opportunity to visit the California Airport Residency site in San Francisco in November 1997. She became concerned about the program after half a dozen of her clients reported having problems trying to re-enter the country. The director was able to set up a meeting with DHS and INS officials to find out how the program operated (it was not stated whether she spoke to the DHS and the INS together or separately). When asked how they chose particular people to interview, she learned that flights from Asian and Latin America, principally Mexico, and women of childbearing age were targeted. She described the extra screening conducted near the customs checkpoint:

> They are looking at women of Asian and Latino origin, not who looked pregnant, but 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? And if someone ended up showing their Medi-Cal card, then they were totally in the next realm of interview.[51]

According to the clinic director, the process of determination appeared "purely arbitrary." She went on to explain the complicated interplay between the federal INS official and the state DHS representative. The exchanges played on the fact that there were parallel but conflicting agendas, laws, and interpretations of regulations. With the DHS official sitting quietly beside him, the INS agent would question the woman until she described applying for Medi-Cal after being advised at the county office of her eligibility. At that point, the INS agent would raise questions as to whether she was truly eligible and advise her to consider paying back the benefits to avoid being sent to court for an eligibility determination, or the even more severe penalty of being deported and permanently denied future entry. After instilling these doubts and fears, the

50. *Id.* at 34.

51. Interview with clinic director (Oct. 1998).

woman was advised of the costs of the services she received and provided the opportunity to repay DHS. As a result of these intimidating practices, there were lines of immigrants at the airport waiting to pay back the health benefits they used through Medi-Cal.

According to our interviewers, both the Port of Entry Detection and Airport Residency 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, denied re-entry, and even deported by a seemingly arbitrary public charge determination were frightening propositions for all immigrants.

CONCLUSION

The emergence of these highly nationalistic and ethnocentric policies signifies a society that is opposed to a sizable foreign-born population in their midst.[52] The continued "browning" of America is certainly evident in the recent 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% and the Latino (or Hispanic, as defined by the Census Bureau) population grew 38.8%.[53]

These policies and associated programs particularly target immigrant women who are pregnant or of child-bearing age. This was 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 devising a method to slow down the rate of population increase among Latinos and Asians. By targeting immigrant women with children, it appears that they attempted to interrupt the flow of immigration as well as the likelihood of more childbirth by immigrant women. However, recent immigration numbers show that these policies have not worked as intended.[54] Sassen writes:

> Recent reforms in immigration law, ostensibly designed to rationalize immigration policy, have not only failed to slow immigration but threatens to do harm both to our own society and to the immigrants themselves. . . . The combination of such sanctions and a regularization program that excludes a large number of undocumented workers will

52. *See generally* GREGORY DEFREITAS, IMMIGRATION, INEQUALITY, AND POLICY ALTERNATIVES (Russell Sage Foundation Working Paper, 1995).

53. *See generally Hispanic and Asian Populations Expand*, N.Y. TIMES, Aug. 20, 2000, at A15.

54. In fact, Thomas J. Espenshade and his colleagues argue that there were a number unintended consequences as a result of the 1996 policies: 1) limited legal migration, and 2) increase in undocumented migration. *See generally* Thomas J. Espenshade et al., *Implications of the 1996 Welfare and Immigration Reform Acts for U.S. Immigration*, 23 POPULATION & DEV. REV. 769, 770 (1997).

> contribute to the formation of an immigrant underclass that is legally as well as economically disadvantaged.[55]

These programs perpetuate the cycle of poverty among low-income immigrant women. By criminalizing access to health care, immigrant women are reluctant to receive prenatal care that may alleviate potentially costly future health problems. Low-income immigrant families' already tenuous financial situation becomes more stressed as they seek other means to recover a public benefit for which they are ineligible. The recent 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.[56] It is apparent that immigrants are well aware of this anti-immigrant message.

It is apparent that, within contemporary social welfare discourse, welfare dependence and not poverty or unemployment is viewed as the social ill that is the appropriate target for state action.[57] The threat of public charge, or the potential dependence on welfare benefits, has made it clear that immigrant women are undeserving and unwanted.

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55. *See generally* SASSEN, *supra* note 29.

56. *See generally* Michael Fix & Jeffrey S. Passel, *Immigration and Immigrants Setting the Record Straight*, *at* http://www.urban.org/pubs/immig/immig/htm (last visited Feb. 23, 2001). Also, DeFreitas notes that immigration at current levels do not harm domestic wages or employment. "[I]mmigrants appear to contribute more in federal, state, and local taxes than they use in public assistance and services." DEFREITAS, *supra* note 52.

57 *See generally* AMOTT & MATTHAEI *supra* note 33.