

Borders Across Bodies: Assessing the Balance of Expanding CHIP Coverage at the Expense of Advancing Fetal Personhood

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“I know a few things to be true. I do not know where I am going, where I have come from is disappearing, I am unwelcome and my beauty is not beauty here. My body is burning with the shame of not belonging; my body is longing. I am the sin of memory and the absence of memory.”¹

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1. Warsan Shire, “Conversations about Home (at the Deportation Center),” in *Teaching My Mother How to Give Birth* 24, 26 (2011).

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INTRODUCTION

Women of color disproportionately suffer from inadequate reproductive health care and these disparities in health-care access are further magnified for undocumented immigrants.² Undocumented immigrants struggle to access health care for several reasons, including a lack of employer-sponsored health insurance and “fear of coming forward to access services and support for which they are eligible due to the fear of deportation.”³ For those without health insurance, substantive health-care services are often only accessible through last-resort visits to the emergency room.⁴ The difficulties undocumented immigrant women

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2. If/When/How, “Women of Color and the Struggle for Reproductive Justice,” 3-10 (2017), <https://perma.cc/UZN9-475P>.
 3. Jamila Taylor, “5 Ways Immigration Justice is Reproductive Justice,” *Center for American Progress* (10 Oct. 2017), <https://perma.cc/4V8G-4YHX>; see also National Women’s Law Center, “Immigrant Rights and Reproductive Justice: How Harsh Immigration Policies Harm Immigrant Health,” 1-2 (2017), <https://perma.cc/8N9M-7DQM> (describing laws limiting immigrant access to health insurance and how fears of deportation deter some women from seeking care).
 4. See e.g. Rachel Garfield, Rachel Licata, & Katherine Young, “The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA,” *Kaiser Family Foundation* (6 Feb. 2014), <https://perma.cc/F5B4-MGCD> (“Notably, 20% of uninsured adults report the emergency room as their usual source of care – almost double the share of adults with Medicaid and ten times higher than adults with employer coverage (2%).”); Denisse Rojas & Miranda Dietz, “Providing Health Care to Undocumented Residents,” *University of California Berkeley Center for Labor Research & Education*, 5-7 (4 Oct. 2016), <https://perma.cc/R5W7-DUXS> (providing examples of inclusive safety-nets that remove restrictions of care for undocumented immigrants and how these safety-nets lessen reliance on emergency services); Dennis Andrulis, Christina An, & Carol Pryor, “Getting Health Care When You are Uninsured,” *The Access Project*, 5, 18-19 (Oct. 2000), <https://perma.cc/JHJ3-FCW5> (detailing the use of emergency services by uninsured

confront in securing prenatal care illustrate how the mainstream reproductive rights movement may not effectively address the reproductive health needs of immigrant populations.⁵

Recently, critics of the Trump administration have scrutinized efforts to curtail access to reproductive and health-care services; however, this administration only affirms the long-standing disparities immigrant women face in achieving reproductive justice.⁶ Because the Trump administration has overtly limited access to reproductive health services,⁷ it is unlikely that executive action will support expanded reproductive health care for undocumented populations on the federal scale. Still, individual state action through the State Children's Health Insurance Program (CHIP) may provide relief.⁸ This Article outlines a potential pathway for expanding reproductive health care to undocumented immigrants through CHIP's unborn persons exception. However, use of the CHIP exception could also give rise to expanded fetal personhood arguments.

This Article examines CHIP regulations for the unborn, arguing that while the short-term goal of increasing access to pregnancy-related care for undocumented immigrants is admirable, utilization of fetal personhood arguments

individuals in Cleveland, Ohio).

5. Gavrielle Jacobovitz, "Reproductive Healthcare Access Limited for Many Undocumented Women," *NBC4 News* (18 Jan. 2019), <https://perma.cc/T7SA-AKBR>; Laurel Ranger, "Advocating for Access to Prenatal Care for Undocumented Immigrants: Challenges and Benefits Examined," *Medical Bag* (25 Jan. 2019), <https://perma.cc/H35N-ZPNN>; Jacqueline Howard, "The Stress Pregnant Immigrants Face in America," *CNN* (24 Oct. 2018), <https://perma.cc/4S5Y-Z5GT>.
6. Alison Siskin, "Noncitizen Eligibility for Federal Public Assistance: Policy Overview," *Congressional Research Service*, 1 (2016), <https://perma.cc/7N85-ETDG> (noting that "[t]he extent to which residents of the United States who are not U.S. citizens should be eligible for federally funded public health aid has been a contentious issue since the 1990s.").
7. See e.g. Nurith Aizenman, "Few Groups Reject Abortion-Restricted U.S. Global Health Funds," *NPR* (7 Feb. 2018), <https://perma.cc/TD8Z-F3KE> (discussing President Trump's "Mexico City policy," which "cuts off U.S. aid to international groups unless they promise not to provide or promote abortion, even with non-U.S. funding sources."); Cara Anna, "Trump's Global Gag Rule Goes Far Beyond Abortion, Groups Say," *AP News* (23 Jan. 2018), <https://perma.cc/C3JR-7R4E> (noting that President Trump "went where no administration has gone before" because "for the first time foreign NGOs that even discuss abortion as an option are barred not only from about \$575 million in U.S. family planning funds but also an estimated \$8.8 billion in U.S. global health aid."). See also, for example, President Trump's numerous attempts to tamp down on illegal immigration in general: "Executive Order No. 13767, Border Security and Immigration Enforcement Improvements," 82 *Federal Register* 18 (25 Jan. 2017), <https://perma.cc/YA7U-SNT7>; Presidential Proclamation No. 9822, "Addressing Mass Migration Through the Southern Border of the United States," 83 *Federal Register* 221 (7 Feb. 2019), <https://perma.cc/VY3D-BQ4W>; "Remarks by President Trump in Meeting with Conservative Leaders on His Immigration Proposal," *The White House* (23 Jan. 2019), <https://perma.cc/B9UX-EM7S>; "Executive Order No. 13768, Enhancing Public Safety in the Interior of the United States," 82 *Federal Register* 18 (30 Jan. 2017), <https://perma.cc/RK89-LKJX>; Executive Order No. 13780, "Protecting the Nation from Foreign Terrorist Entry into the United States," 82 *Federal Register* 45 (9 Mar. 2017), <https://perma.cc/62GM-PNR6>.
8. Previous versions of the law were abbreviated to SCHIP but a 2009 reauthorization of the law changed the name to CHIP. For clarity, this Article employs the current usage (CHIP). As relevant to this Article, there are no significant differences between the two versions of the program and this Article therefore quotes from sources analyzing SCHIP.

has potential to limit reproductive rights in other areas. At every point in the reproductive process, laws undermine access to health care for undocumented immigrants, particularly through Medicaid exclusions and the recent increase in the use of clinics as enforcement centers. Part I details obstacles to reproductive health care for undocumented immigrants. It explores Medicaid's history and explains how reproductive health has not been adequately prioritized. Part II documents modern immigration enforcement trends through the Clinton, Bush, and Obama administrations. It illustrates how the Trump administration is using expanded powers from prior administrations in new, concerning ways that influence perceptions of immigrant health and safety. Additionally, this Part explores intersecting concerns between immigration and Medicaid throughout the Trump administration. Part III explains CHIP's role in expanding care to undocumented women through a controversial interpretation that allows health-care coverage for "a child from the time of conception." Under CHIP, some forms of reproductive care can be administered to a mother, regardless of her citizenship status. Part IV outlines possible ethical and legal hurdles to expanding prenatal care under the CHIP exception. It argues that while CHIP may help undocumented immigrants secure prenatal care, the CHIP pathway may ultimately undermine access to reproductive care by advancing fetal personhood arguments.⁹ The Article concludes by noting that while CHIP may fill health-care gaps when presidential administrations fail to offer adequate access to reproductive health care, advocates should consider how state and local clinic policies might better include undocumented immigrants in pursuit of supportive reproductive health policies.

I. UNHEALTHY POLICY: HOW MEDICAID HAS MARGINALIZED HEALTH-CARE ACCESS FOR IMMIGRANT POPULATIONS

In order to fully understand the disparities undocumented immigrants face when trying to access reproductive health care, it is first necessary to understand the history of Medicaid and the services it provides. While Medicaid is often described as a "safety-net" for public health, its exclusions, notably through the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, demonstrate that it is not designed for full public use.¹⁰ This Part explores how Congress has intentionally excluded certain populations from using Medicaid. It describes health-care challenges for immigrant populations imposed by the Trump administration. It also explains how communities would be better served through greater access to reproductive health care.

A. Medicaid: An Inclusive "Safety-Net" with Exclusive Eligibility

Medicaid is the United States' major national health-care program for

9. This research is largely focused on undocumented Latinx populations, although immigration and health care concerns extend beyond undocumented Latinx populations.

10. See notes 23-30 and accompanying text.

individuals and families living near or below the federal poverty line.¹¹ Under Medicaid, the federal government helps pay for state expenditures for “medically needy persons.”¹² Altogether, Medicaid finances nearly 20 percent of all personal health-care spending in the United States.¹³ Moreover, Medicaid covers “nearly half of all births in the typical state,” three-fourths of children living in poverty, almost half of children living with special needs, and almost half of nonelderly, disabled adults.¹⁴

As discussed below, because states co-administer the program, they are able to impose additional criteria upon individuals seeking assistance; thus, eligibility for participation varies by state.¹⁵ When originally enacted, Medicaid “was built around traditional categories of welfare recipients.”¹⁶ It was structured to “designate who among the poor is most deserving of assistance”; consequently, populations like the disabled, elderly, pregnant women, and children were prioritized.¹⁷ However, eligibility standards have shifted over time.

