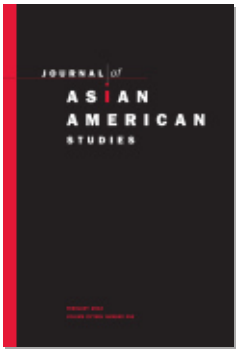
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Challenging Public Charge Policy: Coalitional Immigrant Community Strategies

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CHALLENGING PUBLIC CHARGE POLICY

Coalitional Immigrant Community Strategies

lisa sun-hee **park**

THIS ARTICLE HIGHLIGHTS THE COORDINATED coalitional strategies of frontline community health care providers and immigrant health policy advocates working to ensure prenatal care to low-income immigrant women in California. Using a multilayered community-based network, they were able to successfully challenge federal immigration policy regarding "public charge," which had significant impact on access to health care for low-income, pregnant immigrant women in the 1990s.

Sophia Chen's[1] experience at the Los Angeles International (LAX) Airport exemplifies the situation that thousands of low-income immigrant women faced during a historic moment of anti-immigrant legislation. In 1998, twelve months after the birth of her twin girls, Chen had traveled to China to introduce the girls to their grandparents. When she and the twins returned to Los Angeles a few weeks later anxious to go home, they were detained unexpectedly by the Immigration and Naturalization Service (INS).[2] Chen, who legally resides in the United States, was asked how she paid for the delivery of her babies. When she stated that she had received Medicaid, she was sent into another office to speak with a state Department of Health Services (DHS) agent. After hours of shuttling from one room to another, 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: immediately repay $4,000 for the medical expenses

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she incurred during her prenatal care and delivery; or take the next flight back to China and come back when she had enough funds to cover the medical bill. Startled, Chen protested that she had filled out all the proper application forms and was legally eligible for Medicaid benefits. The INS official responded that that did not matter and that there were no avenues for appeal.

In the end, Chen chose the second option. She could not raise enough money right away. Devastated, Chen left the twins alone at the airport and boarded the next plane to China. Her mother-in-law drove from Oakland in northern California to pick up the twins. 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 Asian and Latina immigrant women of childbearing age were being targeted by a new health insurance fraud detection program run by the INS and DHS agencies at ports of entry, including the border of California and Mexico, the San Francisco International Airport, and the LAX Airport. The community health clinic director of the immigrant advocacy organization described the extra screening conducted near the customs checkpoint at the airport 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 twenty and forty-five. Then, [they were] asked a series of light interview questions. And in those light interview questions, [if it was] 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.

An official state audit confirms their findings.[3] The audit found that immigrant women who had legally used public health insurance (Medi-Cal is California's Medicaid Program) for prenatal care and delivery were "asked" to repay the cost of their health care (sometimes double or triple the actual cost) if they wanted to return to their home in the United States. As part of their report, the auditors reviewed 440 case files of individuals who had been investigated by the program. Their conclusions overwhelmingly sup-

port the administrative process described by the community health clinic director and other immigrant health advocates I interviewed.

Beginning in 1998, my research team and I interviewed 196 safety-net health care providers, immigrant health advocates, government officials, and low-income immigrant women in several different 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 prenatal care access.

There were two Port of Entry Detection (PED) programs. The first program officially began in 1994, in the midst of and yet strategically under the radar of the intense battle over Proposition 187.[4] This pilot program combined two specific tactics to root out Medicaid fraud: prevent fraud before it happens;[5] and target documented immigrants/noncitizens trying to return to the United States through ports of entry.[6] This first program 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 from reimbursements, the program expanded to include the LAX Airport a few months later, and the San Francisco International Airport in 1996. The later program located at those airports was called the California Airport Residency Review (CARR).