Medicaid is a jointly-funded program that both states and the federal government contribute to; states are eligible for federal funding if their programs meet appropriate federal guidelines.¹⁸ In order to be eligible for matched funding by the federal government, certain populations and services must be included.¹⁹ The “flexibility” afforded by the state-federal partnership means program administration varies significantly by state.²⁰ Some states expand coverage beyond the federal minimums for populations and services by obtaining waivers under Section 1115 of the Social Security Act, which permits the secretary of the Department of Health and Human Services (HHS) to evaluate and approve state-

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11. “U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs,” *U.S. Department of Health and Human Services, Office of The Assistant Secretary for Planning and Evaluation*, <https://perma.cc/AFY6-4C3P> (codified at 42 U.S.C. 9902(2)); see also “Frequently Asked Questions Related to the Poverty Guidelines and Poverty,” *U.S. Department of Health and Human Services, Office of The Assistant Secretary for Planning and Evaluation*, <https://perma.cc/FNT7-DA34>.
 12. See Sydney E. Bernard & Eugene Feingold, “The Impact of Medicaid,” 1970 *Wisconsin Law Review* 726, 734 (1970) (detailing the extensive legislative history regarding Medicare and Medicaid).
 13. Robin Rudowitz & Rachel Garfield, “10 Things to Know about Medicaid: Setting the Facts Straight,” *Kaiser Family Foundation* (12 Apr. 2018), <https://perma.cc/4GFS-SBRN>.
 14. *Id.*
 15. See *id.* at 734-36; see also Abbe R. Gluck & Nicole Huberfeld, “What Is Federalism in Healthcare For?,” 70 *Stanford Law Review* 1689, 1710 note 82 (2018) (providing examples of states with “particular anxieties about federal intervention in areas involving both the family and minority populations”).
 16. Mark A. Hall, “States’ Decisions Not to Expand Medicaid,” 92 *North Carolina Law Review* 1459, 1462 (2014).
 17. *Id.*
 18. “Financial Management,” *Centers for Medicare & Medicaid Services*, <https://perma.cc/XW2G-BKYY>.
 19. Samantha Artiga et al., “Current Flexibility in Medicaid: An Overview of Federal Standards and State Options,” *Kaiser Family Foundation* (31 Jan. 2017), <https://perma.cc/MS8N-Q4UK> (detailing minimum standards and state options in meeting Medicaid eligibility).
 20. Rudowitz & Garfield, note 13 (providing details in Figure 3 to show how Medicaid expansion has met changing health needs throughout the decades).

specific changes to Medicaid and CHIP among other things.²¹ However, states have also used Section 1115 waivers to restrict access to Medicaid.

Additionally, significant federal policies throughout various presidential administrations have also restricted access to Medicaid.²² Often, these changes accompany significant immigration reform efforts.²³ Most notably, in 1996, Congress passed, and President Clinton signed into law, a restrictive social welfare reform law that contracted noncitizens' access to public assistance programs such as Medicaid.²⁴ This law, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), represents one of the most significant efforts to reform both immigration and health care in one fell swoop.²⁵ PRWORA broadly established comprehensive restrictions on the eligibility of noncitizens for means-tested public assistance, creating a gradient for assessing citizenship status and public program eligibility.²⁶ Under PRWORA, lawful permanent residents, such as green card holders, refugees, and asylum-awardees are "qualified" for Medicaid after five years of lawful residence.²⁷ However, "some temporary workers, students and tourists, people granted temporary protected status, and unauthorized immigrants" are deemed "nonqualified" under the Act.²⁸ "Unauthorized immigrants" include those who are not lawful permanent residents, refugees, asylees, "and [those who] have not otherwise been granted permission under specific authorized temporary statuses for lawful residence and work."²⁹ Thus, under PRWORA, undocumented immigrants are barred from almost all federal

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21. See e.g. Hannah Katch & Judith Solomon, "Restrictions on Access to Care don't Improve Medicaid Beneficiaries' Health," *Center on Budget & Policy Priorities* 1-7 (11 Dec. 2018), <https://perma.cc/U5R3-MCS7> (detailing various Medicaid waivers throughout states and highlighting how penalties for access to care in states like West Virginia and Indiana had numerous health consequences). For additional information on Section 1115 waivers, see Elizabeth Hinton et al., "Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers," *Kaiser Family Foundation* (12 Feb. 2019), <https://perma.cc/54VH-7FU5> ("States can obtain 'comprehensive' Section 1115 waivers that make broad changes in Medicaid eligibility, benefits and cost-sharing, and provider payments across their programs.").
 22. Part II.B. addresses reform under the Trump administration in more detail.
 23. See notes 29-31, 57, and accompanying text; see also "Immigrants and Welfare Reform: Glossary," *Migration Policy Institute* (1 Aug. 2002), <https://perma.cc/7XLY-VDP4> (detailing significant intersections between immigration and welfare reforms).
 24. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.
 25. Audrey Singer, "Welfare Reform and Immigrants," *Brookings Institute* (1 May 2004), <https://perma.cc/PJW6-H9WU>; Philip Kretsedemas & Ana Aparicio, *Immigrants, Welfare Reform, and the Poverty of Policy*, 22 (2004) ("PRWORA restricted immigrant eligibility in all federally funded assistance programs. Prior to its enactment, legal immigrants residing in the United States by and large had access equal to citizens with regard to public assistance benefits.").
 26. Karina Fortuny & Ajay Chaudry, "A Comprehensive Review of Immigrant Access to Health and Human Services," *Urban Institute* 3 (2011), <https://perma.cc/9PVK-5B4E>.
 27. *Id.*; see also "Mapping Public Benefits for Immigrants in the States," *PEW Charitable Trusts*, 2 (2014), <https://perma.cc/WWQ2-4APL>.
 28. *PEW Charitable Trusts*, note 27.
 29. Fortuny & Chaudry, note 26, at vi.

programs, with the exception of emergency Medicaid.³⁰

B. Expanding Reproductive Health Care Would Help Communities

Women make up the majority of Medicaid enrollees.³¹ Currently, Medicaid covers approximately twenty-five million women, “two-thirds of whom are in their reproductive years.”³² Because low-income women have higher rates of unintended pregnancies than women in other socioeconomic brackets, public insurance programs, including Medicaid, help to cover approximately 65 percent of unplanned U.S. births.³³ Without Medicaid, millions of women, particularly low-income and/or women of color, would lack sufficient health care.

Expanding insurance coverage is critical to improving health outcomes for both women and children.³⁴ Studies cannot overstate the importance of securing preventative care.³⁵ Immigrants are less likely to have a primary care provider or other regular source of health care and many immigrant children do not see a care provider for more than a year at a time.³⁶ Repeatedly, researchers have shown that access to preventive health-care services improves community health and reduces health-care expenditures, yet immigrants are less likely to access or utilize preventive services, especially in areas like pediatric and prenatal preventive

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30. See PRWORA § 401(b)(1)(A) (8 U.S.C. § 1611(b)(1)(A) (2012)). Emergency Medicaid covers the treatment of an emergency medical condition, which is manifested through “acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (A) placing the patient’s health in serious jeopardy, (B) serious impairment to bodily functions: or (C) serious dysfunction of any bodily organ or part.” 42 U.S.C. § 1396b(v) (2012).
 31. “Research Brief: The Impact of Medicaid Coverage Restrictions on Abortion,” *Ibis Reproductive Health* (Nov. 2015), <https://perma.cc/8A95-UC9F> (“Women make up 67% of Medicaid enrollees.”).
 32. “Medicaid & Reproductive Justice,” *National Latina Institute for Reproductive Health* (Aug. 2018), <https://perma.cc/8DG9-MDUS>.
 33. Adam Sonfield & Kathryn Kost, “Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010,” *Guttmacher Institute*, 8 (Feb. 2015), <https://perma.cc/KTS4-RAT4> (“Nationally, 68% of the 1.5 million unplanned births in 2010 were paid for by public insurance programs, compared with 51% of all births and 38% of planned births.”).
 34. See e.g. Larisa Antonisse et al., “The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review,” *Kaiser Family Foundation* (28 Mar. 2018), <https://perma.cc/8VHR-V4GL> (assessing ACA and Medicaid expansion trends and reporting that “[s]tudies show improved self-reported health following expansion, and multiple new studies demonstrate a positive association between expansion and health outcomes”). For additional commentary on intersections between isolationist policies and public health, see Christine Coughlin & Adam Messenlehner, “Isolationist Policies Threaten Public Health,” 107 *American Journal of Public Health* 860 (2017).
 35. See e.g. Jean Edward, “Undocumented Immigrants and Access to Health Care: Making a Case for Policy Reform,” 15 *Policy, Politics, & Nursing Practice* 5 (2014) (noting that preventive prenatal care leads to “a decrease in the rates of prematurity, low-birth-weight babies, and related postnatal costs” and “improving access to health care services for undocumented immigrants can have significant impacts on health indicators for the nation as a whole”).
 36. See Sylvia Guendelman et al., “Unfriendly Shores: How Immigrant Children Fare in the U.S. Health System,” 20 *Health Affairs* 257, 261-62 (2001).

care.³⁷ Access to preventive health care is a cost-effective way to improve health outcomes of children.³⁸ In addition, “providing prenatal care for undocumented immigrants would lead to a decrease in the rates of prematurity, low-birth-weight babies, and related postnatal costs.”³⁹ Improving access to reproductive care for undocumented immigrants not only helps to secure immediate individual and familial benefits but also benefits the public at large.⁴⁰

C. The Reality of Prenatal Care for Undocumented Women

While the U.S. medical sector is incredibly technologically advanced, many immigrant women lack access to adequate prenatal care.⁴¹ Results comparing foreign-born perinatal outcomes to those of women born in the U.S. may be surprising. Foreign-born women in several ethnic groups have been noted to have significantly better perinatal outcomes compared with their U.S.-born counterparts.⁴² Foreign-born Mexican women, in particular, have positive perinatal outcomes compared to U.S.-non-Hispanic populations, despite lower average socioeconomic status.⁴³ Yet, perinatal outcomes deteriorate for U.S.-born Mexican women.⁴⁴ Problems in accessing reproductive health services stem not only from health-care eligibility restrictions but also from immigration enforcement. When immigrant mothers forgo care out of fear of enforcement, health-care providers cannot help their patients plan, monitor, and prepare for possible complications. For example, one study assessing the maternal outcomes of undocumented women in Colorado shows that “[o]nly about half of the