According to the state 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 identified was pregnancy related. This is 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 those eligible for Medi-Cal benefits. For example, slightly less than 20 percent of the latter in July 1998 were between the ages of twenty-one and forty, yet this age group represented more than 80 percent of the individuals investigated by both programs. In 1997, nonimmigrants[7] 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 by the programs. It is worth noting that most of those detained at the points

Table 1.
Profile of Individuals Investigated by PED and CARR

	Percent	
Gender	97	Women (430 cases)
Age*	86	21–40 years old
Documentation status	80	Nonimmigrant aliens living in CA and eligible only for pregnancy and emergency services
Families with children	89	
Nationalities/PED	98	Mexico
Nationalities/CARR at LAX	40	Mexico, El Salvador, Guatemala, Honduras
	17	Philippines, Korea, China
	43	Unknown
Nationalities/CARR at SFO	19	Mexico
	51	Philippines, Korea, China
	30	Unknown

*Average age ranged from 29 to 35 years old
N = 440 case files

of entry were not undocumented or "illegal" immigrants. They held some form of documentation, including a temporary border pass, a U.S. tourist visa, a student visa, or a temporary visa. And, as noted in my earlier interview with the community health clinic director, particular nationalities appear to be targeted 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.

The PED programs existed for five years (1994–1999) until they were terminated as a result of a concerted effort by community advocates who helped facilitate damaging lawsuits against the DHS, a highly critical state audit, and federal clarification of public charge law by the INS. This article focuses on the immigrant community effort to challenge this recent formal application of public charge legislation. Their success was due in

large part to the advocates' ability to use a coalition of both Latino/a and Asian immigrant organizations to provide a powerful, alternative narrative that articulated the state's (ir)responsibility and (il)legality in its relationship with immigrants. However, despite the termination of this particular PED program, it is indicative of a larger social phenomenon that has long historical roots in our national ideology. It is simply the latest incarnation of a gendered, classed, and deeply racial tool of immigrant criminalization.

Necessity of Coalitions in Immigrant Advocacy

California is home to one-third of all immigrants 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. Currently, Asians and Latinos/as comprise the vast majority of immigrants to the United States. In the 1990s, these two diverse groups accounted for 80 percent of all incoming immigrants, with each group roughly comprising 40 percent. 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.[8]

In my research, I found that despite the stark differences among the various immigrant communities, salient and strategic moments of interconnection 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 immigrants—particularly uncontrolled Latina fertility—played strongly into overall anti-immigrant sentiments. However, Asian immigrants' relative invisibility in the national nativist discourse does not imply that they were somehow protected from its effects. Lynn Fujiwara notes that Asian immigrants are precariously situated within a racial discourse that obscures their role and impact.[9] In reality, poverty among Asian Pacific Americans rose from 11.9 to 13.5 percent from 1990 to 1994. As part of an increasingly class-bifurcated wave of Asian immigration, poverty rates among Southeast Asians are astounding: 47 percent of Cambodians, 66 percent of Hmong, 67 percent of Laotians, and 34 percent of Vietnamese officially lived in poverty ac-

cording to the 1990 census.[10] These Asian immigrants were constructed as the "bad" immigrants. Their use of public assistance expelled them from the mythic model minority category. However, the undeserving, bad immigrant/minority fulfills an important function equal to that of the model minority. In fact, these two categories exist in direct relation to each other, and one cannot exist without the other.

The image of the undeserving immigrant was powerfully portrayed through negative perceptions of motherhood and mothering of ethnic immigrant minorities. These images played a considerable part 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. Fujiwara writes, "The racialized/gendered images of migrant Latinas crossing the border to have their children and receive medical care through state-funded health care services played on working- and middle-class resentments over perceived misuse of their tax dollars."[11]

These sentiments were 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 Proposition 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 mid-1800s that brought so many Chinese workers, as well as many 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 Mexicanos.[12]

Historical precedent reminds us that these nativist concerns have a tendency to expand to encompass other vulnerable communities under certain political and economic conditions. The PED programs highlight the links among immigrants of different nationalities. In this specific case, Latinas (specifically Mexicans) were the initial test, and, once deemed successful, the program expanded from the border crossing sites to the international airports to target Asian immigrants. Evidently, the implications of various policies can expose the ways in which different racial/ethnic populations are intertwined. At certain historical moments, particular racial 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.[13]

Today, immigrants from Latin American nations are the most visibly attacked, both verbally and physically, for their use of public benefits. However, as the Port of Entry fraud detection programs attest, the target can easily shift to others deemed foreign—including those presumed model minorities. Nicholas DeGenova explains, "Latinos and Asians do not exist in isolation, within the narrow, hermetically sealed segregation for their officially designated respective corners, but rather, together, are dynamically implicated in historical as well as ongoing transnationalized reconfigurations of the broader social formation of the U.S. nation-state itself."[14]