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37. See e.g. Adam L. Cohen & Dimitri A. Christakis, “Primary Language of Parents is Associated with Disparities in Pediatric Preventive Care,” 148 *Journal of Pediatrics* 254, 256-57 (2006) (noting “infants of a parent whose primary language was not English were half as likely to receive all recommended preventive-care visits compared with infants of a parent whose primary language was English” and that “[p]arents who are undocumented aliens may avoid medical care for their children for fear of being discovered and deported.”).
38. Edward, note 35.
39. *Id.* at 8; see also Olveen Carrasquillo et al., “Health Insurance Coverage of Immigrants Living in the United States: Differences by Citizenship Status and Country of Origin,” 90 *American Journal of Public Health* 917, 917-23 (2000).
40. See Part III.
41. “Committee Opinion: Health Care for Unauthorized Immigrants,” *American College of Obstetricians & Gynecologists* (Mar. 2015), <https://perma.cc/KM2X-EM3B> (reaffirmed 2017) (“[B]arriers to access result in [unauthorized immigrants] receiving fewer preventive health care services, including prenatal care, and reporting poorer reproductive health outcomes.”).
42. Gopal K. Singh & Stella M. Yu, “Adverse Pregnancy Outcomes: Differences between US- and Foreign-Born Women in Major US Racial and Ethnic Groups,” 86 *American Journal of Public Health* 837 (1996).
43. Arturo Cervantes, Louis Keith, & Grace Wyshak, “Adverse Birth Outcomes Among Native-Born and Immigrant Women: Replicating National Evidence Regarding Mexicans at the Local Level,” 3 *Maternal & Child Health Journal* 99, 106 (1999) (examining the epidemiological paradoxes between immigrants and native-born women).
44. Ashima Madan et al., “Sociocultural Factors that Affect Pregnancy Outcomes in Two Dissimilar Immigrant Groups in the United States,” 148 *The Journal of Pediatrics* 341, 342 (2006) (comparing perinatal risks and outcomes in foreign- and U.S.-born Asian-Indian and Mexican women).

undocumented women began prenatal care in their first trimester, as compared to almost 85 percent of the general population.”⁴⁵ Thus, immigration status influences access to prenatal care, as well as perinatal outcomes.

Problems in accessing reproductive health services burden not only individual women but also the public. The U.S. General Accounting Office reported that emergency Medicaid expenditures have climbed in states with particularly high immigration rates; relatedly, uncompensated care costs have surged.⁴⁶ In 2004, childbirth and pregnancy complications accounted for approximately 82 percent of North Carolina’s overall emergency Medicaid spending.⁴⁷ In addition, children of immigrants are generally found to have higher per capita expenditures for emergency department visits compared to native-born children.⁴⁸ Due partially to the exclusion of undocumented immigrants from health insurance coverage, hospitals face unreimbursed expenses for non-emergent services.⁴⁹ Researchers argue that these unreimbursed expenses make health exchanges more expensive because providers increase prices for those with private insurance to cover the costs of providing uncompensated care to uninsured populations.⁵⁰ Restricting access to prenatal care undermines women’s health and strains health-care systems. Yet, CHIP provides a potential pathway to assist undocumented women in securing immediate access to prenatal care.

II. IMMIGRATION: PRIOR ADMINISTRATIONS’ ACTIONS ILLUMINATE CURRENT DISCRIMINATION

While the Trump administration has prioritized immigration enforcement,

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45. Mary M. Reed et al., “Birth Outcomes in Colorado’s Undocumented Immigrant Population,” 5 *BMC Public Health* 100, 100-03 (2005).
 46. See “Report to Congressional Requesters, Undocumented Aliens: Questions Persist about Their Impact on Hospitals’ Uncompensated Care Costs (GAO-04-472),” *United States General Accounting Office*, 11 (May 2004), <https://perma.cc/67SU-G3SL>; Bruce Japsen, “Unpaid Bills Squeeze U.S. Hospitals’ Resources,” *Chicago Tribune* (22 Oct. 2006), <https://perma.cc/KJC3-LFCU>; see also Hailey Cleek, “Sanctuary Clinics: Using the Patient-Physician Relationship to Discuss Immigration Policy as a Public Health Concern,” 53 *Wake Forest Law Review* 979, 984-85 (2018) (discussing how reliance on EMTALA impacts community health).
 47. See C. Annette DuBard & Mark W. Massing, “Trends in Emergency Medical Expenditures for Recent and Undocumented Immigrants,” 297 *Journal of American Medical Association* 1085, 1085-92 (2007).
 48. Sarita A. Mohanty et al., “Healthcare Expenditures of Immigrants in the United States: A Nationally Representative Analysis,” 95 *American Journal of Public Health* 1431, 1431-38 (2005) (“[P]er capita emergency department expenditures for immigrant children were significantly higher because immigrant children’s costs per visit were much higher. This finding suggests that immigrant children may be sicker when they arrive at the emergency department. The higher emergency department expenditures . . . for immigrant children probably reflect poor access to primary care[.]”).
 49. See “The Consequence of Being Uninsured,” *National Immigration Law Center*, 4-6 (Aug. 2014), <https://perma.cc/6AM7-4D33> (describing “the hidden health tax” and consequences for the healthcare system).
 50. See “The Impact of Unreimbursed Care on the Emergency Physician,” *American College of Emergency Physicians*, <https://perma.cc/4YQM-BNFK> (noting that “55% of an emergency physician’s time is spent providing uncompensated care”).

its hostile immigration policies are not unique. This Part provides an overview of modern immigration laws and describes policies from the Clinton, Bush, and Obama administrations that significantly expanded immigration enforcement. It explores the recent perception that clinics are potential immigration enforcement centers, causing undocumented immigrants to fear the use of such services. Lastly, this Part illustrates how the Trump administration's enforcement priorities pose a unique threat to immigrant health.

A. Overview

The Clinton administration restructured immigration policy and enforcement following PRWORA's Medicaid overhaul. Most notably, the Clinton administration targeted illegal immigration through the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA).⁵¹ IIRIRA created some of the toughest existing immigration measures.⁵² First, IIRIRA passed Section 287(g), an amendment to the Immigration and Nationality Act (INA), which allows local law enforcement agencies to perform specific, delegated immigration enforcement functions.⁵³ Second, IIRIRA significantly broadened the scope and definition of criminal convictions that may be used against an individual in deportation proceedings.⁵⁴ IIRIRA encouraged the then-growing trend of prosecuting immigration offenses criminally and swiftly.⁵⁵

Following the Clinton administration and in response to the September 11, 2001 attacks on the World Trade Center, George W. Bush signed into law the Homeland Security Act, which created the Department of Homeland Security

51. Illegal Immigration Reform and Immigrant Responsibility Act of 1996, P.L. 104-208, 110 Stat. 3009-546 (1996).

52. See Donald Kerwin, "From IIRIRA to Trump, Connecting the Dots to the Current US Immigration Policy Crisis," 6 *Journal on Migration and Human Security* 192, 193 ("IIRIRA set the stage for the growth of the immense US immigration enforcement system by authorizing significant funding for border and interior enforcement and by establishing an interlocking set of enforcement partnerships and programs. It also restricted legal immigration, particularly by low-income applicants.").

53. Codified at 8 U.S.C. § 1357(g). Yet, the "federal government did not enter into any 287(g) agreements with state or local jurisdictions until 2002." See "The Performance of 287(g) Agreements," *U.S. Department of Homeland Security, Office of the Inspector General*, 2 (Mar. 2010), <https://perma.cc/R7LZ-2WAD>. Consequently, this Article focuses on the effects of 287(g) throughout the Bush administration.

54. See IIRIRA, Pub. L. No. 104-208, Div. C., § 321, 110 Stat. 3009-546, 3009-627 to -628 (1996) (amending the definition for "aggravated felony"); House Report 104-879, Report on the Activities of the Committee on the Judiciary of the House of Representatives (1997) (broadening the "definition of 'conviction' for immigration law purposes to include all aliens who have admitted to or been found to have committed crimes[, which] . . . will make it easier to remove criminal aliens, regardless of specific procedures in States for deferred adjudication or suspension of sentences").

55. Stephen H. Legomsky, "The New Path of Immigration Law: Asymmetric Incorporation of Criminal Justice Norms," 64 *Washington & Lee Law Review* 469, 479 (2007) ("Justice Department statistics show almost a tripling of prosecutions from 1984 to 1994. Following Congress's enactment of IIRIRA in 1996, another jump occurred. From fiscal year 1997 to fiscal year 1998, prosecutions for all immigration offenses leaped from 17,807 to 22,857.").

(DHS) as a new executive agency and thus authorized what constitutes “the single-largest government reorganization since the creation of the Department of Defense.”⁵⁶ Beginning in March 2003, the Bureau of Immigration and Customs Enforcement (ICE) became operational as a component agency of DHS, eventually exercising “a unique combination of civil and criminal authorities” to enforce federal immigration laws.⁵⁷ ICE is principally “responsible for enforcing federal immigration laws as part of its homeland security mission”; yet ICE also trains and pays both state and local agents to “perform” immigration-related law enforcement.⁵⁸ This shift largely resulted from the implementation of two federal initiatives: (1) Section 287(g) of the INA, and (2) the Secure Communities program.⁵⁹ Section 287(g) authorizes ICE to enter into agreements with state and local law enforcement agencies to enforce federal immigration laws.⁶⁰ The Secure Communities program, which was suspended under the Obama administration but reinstated by the Trump administration,⁶¹ facilitates the sharing of local arrestees’ fingerprints and information with Federal Bureau of Investigation and ICE.⁶² Although ICE priorities have shifted over time, ultimately its past immigration policies set the stage for broadened enforcement strategies in the Trump administration.

More recently, the Obama administration also advanced policies that contribute to the current anti-immigrant legal apparatus when it repeatedly failed to expand health insurance coverage for undocumented immigrants.⁶³ Although the Patient Protection and Affordable Care Act (ACA) helped to bring new individuals into the health insurance market, the ACA explicitly excludes

56. “Celebrating the History of ICE,” *U.S. Department of Homeland Security* (last updated 1 Mar. 2019), <https://perma.cc/XDL4-LFX4>; Homeland Security Act of 2002, Pub. L. No. 107-296, 116 Stat. 2135.

57. “Celebrating the History of ICE,” note 56.

58. “Delegation of Immigration Authority Section 287(g) Immigration and Nationality Act,” *U.S. Immigration and Customs Enforcement* (10 Aug. 2018), <https://perma.cc/92TD-J7MB>; Kate Wheeling, *What Happens When Local Police Get Involved in Immigration Enforcement*, *Pacific Standard* (28 Mar. 2017), <https://perma.cc/8XRA-34VZ>.

59. See Scott D. Rhodes et al., “The Impact of Local Immigration Enforcement Policies on the Health of Immigrant Hispanics/Latinos in the United States,” 105 *American Journal of Public Health* 329, 329 (2015) (discussing the interplay of these two programs); “Delegation of Immigration Authority,” note 58. Currently, ICE has 287(g) agreements with seventy-eight law enforcement agencies in eighteen states. *Id.* ICE has trained and certified more than 1,514 state and local officers to enforce immigration law. *Id.* For additional discussion, see Alia Al-Khatib, “Putting A Hold on Ice: Why Law Enforcement Should Refuse to Honor Immigration Detainers,” 64 *American University Law Review* 109, 124-30 (2014).

60. 8 U.S.C. § 1357(g).

61. See 8 U.S.C. § 1644 (2012); “Secure Communities,” *U.S. Immigration & Customs Enforcement* (last updated 20 Mar. 2018), <https://perma.cc/MG72-HNR7> (noting that in January 2013, “ICE completed full implementation of Secure Communities to all 3,181 jurisdictions within 50 states, the District of Columbia, and five U.S. Territories”).

62. “Secure Communities,” note 61 (“Under Secure Communities, the FBI automatically sends the fingerprints to DHS to check against its immigration databases. If these checks reveal that an individual is unlawfully present in the United States or otherwise removable, ICE takes enforcement action[.]”).

63. See notes 64-65 and accompanying text.

undocumented immigrants both from Medicaid and ACA exchanges—even if the undocumented immigrant can pay for coverage themselves.⁶⁴ In 2015, the Obama administration threatened to cut coverage for over 300,000 immigrants who failed to provide proof of citizenship.⁶⁵ While the Trump administration has signaled new concerns regarding Medicaid provisions and eligibility, frustrations within the immigrant community are not new.

B. Trump Administration Medicaid Overhauls

Most recently, the Trump administration has demonstrated a significant willingness to dramatically reform Medicaid. By drastically reducing spending and enrollment-aid efforts, the Trump administration has targeted populations that benefitted from the ACA Medicaid expansion.⁶⁶ Most notably, the administration has favored imposing work requirements as a condition for eligibility. In January 2018, the Centers for Medicare and Medicaid Services (CMS)—the federal agency that administers a number of health-care programs—issued a State Medicaid Director letter providing sub-regulatory policy guidance to states seeking to impose work requirements.⁶⁷ As of April 2019, CMS has approved such work requirements in nine states: Arizona, Arkansas, Indiana, Kentucky, Michigan, New Hampshire, Ohio, Utah, and Wisconsin.⁶⁸ According to the Kaiser Family Foundation, if all fifty states were to adopt such work requirements, up to four million Americans would potentially lose access to Medicaid.⁶⁹ While not all

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64. See 42 U.S.C. § 18082(d) (2012) (describing that in order to be eligible for a health plan through a marketplace offered under the Act or to claim tax credits, an individual must be “a citizen or national of the United States or . . . lawfully present in the United States.”). Even after gaining legal permanent resident status, immigrants are barred from accessing Medicaid for the first five years that they are in the United States. See Shawn Fredmstad & Laura Cox, Kaiser Commission on Medicaid & the Uninsured, *Covering New Americans: A Review of Federal and State Policies Related to Immigrants’ Eligibility and Access to Publicly Funded Health Insurance*, <https://perma.cc/2HTL-MV3G>.
65. “HHS to Consumers: Your Marketplace Health Insurance May End,” *The Washington Post*, <http://apps.washingtonpost.com/g/page/national/hhs-to-consumers-your-marketplace-health-insurance-may-end/1250/> (providing a copy of the HHS letter that requests documentation of citizenship or immigration status); Amy Goldstein, “Administration Warns Some Could Lose Health-care Coverage on Federal Exchange,” *The Washington Post* (12 Aug. 2014), <https://perma.cc/2YZT-BAKR>.
66. Congress repeatedly tried and failed to repeal the Affordable Care Act. Alternatively, Congress has tried to undermine Medicaid expansion packaged with the ACA. See “Sabotage Watch: Tracking Efforts to Undermine the ACA,” *Center on Budget and Policy Priorities* (last updated 28 Jan. 2019), <https://perma.cc/H7W4-RQC3>.
67. Letter from Brian Neale, Director, “Centers for Medicare and Medicaid Services, to State Medicaid Directors” (11 Jan. 2018), <https://perma.cc/DA5Q-Y9AL> (“Subject to the full federal review process, CMS will support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects authorized under section 1115 of the Social Security Act (the Act).”).
68. “Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State,” *Kaiser Family Foundation* (23 Jan. 2019), <https://perma.cc/5BVF-92AE> (approved programs in Arkansas and Kentucky have been set aside by a court).
69. Rachel Garfield et al., “Implications of a Medicaid Work Requirement: National Estimates of

states have demonstrated interest in adopting work requirements, Republican members of Congress have emphasized that states should implement work requirements, even introducing legislation that would implement such requirements at a federal level.⁷⁰

In October 2018, the Trump administration proposed a hotly contested change to existing “public charge” policies.⁷¹ Under current law, an immigrant is deemed a public charge, and thus denied green card status, if an immigration official determines they are likely to primarily rely on the government for support. However, currently, Medicaid can only be used as evidence of public charge status when used to pay for long-term institutional care. The proposed rule would radically expand the extent to which an immigrant’s potential use or even past use of public benefits could be used against them.⁷² Under the proposed rule, if officials find that an immigrant has a high likelihood of using Medicaid, food stamps, or housing programs, they could use that fact against them. Advocates highlight that this proposal has a “chilling effect” on immigrants’ use of social services.⁷³ Families may be unwilling to use Medicaid or food stamps out of fear of being denied legal permanent resident status.⁷⁴ The proposal is particularly relevant to this Article’s discussion of CHIP because states may administer CHIP as a program separate from Medicaid or use CHIP funds to expand their Medicaid program’s coverage of children. In emphasizing the potential drastic effects of this rule, one health care policy expert observed: “It’s unclear what would happen to beneficiaries in states that have opted to implement CHIP as part of a Medicaid

Potential Coverage Losses,” *Kaiser Family Foundation* (27 June 2018), <https://perma.cc/SS7G-RRBX> (“Overall, among the 23.5 million non-SSI, non-dual, nonelderly Medicaid adults, disenrollment ranges from 1.4 million to 4.0 million[.]”).

70. See e.g. “Medicaid Reform and Personal Responsibility Act of 2017,” Senate Bill 1150, 115th Congress (2017), <https://perma.cc/L5JY-NGCY>.
71. “Inadmissibility on Public Charge Grounds,” 83 *Federal Register* 196 (proposed 10 Oct. 2018), <https://perma.cc/G6MS-MTLV> (“DHS seeks to better ensure that aliens subject to the public charge inadmissibility ground are self-sufficient, i.e., do not depend on public resources to meet their needs, but rather rely on their own capabilities, as well as the resources of family members, sponsors, and private organizations.”). In 1996, IIRRA amended the public-charge language. Under IIRRA, immigration officials consider a “totality of the circumstances,” including age, family status, health, educational and work skills, and financial status. See “Illegal Immigration Reform and Immigrant Responsibility Act of 1996,” Pub. L. 104-208, Criminal Division, § 1(a), 110 Stat. 3009-546 (codified as amended at 8 U.S.C. § 1101(a)(13)).
72. See “Inadmissibility on Public Charge Grounds,” note 71.
73. See e.g. Jeanne Batalova et al., “Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families’ Public Benefits Use,” *Migration Policy Institute* (June 2018), <https://perma.cc/WR9R-CLD4> (analyzing data on use of public benefits among noncitizens and naturalized citizens to assess the potential magnitude of the proposed rule’s effects on immigrant communities).
74. Lisa Schencker, “Illinois Doctors Say Trump Immigration Proposal Already Scaring Away Patients,” *Chicago Tribune* (2 Dec. 2018), <https://www.chicagotribune.com/business/ct-biz-immigration-proposal-scaring-people-from-medicaid-1202-story.html> (detailing critiques from the Illinois Coalition for Immigrant and Refugee Rights, Sergeant Shriver National Center on Poverty Law, and the Illinois chapter of the American Academy of Pediatrics’ Refugee Immigrant Child Rights Initiative).

expansion rather than a separate program.”⁷⁵ Although more than half of CHIP beneficiaries are covered through Medicaid expansion programs, CMS’s policy-guidance letter does not address whether children using CHIP under their parent or their parent’s pending legal permanent resident status would be subject to scrutiny under the “public charge” requirements.⁷⁶

C. New Concerns: The Trump Administration and Clinic Safety Perceptions

While concerning policies directed at immigrant health and safety are not new, the Trump administration’s aggressive policy of detaining undocumented immigrants poses significant challenges for health-care providers who serve immigrant communities. *The New York Times* explored these challenges in central North Carolina. For several years, Dr. Evan Ashkin, a professor of family medicine at the University of North Carolina, has served and supported uninsured immigrant patients.⁷⁷ Yet, recently, he found that a longtime patient experiencing first-trimester bleeding refused to seek an ultrasound out of fear “that immigration agents might be waiting.”⁷⁸ For decades, clinics serving immigrant communities were safe havens, in that they were unlikely targets for immigration enforcement. After the 2016 election, perceptions shifted and new anxieties regarding potential ICE activity has prevented some undocumented immigrants from seeking care.⁷⁹ Fortunately, the patient’s bleeding stopped, but these concerns remain.

Anecdotal evidence suggests that immigrant patients nationwide are fearful.⁸⁰ One doctor in Philadelphia heard about “some families and patients who are concerned about coming to [the community health center]” and noticed “a rumor circulating that [his] organization had given out information to (Immigration and Customs Enforcement) agents,” which was concerning.⁸¹ Clinic operators in Texas and Oregon echoed his concerns, with Carlos Olivares, CEO of an organization that operates a health facility in a Latinx community near Portland, observing: “Our no-show ratios increased, and we experienced a tremendous amount of phone calls and expressions of concern from patients.”⁸² Even in states perceived to be less impacted by Latinx immigration, clinic operators agree with this trend.⁸³ Throughout the country, stories detail the fear

75. Sara Rosenbaum, “A New ‘Public Charge’ Rule Affecting Immigrants Has Major Implications for Medicaid,” *The Commonwealth Fund* (16 Oct. 2018), <https://perma.cc/GY8R-DMZC>.