Clarification Lessons

Calling the PED programs a "witch hunt" that were a "scandalous misuse of state power,"[15] a strong network of immigrant advocates successfully worked to undermine them. The network stretched from small, community-based health care clinics to regional immigrant health care administrators, to state-level legal advocates, to federal immigration policy analysts. They understood the underlying implications of public charge

policy to go far beyond the specific programs at hand. The detrimental effects of a wide-reaching public charge policy could have grave consequences not only for low-income immigrants but also for the general constitutional protections of due process and equal rights for all U.S. residents. The effective documentation and dissemination of these policy effects were key in their success in formally changing the application of this long-standing law.

This collaborative effort was initiated as reports about the PED programs spread to immigrant communities, their health care providers, and then to immigrant legal advocates. 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 of 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.

An advocate described their efforts to clarify public charge policy as part of "a classic textbook example of policy change." A grassroots mobilization of policy makers, a media campaign, and the assistance of strategic community (that is, 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 can apply this rule.

According to this attorney, the severe misapplication of this law occurred with the passage of welfare reform in 1996. She explains: "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 and

neoliberal fixation on personal responsibility that brought about Proposition 187 in California, and the federal welfare and immigration laws, the clarification was viewed as a significant win. Crucial to this win was a broad-based mobilization.

Legal advocates and community health care providers were able to convince the Department of Justice and the INS to issue new field guidelines 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 are not intended for income maintenance are not subject to public charge consideration.[16] In other words, the use of Medi-Cal or other health services alone will not affect immigration status unless these and other government funds are used to pay for long-term care (that is, nursing home or other institutionalized care). Also, the use of food stamps, WIC (Women, Infant, and Children—a supplemental nutritional program), public housing or other noncash programs is protected from public charge consideration. However, receipt of cash welfare or general assistance may affect one's immigration status.

In assessing their successful challenge to public charge determination, immigrant advocates effectively employed two key strategies that were crucial in stemming the anti-immigrant sentiment, at least to some extent. First, a broad network of advocates—of various racial/ethnic backgrounds and citizenship status—created a systemic approach to information dissemination. Second, this coalition worked to intervene and insert an alternative understanding of the effects of public charge applications and essentially flipped the standard script of the legislation's intent.

Flipping the Script

The first strategy required comprehending the issue in broad-based terms to bring together various stakeholders or participants who are affected. 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 is imperative in this systemic approach that links together a wide spectrum of knowledge and that can flow from one end to the other. The formal two-page clarification of public charge policy came from the INS only after years of concentrated pressure that was strategically organized by these advocates.

Community health workers meticulously documented the effects of this misapplication by governmental agencies and "flipped" the "personal responsibility" trope on its head and placed the responsibility of clearing up the confusion on the state. The power of these stories, in addition to the shaky legal grounds on which the PED programs stood, pushed the federal government to more clearly limit the reach of public charge policy.

The second strategy required meticulous readings of policies (particularly when new laws were introduced) in order to ascertain the most effective way to insert the alternative narratives of policy impacts. These personal stories relayed by community clinics and organizations were used as powerful correctives to governmental narratives. An advocate based in San Francisco explained, "We always have to be monitoring and vigilant. Bureaucracies make mistakes, either intentionally 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 is a tedious but necessary foundation of their advocacy. These protectors of immigrant rights are part of a loosely structured coalition of nonprofit organizations that, in effect, function as a regulatory body keeping governmental actions in check. Their jobs require that they know not only the language of the state and regulation but also their intersection with other policies and how they are actually experienced by people.

Continuing Consequences of Public Charge Law

In assessing their overall efforts, the advocates are pragmatic about their short-term gains and more than a little ambivalent about long-term impacts. One advocate said, "I don't think any of us want 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."

As important as clarification is from a policy standpoint, it did not resolve all public charge issues nor did it increase an overall sense of freedom or security for Asian and Latino/a immigrant families. One advocate recalled her disappointment from "just 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 is that public charge law still exists, just in more prescribed terms. Pressing questions remain, including what kinds of benefits recipients are obligated to repay, and what, if any, avenues of appeal or legal waivers are possible. 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, "The 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."