76. See *id.*

77. Jan Hoffman, “Sick and Afraid, Some Immigrants Forgo Medical Care,” *The New York Times* (26 June 2017), <https://perma.cc/PYL5-Y356>.

78. *Id.*

79. *Id.*

80. Harris Meyer, “Tougher Immigration Enforcement is Taking a Toll on Healthcare,” *Modern Healthcare* (21 Apr. 2017), <https://perma.cc/JKN7-4BH7>.

81. *Id.*

82. *Id.*

83. See e.g. John. S. Luque et al., “Access to Health Care for Uninsured Latina Immigrants in

immigrant communities face in seeking health care.⁸⁴

Inconsistent enforcement of ICE's "sensitive location" policy has also stirred anxiety. This policy, which remains in effect on ICE's website, instructs agents to generally avoid immigration enforcement actions at sensitive locations,⁸⁵ including schools, hospitals, and places of worship.⁸⁶ Hospitals include "[m]edical treatment and healthcare facilities, such as hospitals, doctors' offices, accredited health clinics, and emergent or urgent care facilities."⁸⁷ A 2011 ICE memo provides additional details:

Supervisors should take extra care when assessing whether a planned enforcement action could reasonably be viewed as causing significant disruption to the normal operations of the sensitive location. ICE employees should also exercise caution. For example, particular care should be exercised with any organization assisting children, pregnant women, victims of crime or abuse, or individuals with significant mental or physical disabilities.⁸⁸

ICE generally avoids enforcement at sensitive locations, but such enforcement may occur in limited circumstances.⁸⁹ "ICE officers and agents may conduct an enforcement action at a sensitive location if there are exigent

South Carolina," 18 *BMC Health Services Research* 310 (2018), <https://perma.cc/5P47-GBRZ>; Alexia Elejalde-Ruiz, "Fear, Anxiety, Apprehension: Immigrants Fear Doctor Visits Could Leave them Vulnerable to Deportation," *Chicago Tribune* (22 Feb. 2018), <https://www.chicagotribune.com/business/ct-biz-immigration-fears-hurt-health-care-access-0225-story.html> (noting health-care challenges undocumented immigrants face in Chicago); Ruben Castaneda, "Health Care Workers Deploy Creative Strategies to Calm Terrified Immigrant Patients," *U.S. News* (16 Nov. 2017), <https://health.usnews.com/wellness/family/articles/2017-11-16/health-care-workers-deploy-creative-strategies-to-calm-terrified-immigrant-patients> (detailing anxieties for undocumented immigrant communities in Oregon).

84. See e.g. Claudia Boyd-Barrett, "Fear Pushes More Immigrants to Avoid Seeking Medical Care," *California Health Report* (5 Feb. 2018), <https://perma.cc/VB9S-3A6C>; Rebecca Adams, "Immigration Crackdown Raises Fears of Seeking Health Care," *Roll Call* (25 Jan. 2018), <https://perma.cc/5K7B-CVYS>. For additional discussion, see generally Karen Hacker et al., "Provider's Perspectives on the Impact of Immigration and Customs Enforcement (ICE) Activity on Immigrant Health," 23 *Journal of Health Care for the Poor & Underserved* 651 (2013).
85. "FAQ on Sensitive Locations and Courthouse Arrests," *U.S. Immigration & Customs Enforcement* (25 Sept. 2018), <https://perma.cc/CY47-7TKT> (explaining that schools include "pre-schooling, primary schools, secondary schools, post-secondary schools up to and including colleges and universities, and other institutions of learning such as vocational and trade schools" and that places of worship include "churches, synagogues, mosques or other institutions of worship, such as buildings rented for the purpose of religious services"); see also John Morton, "Enforcement Actions at or Focused on Sensitive Locations," *Memorandum from Director of U.S. Immigration & Customs Enforcement* (24 Oct. 2011), <https://perma.cc/JX8U-8B8G>; David Aguilar, "Enforcement Actions at or Near Certain Community Locations," *Memorandum from Deputy Commissioner, U.S. Customs & Border Protection* (18 Jan. 2013), <https://perma.cc/675R-8JQL>.
86. "FAQ on Sensitive Locations and Courthouse Arrests," note 85.
87. *Id.*
88. Memorandum from John Morton, note 85.
89. "FAQ on Sensitive Locations and Courthouse Arrests," note 85.

circumstances, if other law enforcement actions have led officers to a sensitive location, or with prior approval from an appropriate supervisory official.”⁹⁰ Yet, considering patient recollections, ICE appears to be breaking its own rules.⁹¹ And the reproductive health community became alert to sensitive location enforcement after a ten-year-old girl in Texas was taken into custody by border patrol officials following an emergency surgery.⁹² Advocates and health-care providers remain concerned about ICE’s interactions with sensitive locations.

ICE has also been inconsistent regarding its policy of de-prioritizing detainment and arrest of pregnant women.⁹³ Relying on the August 2016 ICE policy memo, DHS’s Advisory Committee on Family Residential Centers recommended that pregnant women should not be detained in family detention centers.⁹⁴ The 2016 policy addressing this issue requires that ICE not detain pregnant women unless the mandatory detention statute applies or “extraordinary circumstances” exist. Recently, advocate groups jointly filed a complaint on behalf of numerous women who are or were pregnant and detained by ICE.⁹⁵ In

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90. See generally “Sensitive Location FAQs,” *U.S. Customs & Border Protection* (22 Aug. 2016), <https://perma.cc/3S7Y-4TP6> (describing how sensitive locations policies, which remain in effect, provide that enforcement actions at sensitive locations should generally be avoided).
91. See Bill Ong Hing, “Entering the Trump Ice Age: Contextualizing the New Immigration Enforcement Regime,” 5 *Texas A&M Law Review* 253, 305-06 (2018) (addressing general changes with respect to enforcement activity at sensitive locations); John Burnett, “Border Patrol Arrests Parents While Infant Awaits Serious Operation,” *NPR* (20 Sept. 2017), <https://perma.cc/53QS-99AZ> (detailing an ICE arrest of parents in a Texas waiting room); Renee Gross, “ICE, Homeland Security Outreach Program Ignites Concern over Patient Information,” *Southern California Public Radio* (9 Aug. 2017), <https://perma.cc/EEX5-94CD> (reporting on critiques of a new DHS outreach program); Jorge Rivas, “Hospitals Now Have to Train to Keep ICE Agents Out of Their Buildings,” *Splinter* (6 April 2018), <https://perma.cc/E75R-6XF3> (detailing “ICE drills” in California); Senator Sheldon Whitehouse, “Whitehouse Calls for an Investigation into Immigration Arrest at Hospitals, Schools, and Churches,” *Press Release* (14 Nov. 2017), <https://perma.cc/6MLJ-D7YH> (calling for “an investigation into ongoing violations of federal policies regarding immigration enforcement at sensitive locations like schools, hospitals, and religious institutions”).
92. Shannon Dooling, “American Medical Association Takes Stance Against ICE Patrolling Inside Hospitals,” *WSHU Public Radio* (17 Nov. 2017), <https://perma.cc/4SVX-Y63Q>.
93. See notes 94-95 and accompanying text; see also Chantal Da Silva, “Ice Agents Detain Woman Despite ‘High-Risk’ Pregnancy and Deny Her Medication for Days, Immigration Lawyers Say,” *Newsweek* (21 Jan. 2019), <https://perma.cc/3UMD-53RR>.
94. “Report of the DHS Advisory Committee on Family Residential Standards,” *U.S. Department of Homeland Security* 9, 79, 113, 123 (30 Sept. 2016), <https://perma.cc/NM89-MTUB> (“In a memorandum to ICE Field Officers issued in August 2016, ICE explicitly states that if a pregnant detainee is not subject to mandatory detention or is eligible for parole following a positive credible fear interview, she will be released unless the Field Office Director determines that there are extraordinary circumstances. The ACFRC agrees that pregnant women should not be detained in the FRCs. This policy is consistent with the information provided by ICE.”).
95. “Letter from ACLU et al., to Cameron Quinn, Officer for Civil Rights and Civil Liberties, Department of Homeland Security, and John Roth, Inspector General, Department of Homeland Security, regarding U.S. Immigration & Customs Enforcement’s Detention and Treatment of Pregnant Women,” *American Civil Liberties Union* (26 Sept. 2017), <https://perma.cc/EFE8-Q77S> (“We are gravely concerned with the agency’s failure to abide by its own policy against detaining pregnant women, the detention conditions that have been reported by pregnant women in various detention facilities across the country, and the lack of

sum, the Trump administration's *priorities* run contrary to official *policies* and improperly burden individuals who may not be subject to the official policy.

III. CHIP MAY PROVIDE RELIEF FOR UNDOCUMENTED WOMEN IN CERTAIN STATES

Since the passage of Medicaid eligibility restrictions through PRWORA, access to reproductive health care for undocumented immigrants has been limited.⁹⁶ Undocumented immigrant women not only lack access to Medicaid but also face the fear that clinics may be subject to immigration enforcement activities. Too often, undocumented women must simply wait for conditions to worsen to seek emergency care or continue throughout pregnancies unaware of potential conditions. However, the State Children's Health Insurance Program (CHIP) may provide aid for undocumented women and, in effect, help secure immediate access to prenatal care.⁹⁷ This Part examines the disparities of prenatal care for undocumented women while exploring potential relief through CHIP.

Congress enacted CHIP as part of the Balanced Budget Act of 1997 as an attempt to expand health insurance to children through Title XXI.⁹⁸ Under CHIP, "targeted low-income children"—not their parents—are provided with health-care coverage.⁹⁹ Like Medicaid, CHIP is a federal-state partnership, allowing states to provide coverage beyond existing federal provisions.¹⁰⁰ State coverage is typically extended by creating a separate child health program, expanding eligibility for benefits under the state's Medicaid plan, or combining both approaches.¹⁰¹ The CHIP program helps uninsured children in families that earn incomes above the state-set eligibility ceilings for Medicaid.¹⁰² Thus, it helps fill the "gap of coverage" for low-income children.¹⁰³ In 2002, with momentum for health-care

quality medical care provided to women who are pregnant or have suffered miscarriages while in custody."). The American Immigration Council, America Immigration Lawyers Association, Women's Refugee Commission, RAICES, and other groups joined the ACLU.

96. See Part I; see also Kinsey Hasstedt et al., "Immigrant Women's Access to Sexual and Reproductive Health Coverage and Care in the United States," *The Commonwealth Fund*, 1 (Nov. 2018), <https://perma.cc/8ZCF-BWGB> ("Immigrant women are less likely to have coverage and use sexual and reproductive health services than U.S.-born women, which may increase their risk of negative outcomes."); see generally Leighton Ku & Sheetal Matani, "Left Out: Immigrants' Access to Health Care and Insurance," 20 *Health Affairs* 247 (2001), <https://perma.cc/EDX4-XADQ> (explaining that immigration status stifles health-care access).
97. Yet this policy would substantially advance fetal personhood arguments. See Part V.
98. State Children's Health Insurance Program, 42 U.S.C. § 1397ee(a) (2012); 42 U.S.C. § 1397jj(b) (2012).
99. *Id.*
100. "Medicaid and CHIP," *National Conference of State Legislatures*, <https://perma.cc/SQF5-G74N>.
101. State Children's Health Insurance Program, 42 U.S.C. § 1397aa(a) (2012).
102. "Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults," *Kaiser Family Foundation*, 1 (Mar. 2018), <https://perma.cc/QV4T-WAQB>.
103. See e.g. Lara Shore-Sheppard, "Medicaid and CHIP: Filling in the Gap of Children's Health Insurance Coverage," *EconoFact* (22 Jan. 2018), <https://perma.cc/E288-3WC5>.

reform building during Bush's first term, HHS secretary Tommy G. Thompson promised to "enable states to make immediate use of the extensive funding already available under CHIP to provide prenatal care for more low-income pregnant women and their babies."¹⁰⁴

The promised expansion of CHIP funds went into effect that same year and, with it, the Bush administration created a new pathway for undocumented women to secure prenatal care. Since 2002, states have had the option to provide health coverage, including prenatal care and delivery services, to unborn children through a state plan amendment.¹⁰⁵ The policy change addressed a coverage gap under then-existing law: "Babies who were born to low-income families would be eligible for CHIP upon birth, but their mothers might not have had adequate prenatal care because their family incomes were not low enough to qualify for Medicaid."¹⁰⁶ This new pathway was largely motivated by a desire to secure the health of unborn children, not their mothers.

Within the state plan amendment, mothers can claim pregnancy-related services or treatment for conditions that could complicate the pregnancy, including medical conditions, diagnoses, or illnesses that "might threaten" the health of the unborn child.¹⁰⁷ Postpartum care and other post-delivery services, to be conferred on the mother, are generally not covered within the state amendment plan.¹⁰⁸ In effect, the state amendment plan enables states to provide prenatal care to pregnant women, including those within Medicaid federal poverty gaps or those ineligible for Medicaid, in order to benefit an eligible unborn child.¹⁰⁹

Undocumented immigrants are not eligible for CHIP because the program is governed by PRWORA restrictions.¹¹⁰ However, CHIP allows pregnant undocumented people to access care through the treatment of their unborn child: a birth-right citizen who qualifies for CHIP benefits.¹¹¹ Rather than granting

104. See Cynthia Dailard, "New SCHIP Prenatal Care Rule Advances Fetal Rights at Low-Income Women's Expense," *Guttmacher Institute* (1 Dec. 2002), <https://perma.cc/HFL5-W68W> (quoting Secretary Tommy G. Thompson).

105. See "State Children's Health Insurance Program," 42 C.F.R. § 457 (2004).

106. Dailard, note 104. CHIP drew attention to pregnant women's lack of access to health care and several bipartisan bills sought to improve such access. Despite these efforts, however, pregnant women were not guaranteed access and low-income children "still lacked the healthiest possible start in life." *Id.*

107. See "State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children," 67 *Federal Register* 191, at 61,968 (2 Oct. 2002), <https://perma.cc/GC7Y-9GBW>.

108. See *id.* at 61,969.

109. See *id.* at 61,966-67 ("This regulation provides states with the flexibility to assure essential prenatal care to the maximum number of unborn children, regardless of the immigration status of their mothers.").

110. See *id.* at 61,966; see also *id.* at 61,956 ("In order to provide prenatal care and other health services, this final rule revises the definition of 'child' under the State Children's Health Insurance Program (SCHIP) to clarify that an unborn child may be considered a 'targeted low-income child' by the State."). See Part I for federal health plan exclusion criteria for immigrants.

111. U.S. Constitution Amendment XIV, § 1 ("All persons born or naturalized in the United States and subject to the jurisdiction thereof, are citizens of the United States."); see Diana O. Aguilar,

eligibility to non-qualified immigrant mothers, the federal scheme provides benefits to the “‘unborn children’ who will become citizens upon birth.”¹¹² Thus, CHIP applies to all unborn children—regardless of their mother’s immigration status. While attenuated, the CHIP framework was the first time that undocumented immigrants could meaningfully overcome the exclusivity of PRWORA in accessing previously unavailable prenatal care services.

CHIP requirements vary by state, but online resources can assist individuals in determining eligibility.¹¹³ Generally, household size and income level are determinative.¹¹⁴ In some cases, a low premium or other cost-sharing fees may apply.¹¹⁵ Parents should confirm eligibility requirements at a state CHIP office to determine if their unborn child qualifies.¹¹⁶

CHIP’s complexity can create barriers for policymakers seeking to provide undocumented populations with answers regarding their eligibility. As of March 2019, sixteen states have expanded coverage to “unborn persons” through the state plan amendment.¹¹⁷ Many pregnant women, however, may not know whether their state has adopted such a program. In order to meaningfully engage patient populations, states should conduct outreach and education programs. Expanding Title V toll-free hotlines, which already help individuals navigate Medicaid and CHIP eligibility, can help women successfully apply for services.¹¹⁸ Because undocumented immigrants are traditionally barred from social services, physicians working with undocumented populations are best situated to address the CHIP solution.¹¹⁹ Thus, if states seek to promote the use of CHIP,

“Using SCHIP to Offer Prenatal Care to Undocumented and Non-Qualified Immigrants in Wisconsin: The Benefits, Risks, and Shortcomings,” 20 *Wisconsin Women’s Law Journal* 263, 270 (2005) (“The child, automatically born a U.S. citizen, becomes eligible for all Medicaid-covered services if the family meets Medicaid’s income requirements.”); see also Beth A. Mandel, “Fighting for Fetal Rights at the Expense of Women’s Health: The Redefinition of ‘Child’ Under the State Children’s Health Insurance Program,” 73 *University of Cincinnati Law Review* 319, 339 (2004); see generally Elisabeth H. Sperow, “Redefining Child Under the State Children’s Health Insurance Program: Capable of Repetition, Yet Evading Results,” 12 *American University Journal of Gender, Social Policy & the Law* 137 (2004) (discussing the general judicial and legislative underpinnings of this regulation).

112. Aguilar, note 111, at 270 (noting that “[a] woman’s eligibility hinges on the ‘citizen fetus’ inside of her”).
113. See e.g. “Find Coverage for Your Family,” *Centers for Medicare & Medicaid Services* (last accessed 3 Apr. 2019), <https://perma.cc/E5NN-PCPG>.
114. “State Children’s Health Insurance Program,” *Benefits.gov* (last accessed 3 Apr. 2019), <https://www.benefits.gov/benefit/607>.
115. *Id.*
116. *Id.*
117. “Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults,” *Kaiser Family Foundation* (31 Mar. 2019), <https://perma.cc/QW79-3QSX>.
118. “Title V Maternal and Child Health Services Block Grant Program,” *Health Resource & Services Administration* (last reviewed Jan. 2019), <https://perma.cc/P7LB-C4VJ>.
119. Undocumented immigrants are generally excluded from means-tested benefits like SNAP, TANF, and SSI. Consequently, undocumented mothers may be unfamiliar with social workers or other individuals at state agencies who could help determine eligibility or offer support in navigating administrative barriers. See notes 27-31.

policymakers must ensure that patients are able to access physicians without significant barriers. In order to safeguard reproductive health in this context, states must be willing to recruit interpreters, minimize anti-immigrant rhetoric, address barriers to care in rural communities, support Medicaid funding, and create bilingual information materials.

IV. USING THE CHIP EXCEPTION TO SECURE PRENATAL CARE MAY ADVANCE FETAL PERSONHOOD AND UNDERMINE ACCESS TO OTHER REPRODUCTIVE RIGHTS

Using CHIP to expand access to prenatal care may compromise reproductive justice in other settings. Because the CHIP exception potentially advances fetal personhood arguments, its framework provides a potential challenge to *Roe v. Wade*. While *Roe* affirmed the right to an abortion, its use of the trimester framework has fallen away.¹²⁰ This Part details how the CHIP exception can be critiqued as supporting anti-choice arguments for fetal personhood. Potential anti-choice challenges before the Supreme Court—hinging on the federal personhood argument—are also detailed in this Part. Lastly, this Part explains how fetal-protection laws advance personhood for the fetus at the mother’s expense. Thus, CHIP’s exception not only disrupts the continuity of care for the mother but also aggravates questions of duty between physician and patient.

A. Fetal Protection Laws: How States Changed the Reproductive Landscape

Fetal protection laws have largely emerged from landmark Supreme Court abortion decisions. The Supreme Court held in *Roe v. Wade* that a Texas statute criminalizing abortions was unconstitutional.¹²¹ While the right to terminate or continue a pregnancy was a privacy right within the “penumbra” of the Fourteenth Amendment, the right was not “absolute.”¹²² The Court created a trimester framework, balancing the mother’s right to privacy with the state’s interest in protecting the lives of both the mother and fetus, and determined that a woman holds her privacy right until the point of viability for the fetus.¹²³ Thus, the point of fetal viability became the dividing line between state interference and individual privacy.¹²⁴ Within *Roe*, fetal personhood as a concept had little grounding, as the Court conferred legal rights to only those viable.¹²⁵

120. See *Planned Parenthood of Southeast Pennsylvania v. Casey*, 505 U.S. 833, 877 (1992) (adopting an undue burden framework and replacing the third trimester with viability of the fetus as the dividing line between when abortion is and is not unconstitutional).