Perhaps one of the most profound lessons learned from this policy clarification effort is 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 communities. Given the high concentration of foreign-born populations in California, Asian and Latino/a 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 for 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 providers. Since immigrants were initially told that it was safe to use publicly funded health care, the public charge scare led to questioning 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 report enduring a sense of siege and would rather avoid undue scrutiny. Those areas reporting a strong sense of trust despite these fears are in places where the community feels in touch with known clinic staff who have specialized, local knowledge and policy expertise. However, even these clinics found themselves in a very difficult situation trying to retain a meaningful level of trust with their immigrant patients. A policy analyst working with a strong immigrant collaborative on issues of welfare and health care described 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 governmental action kept her away. Dissemination of public policy change in this political environment poses a formidable challenge. Adding to this challenge is the state of California's refusal to disseminate news of this legal clarification. In our interviews with key informants a year after clarification, many immigrant health advocates and health care providers had no idea this had even happened.

Discussion

Borders are powerful locations for defining who is included and excluded, and how. Borders are also messy spaces in which the contradictions and confusion of boundary maintenance are exposed. Legal scholar Robert Chang astutely observes, "The border is everywhere" and yet can be rendered invisible. "It is through this invisibility that the border gains much of its power."[17] Chang notes that because national borders are imperfect, supplementary mechanisms for exclusion are deployed. As such, welfare and health care policies function to supplement immigration policies in deciphering who belongs and who does not. In doing this, each mechanism roots out the foreign as a threat, thereby necessitating systematic observation, control, and, potentially, deportation. Welfare and health policies, then, inconspicuously extend the power of the border far beyond the literal, physical fence. As such, the border can move from one body or place to another.

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. 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.[18] Since then, public charge—in policy and sentiment—has existed just beneath the surface in U.S. immigration policy, and it has reared its head at key historical moments. Apparently, moments of high demand or desirability for immigrant labor is one such moment that allows for public charge determinations to become a feasible, formal state response. Public charge tempers immigrant labor desirability 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 a sense of increasing "normality" of their presence and, consequently, a greater potential for political influence and social belonging. The mid-1990s, with the passage of major welfare, immigration, and health legislative reforms at the state and federal levels, was one of these "corrective" moments in which labor and political desirability is counterbalanced with heightened public policy disavowal.

The PED programs assumed immigrant health care use was suspicious from the start and required surveillance to prove otherwise. In effect, these programs 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 Proposition 187, DHS and INS viewed the PED programs as an exciting collaborative effort that would lead to greater sharing of information across governmental agencies. With growing interest from neighboring states, PED increasingly pushed the boundaries of immigrant rights, health care access, and constitutional due process.

Immigration policies like public charge reinforce the social subordination of immigrants through programs such as PED, which serve to mark immigrants as in need of surveillance and control. Pregnant immigrant women find themselves in the midst of an intense political debate over not only immigration control but also state control of women's reproduction. 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.[19] Arguments that immigrant women "overuse" health care (meaning they use it at all) and have babies in order to obtain U.S. citizenship question the motive of low-income women in having children.

Unfortunately, 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,[20] this administrative law has undergone very little change. The ability to exclude or deport people on the basis of someone potentially becoming a public burden was established as a powerful tool for social engineering purposes. Despite its disrepu-

table history as a frequently used mechanism in the eugenics movement, it continues to exist. This is due in part because public charge provisions maintain the political and economic vulnerability of low-income immigrants, thereby keeping their labor costs down.

In this way, the accusation of public burden was particularly powerful in promoting the neoliberal ideology of personal responsibility. For Asian and Latino/a immigrants in the 1990s, their criminalization as public burdens recast their legal behavior as "illegal," regardless of their actual citizenship status. While Latinas were first targeted in the PED programs as a test case, the focus on Asian immigrants quickly followed. This is further evidence of their shared social location as "unassimilable aliens and permanent virtual immigrants."[21]

It seems the lessons learned from these health care advocates is applicable more broadly. In their fight for immigrant women's access to health care, they learned that 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 of one regulation to another with the goal of devising an effective challenge that will bring together the appropriate people with the necessary information. This is essential to repair the trust that is required to ensure health care access. 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.