121. See *Roe v. Wade*, 410 U.S. 113, 164 (1973).

122. *Id.* at 129, 153.

123. *Id.* at 164-65.

124. *Id.* at 164.

125. *Id.* at 156-57 (“If this suggestion of personhood is established, the . . . case, of course, collapses, for the fetus’ right to life would then be guaranteed specifically by the [Fourteenth] Amendment.”).

The Court has shifted from the trimester framework, amplifying the tensions between individual privacy and state interests. In *Planned Parenthood v. Casey*, the Court held that women have the right to “choose to have an abortion before viability and to obtain it without undue interference from the State.”¹²⁶ Adopting the “undue burden” framework, the Court described that “the [state’s] . . . interest in potential life must be calculated to inform the woman’s free choice, not hinder it.”¹²⁷ *Casey* reaffirmed women’s liberty interests in securing abortions, yet legitimized the state’s interest in protecting both the health of the fetus “from the outset of the pregnancy.”¹²⁸ Although the interests of the fetus could not “override” that of the mother pre-viability, this shift in language may have potentially implicated later fetal personhood arguments.

This small shift in pregnancy interests was only magnified in *Gonzalez v. Carhart*.¹²⁹ The federal Partial Birth Abortion Ban Act of 2003 prohibited practitioners from “knowingly perform[ing] a partial-birth abortion . . . that is [not] necessary to save the life of a mother.”¹³⁰ Writing that the “medical uncertainty” surrounding these abortion procedures justified the federal restriction as reasonable, and not an undue burden, *Gonzalez* emphasized states’ rights to promote the “respect of human life.”¹³¹ As scholars have noted, such language radically strengthened arguments for fetal personhood laws; the Partial Birth Abortion Ban Act, according to the Court, applied to “both pre-viability and post-viability because . . . a fetus is a living organism while within the womb, whether or not it is viable outside the womb.”¹³² Throughout the years, *Roe*’s trimester viability framework has fallen away. In its place, a new gradient has emerged for fetal protection, permitting states to create new pathways to scrutinize reproduction.

Seeing potential pathways to challenge *Roe*, anti-choice groups have seized numerous opportunities to expand fetal protection laws, ultimately trying to “personify” the fetus. Anti-choice groups have heavily lobbied for fetal protection laws throughout the country.¹³³ Numerous state legislatures have passed fetal homicide laws, which provide a pathway to scrutinize a mother’s actions throughout the entirety of the pregnancy.¹³⁴ While fetal personhood laws may, on

126. *Casey*, 505 U.S. at 846.

127. *Id.* at 877.

128. *Id.* at 846.

129. *Gonzalez v. Carhart*, 550 U.S. 124 (2007).

130. P.L. 108-105, 117 Stat. 1201 (5 Nov. 2003).

131. *Gonzalez*, 550 U.S. at 159, 166-67.

132. *Id.* at 186; see generally Bernice Bird, “Fetal Personhood Laws as Limits to Maternal Personhood at Any Stage of Pregnancy: Balancing Fetal and Maternal Interests at Post-Viability among Fetal Pain and Fetal Homicide Laws,” 25 *Hastings Women’s Law Journal* 39 (2014) (describing this evolution of fetal personhood within the Court and how *Gonzalez* expanded the definition, which thereafter influenced state policy).

133. See Olga Khazan, “Planning the End of Abortion,” *The Atlantic* (15 July 2015), <https://perma.cc/LKZ8-83DY> (“State legislatures have enacted a slew of abortion restrictions in recent years. Americans United for Life wrote most of them.”).

134. “State Laws on Fetal Homicide and Penalty-Enhancement for Crimes Against Pregnant

their face, appear to also protect the life of the mother, these laws, in effect, curb privacy rights and reproductive concerns.

Scholars have noted that fetal homicide laws serve to wholly protect fetal life, rather than both the life of the fetus and the mother, and allow prosecution of any person responsible for fetal death, including the mother.¹³⁵ Fetal protection laws can treat the mother and fetus as separate—potentially antagonistic—entities.¹³⁶ States have criminalized the harming of a fetus in homicide statutes, which are then reinforced through judicial application.¹³⁷ For example, Missouri statutes protects children from the moment of conception.¹³⁸ Accordingly, in *State v. Holcomb*, a Missouri court found that the “killing of a pre-born infant” was within the scope of the state’s first-degree murder statute.¹³⁹ Yet, Missouri is not alone in its conception of fetal personhood.¹⁴⁰ In Louisiana, a “person” is “a human being from the moment of fertilization and implantation” and an “unborn child” is “any individual of the human species from fertilization and implantation until birth.”¹⁴¹ While such criminal prosecutions may garner sympathy from the public, the codified language appears to directly conflict with *Roe*.¹⁴²

Fetal protection laws also criminalize drug use among pregnant women. Under laws prohibiting the delivery of drugs to minors, prosecutors may contend that when pregnant women use drugs, the infant receives those narcotics through the umbilical cord, in violation of the law.¹⁴³ Once again, these violations may garner sympathetic public attention. Research has shown that prenatal exposure to

Women,” *National Conference State Legislatures* (1 May 2018), <https://perma.cc/2HRL-EXMG>.

135. Bird, note 132, at 40.

136. Dawn E. Johnsen, “The Creation of Fetal Rights: Conflicts with Women’s Constitutional Rights to Liberty, Privacy, and Equal Protection,” 95 *Yale Law Journal* 599, 613 (1986) (“Allowing the state to control women’s actions in the name of fetal rights . . . reflects a view of the fetus as an entity separate from the pregnant woman, with interests that are hostile to her interests.”); Janet Gallagher, “Prenatal Invasions & Interventions: What’s Wrong with Fetal Rights,” 10 *Harvard Women’s Law Journal* 9 (1987) (“The claims for legal status for the unborn are based upon scattered case and statutory law which arguably grant implicit legal recognition to fetuses.”); Linda C. Fentiman, “Pursuing the Perfect Mother: Why America’s Criminalization of Maternal Substance Abuse is Not the Answer—A Comparative Legal Analysis,” 15 *Michigan Journal of Gender & Law* 389, 411-19 (2009) (examining research on the history of prosecutions that separate the fetus from the pregnant mother).

137. See “State Laws on Fetal Homicide,” note 134; Aaron Wagner, “Texas Two-Step: Serving up Fetal Rights by Side-Stepping *Roe v. Wade* Has Set the Table for Another Showdown on Fetal Personhood in Texas and Beyond,” 32 *Texas Technology Law Review* 1085, 1100-05 (2001).

138. “Life Begins at Conception – Unborn Child Defined,” *Missouri Annotated Statutes* § 1.205 (1), (2) (2005) (providing that “(1) [t]he life of each human being begins at conception; [and] (2) [u]nborn children have protectable interests in life, health, and well-being”).

139. See *State v. Holcomb*, 956 S.W.2d 286, 292 (Missouri Court of Appeals 1997).

140. See e.g. “Louisiana Criminal Law,” *Louisiana Statutes Annotated* § 14:2(7), (11) (2016).

141. *Id.*

142. See *Roe*, 410 U.S. at 156-57 (“If this suggestion of personhood is established, the . . . case, of course, collapses, for the fetus’ right to life would then be guaranteed specifically by the [Fourteenth] Amendment.”).

143. See e.g. *Johnson v. State*, 578 So.2d 419, 419 (District Court of Appeal of Florida, Fifth District 1990).

drugs can cause various injuries to the unborn child, including increased infant mortality, lower birth weight, and fetal alcohol syndrome.¹⁴⁴ However, an argument for rehabilitation and treatment can be made. But rather than addressing the biopsychosocial roots of addiction, the state has created a criminal pathway to purportedly protect against fetal harm. Fetal protection laws encourage scrutiny of a mother's behavior rather than robust policy development that supports families.

B. Who is the Person Before Us?

Legal personhood has become a political battleground for activists and legislators. Repeatedly, there are attempts at the federal and state levels to confer personhood to fetuses. At the same time, repeated arrests of pregnant women and new mothers receive little sympathy, leaving "bad mothers" subject to state control and punishment.¹⁴⁵ By focusing attacks on unpopular women, anti-choice advocates have curtailed women's access to health services while promoting fetal health.¹⁴⁶ When the state chooses to award health benefits to a fetus rather than a woman in need, it raises a host of questions. Under what circumstances and justifications does the state award these protections and benefits? What constitutes health? Are fetal health efforts actually about the health of the fetus?

Human reproduction does not happen in a vacuum; reproduction occurs subject to social forces and cultural norms that shape the perceptions of reproduction.¹⁴⁷ While abortion has certainly been analyzed in the context of privacy, the circumstances of reproduction often depend upon external public forces. For example, society determines whether a woman may access health care or an abortion.¹⁴⁸ And once a child is born, "[s]ocial relations determine who cares for a child . . . and what resources, rewards, and penalties, carry in the process of nurturing human life."¹⁴⁹ In the context of analyzing fetal health, "it becomes possible to reason about regulating women's conduct without seeming to reason about women at all."¹⁵⁰ Consequently, it is essential to center the mother when discussing policies that potentially promote fetal health.¹⁵¹

Similarly, motherhood has been viewed as an ideology. Society endeavors to justify the status quo; thus, "ideology reflects the preferences of, and operates to serve the interests of, a particular group."¹⁵² Motherhood, then, is not only a

144. See Page McGuire Linden, "Drug Addiction During Pregnancy: A Call for Increased Social Responsibility," 4 *American University Journal of Gender & Law* 105, 107-08 (1995).

145. See Lynn M. Paltrow, "Pregnant Drug Users, Fetal Persons, and the Threat to *Roe v. Wade*," 62 *Albany Law Review* 999, 1002-03 (1999).

146. *Id.* at 1004-05.

147. See Reva Siegel, "Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection," 44 *Stanford Law Review* 261, 267 (1992).

148. *Id.*

149. *Id.*

150. *Id.* at 333.

151. See Part I.C. and Part III (discussing benefits of providing reproductive health care to mothers and how undocumented immigrants especially benefit from prenatal care).

152. April L. Cherry, "Shifting Our Focus from Retribution to Social Justice: An Alternative

biological grant in American culture but also a status reinforced by beliefs and expectations. “Good mothers” are “altruistic”; they serve, care for, and responsibly prioritize their children.¹⁵³ “Bad mothers” place their needs before their children and thus require regulating.¹⁵⁴ Because policy drafting and implementation is suspect to favoring the status quo, potential advocates for expanded reproductive health policies must address whether additional protections are truly inclusive or simply reinforce certain social ideologies.