In the end, the community advocates' successful actions perform a crucial democratic function of governmental checks and balances. The story of public charge administration is one of state power defining who is or is not a burden based upon very narrow and seemingly capricious assessments of a human being's costs and benefits. In the case of the PED program, the state made ineligible people who were eligible using procedures that violated its own laws. It is apparent that social justice work cannot focus solely on changing the state. There must be a counterframing of social justice that goes beyond a market-driven definition of responsibility whether of the state or individual. The bright side of this story is that there are people, as part of their everyday lives, who work behind the scenes to do just that.

Notes

1. All names of interviewees are pseudonyms unless otherwise stated. Also, some personal details were altered or omitted to ensure confidentiality.
2. INS has since been enveloped into the Department of Homeland Security, and its detention and removal functions are conducted by the Immigration and Customs Enforcement (ICE) division.
3. California State Auditor, *Department of Health Services: Use of Its Ports of Entry Fraud Detection Programs Is No Longer Justified* (Sacramento, Calif.: Bureau of State Audits, 1999).
4. Unofficially, DHS initiated an earlier version of this program in the mid-1980s after INS notified DHS that foreigners were entering the country with Medi-Cal benefit documents.
5. Department of Health Services, All County Letter #94-75, September 20, 1994.
6. Department of Health Services, All County Letter #95-18, March 16, 1995. Forbidding reentry at the border is far less bureaucratically taxing than formal deportation.
7. Nonimmigrants are those with some form of documentation, including a border crossing pass, U.S. tourist visa, student visa, or a temporary visa. Medi-Cal eligibility for nonimmigrants is continually debated. Of note is the punitive or narrow reading of eligibility until August 11, 1998, when the California Court of Appeals sided with the plaintiffs in *Latino Coalition for a Healthy California v. Belshé et al.* (California Court of Appeals No. A081229) and forced DHS to rescind its latest efforts to restrict residency.
8. Kevin Johnson, *The "Huddled Masses" Myth: Immigration and Civil Rights* (Philadelphia: Temple University Press, 2004), 281.
9. Lynn Fujiwara, *Mothers without Citizenship: Asian Immigrant Families and the Consequences of Welfare Reform* (Minneapolis: University of Minnesota Press, 2008), xvii.
10. Ibid.
11. Ibid., 8.
12. Alexandra Minna Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America* (Berkeley: University of California Press, 2005), 60. It is also noteworthy that the treatment of Chinese during the gold rush era revealed major anxieties around the boundaries of whiteness and the position of the white male worker and his masculinity. Like the 1990s, the vast majority of people in California during the gold rush were immigrants, but they were European who were defined as white, while the "Foreign Miner's Tax" was exclusively applied to Chinese immigrants. Then the Working Man's Party and other groups emerged to define "working class" in California as white and male. The similarities to the 1990s and today are quite strong.
13. Bill Ong Hing, *Defining America through Immigration Policy* (Philadelphia: Temple University Press, 2004), 28.

14. Nicholas De Genova, "Introduction: Latino and Asian Racial Formations at the Frontiers of U.S. Nationalism," in *Racial Transformations: Latinos and Asians Remaking the United States,* ed. Nicholas De Genova, 16 (Durham, N.C.: Duke University Press, 2006).
15. Personal interview with author, October 3, 2000.
16. INS Fact Sheet, 1999.
17. Robert S. Chang, "A Meditation on Borders," in *Immigrants Out! The Nativism and the Anti-Immigrant Impulse in the United States,* ed. Juan F. Perea, 246 (New York: New York University Press 1997).
18. See Eithne Luibheid, *Entry Denied: Controlling Sexuality at the Border* (Minneapolis: University of Minnesota Press 2002), 9.
19. See Ricky Solinger, *Beggars and Choosers: How the Politics of Choice Shapes Adoption, Abortion, and Welfare in the U.S.* (New York: Hill and Wang, 2001), 206.
20. Park and Park note that an earlier form of public charge existed in the eighteenth century before federal immigration rules existed. The concept dates back to colonial governments in U.S. history. See Edward J. W. Park and John S. W. Park, *Probationary Americans: Contemporary Immigration Policies and the Shaping of Asian American Communities* (New York: Routledge, 2005), 30.
21. DeGenova, *Racial Transformations*, 12.