Many women do not have the luxury of accessing prenatal care without fear. In analyzing border communities in the Rio Grande, one scholar found that public transportation is almost non-existent.¹⁵⁵ And lodging costs compound expenses. When forced to choose “between paying for these expenses and otherwise providing for themselves and their families,” women tend to sacrifice necessary health care.¹⁵⁶ Expanding CHIP for undocumented women is only effective if undocumented immigrants can actually safely access services. Conferring prenatal benefits without granting protections in accessing those benefits leaves women vulnerable. If a mother makes the choice to forgo care in order to otherwise protect herself or her family, she is likely to be cast as a “bad mother.” Yet when a woman is unable to secure health-care services, the fetus may suffer health consequences. Ultimately, when women cannot access health care, fetuses face harm. This stands in direct opposition to the apparent goals for advancing fetal personhood.

While expanding CHIP to increase access to prenatal care is admirable, it is striking that the law only secures care for the “person” inside the “alien.” CHIP allows state plan amendments to extend care to the fetus as an “unborn person,” while maintaining that the mother is “illegal” or an “alien,” and thus ineligible for care. Keith Cunningham-Parmeter wrote an excellent article on the prevailing legal metaphors for immigrants, examining the social and legal consequences of their use.¹⁵⁷ Cunningham-Parmeter details how some immigration reform proposals focus on the need to create a “more manageable and controlled flow” of

Vision for the Treatment of Pregnant Women Who Harm Their Fetuses,” 28 *Journal of Law & Health* 6, 39-40 (2015) (“Motherhood is a hegemonic ideology. . . . A hegemonic ideology, then, is one that reflects the biases of and serves to protect the advantages had by the dominant political or cultural group.”).

153. Id.

154. See id. at 39-41. Assigning and assessing characteristics of motherhood has long been engrained in our society. See e.g. *Bradwell v. People of State of Illinois*, 83 U.S. 130, 142 (1872) (“The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life. . . . The paramount destiny and mission of women are to fulfill the noble and benign offices of wife and mother.”); see generally Melissa Murray, “The Networked Family: Reframing the Legal Understanding of Caregiving and Caregivers,” 94 *Virginia Law Review* 385 (2008) (discussing the legal constructs of family caregiving).

155. See Madeline M. Gomez, “Intersections at the Border: Immigration Enforcement, Reproductive Oppression, and the Policing of Latina Bodies in the Rio Grande Valley,” 30 *Columbia Journal of Gender & Law* 84, 105-06 (2015).

156. Id.

157. See generally Keith Cunningham-Parmeter, “Alien Language: Immigration Metaphors and the Jurisprudence of Otherness,” 79 *Fordham Law Review* 1545 (2011).

legal immigrants who can assimilate to the economy, as opposed to a flood of unwanted individuals.¹⁵⁸ Words matter. As Dean Carolina Nuñez explains, “[i]t is much more palatable to deny rights to an ‘alien’ than it is to deny rights to a ‘person.’”¹⁵⁹ Continuously, the Trump administration has signified that undocumented immigrants will be treated as illegal aliens and prosecuted regardless of past criminal records.¹⁶⁰ Such criminalization is not new.¹⁶¹ But the Trump administration’s overt framing of immigrants as criminals and its zero-tolerance policy exacerbates negative stereotypes of undocumented immigrants in an unprecedented manner, vilifying not only their immigration status but also questioning their personhood.¹⁶² While the CHIP exception may provide an immediate solution for expanding prenatal care, adopting its framework for undocumented immigrants may actually impede the securing of health and safety for communities.

C. Expanding CHIP May Come with Greater Costs

The CHIP policy creates “significant medical and political implications” for pregnant women.¹⁶³ Advocacy groups took immediate issue with the conferral of benefits to the unborn fetus rather than the carrying mother.¹⁶⁴ By directly

158. *Id.* at 1587-88.

159. See D. Carolina Nuñez, “War of the Words: Aliens, Immigrants, Citizens, and the Language of Exclusion,” 2013 *B.Y.U. Law Review* 1517, 1555 (2013).

160. See e.g. @realDonaldTrump, *Twitter* (20 Jan. 2018), <https://perma.cc/LW29-VLTN> (“Democrats are far more concerned with Illegal Immigrants than they are with our great Military or Safety at our dangerous Southern Border.”); “President Donald J. Trump is Acting to Enforce the Law, While Keeping Families Together,” *The White House* (20 June 2018), <https://perma.cc/5CZF-ULHN> (“President Donald J. Trump is using his existing executive authority to address family separation of illegal alien border-crossers.”); Julia Manchester, “Trump: US does not listen to countries on immigration,” *The Hill* (8 Dec. 2017), <https://perma.cc/QL2M-9S9Q> (“One by one we are finding the illegal alien drug dealers, the gang members, the thieves, the criminals and the killers preying on our children, preying on everybody, and we are throwing them the hell out of our country or we are putting them in prison.”) (quoting President Trump).

161. See Karen C. Tumlin, “Suspect First: How Terrorism Policy Is Reshaping Immigration Policy,” 92 *California Law Review* 1173, 1184-203 (2004) (noting that after September 11, 2002, the Department of Homeland Security—the agency created to conduct anti-terrorism policy—also assumed responsibility for immigration and contributed to framing immigrants as inherently “suspect”); César Cuauhtémoc García Hernández, “Deconstructing Crimmigration,” 52 *UC Davis Law Review* 197, 200-13 (tracing the convergence of criminal law and immigration beginning in the 1980s and continuing through the Obama and Trump administrations).

162. See “The Trump Administration’s ‘Zero-Tolerance’ Immigration Enforcement Policy,” *Congressional Research Service Report*, 1-7 (26 Feb. 2019) (explaining that the Trump administration instituted the novel policy of prosecuting *all* adult aliens apprehended crossing the border without inspection, with no exception for asylum seekers or those with minor children), <https://perma.cc/7U5J-BGMM>; Linda Qiu, “Explaining Trump’s Tweets on Crimes by Immigrants,” *The New York Times* (12 Jan. 2019) (fact-checking Trump tweets that greatly inflated the rate of crimes committed by undocumented immigrants), <https://perma.cc/SH4J-B7VG>.

163. Dailard, note 104.

164. See e.g. “ACLU Comments on State Children’s Health Program: Eligibility for Prenatal Care

conferring federal benefits upon an “unborn child,” the Bush administration injected abortion politics into the debate surrounding prenatal care services.¹⁶⁵ Similar instances of balancing public health and criminalization of maternal behaviors demonstrate the potential risks of conferring fetal benefits.

Related legal realms demonstrate the regulation of women’s bodies subject to the health needs of the fetus. Efforts to advance fetal protections often arise through two forms: the first type of initiative threatens to limit women’s ability to participate in the workforce by criminalizing risky behavior before or during pregnancy, and the second type redefines the fetus as a person.¹⁶⁶ In both instances, women’s privacy and bodily integrity are undermined. Recent interventions, such as criminal prosecutions of pregnant mothers for drug use, are framed as necessary to protect fetuses from harm and therefore to prevent a public health crisis.¹⁶⁷ The health and welfare of children and fetuses alike is a legitimate public health concern, yet expanded use of punitive responses against mothers provokes skepticism for the means chosen to address health concerns.¹⁶⁸ When child welfare policies are shaped to place the fetus’s health interests above the mother’s, individuals and families face increased state scrutiny of maternal behaviors throughout pregnancy.

The CHIP exception can be critiqued as bad public health policy in this light. Confusion about eligibility requirements and/or fear that health-care providers or government insurance programs will report undocumented individuals to enforcement authorities deter many immigrants from seeking government-supported health care for which they or their children are eligible.¹⁶⁹ HHS has expressly stated that pregnant women are not entitled to coverage for any care after

for Unborn Children,” *American Civil Liberties Union* (May 2002) (letter from Laura W. Murphy, Director of ACLU Washington National Office, et al. to Thomas Scully, Administrator of the Centers for Medicare & Medicaid Services), <https://perma.cc/Z6JP-WA4V>.

165. Dailard, note 104, at 2 (noting that “[a]lthough the rule on its face does not change the status of legal abortion, any challenge to *Roe v. Wade* that reaches the Supreme Court will . . . contend that an evolving legal trend recognizes fetuses as persons . . . [T]his new SCHIP rule will be an essential piece of evidence in their argument.”); Aguilar, note 111, at 270 (“A woman’s eligibility hinges on the ‘citizen fetus’ inside of her.”).
166. See Linda C. Fentiman, “The New Fetal Protection: The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children,” 84 *Denver University Law Review* 537, 540, note 7 (2006) (“The ostensible purpose of these ‘fetal protection’ policies was to ensure that children born to their female employees would not be injured by their mothers’ on-the-job exposure to toxic chemicals, but the goal of protecting employers against tort liability was also important.”).
167. See e.g. David F. Chavkin, “‘For Their Own Good’: Civil Commitment of Alcohol and Drug-Dependent Pregnant Women,” 37 *South Dakota Law Review* 224, 226 (1991) (“Although traditional criminal charges for [drug] possession, sale or distribution are as applicable to pregnant women as they are to non-pregnant women and to men, many prosecutors have made non-traditional use of existing statutes to single out maternal conduct linked to pregnancy.”).
168. See Ian Vandewalker, “Taking the Baby Before It’s Born: Termination of the Parental Rights of Women Who Use Illegal Drugs While Pregnant,” 32 *N.Y.U. Review of Law and Social Change* 423, 431-32 (2008).
169. See Rhodes et al., note 59. In the context of immunization, immunization for children has been observed to be dependent on the ability of parents to coordinate care. See id.

giving birth.¹⁷⁰ This conflict between a woman's autonomy and the government's interest in overseeing public health and national security is well-recognized in constitutional law.¹⁷¹ Yet, even in those troublesome prior cases, both mother and fetus received *some* legal recognition. Here, in the CHIP exception, the policy advances care only for the unborn. The CHIP exception ignores the mother's reproductive health concerns.

This tension demonstrates the need for health-care reform advocates to promote inclusive policies for undocumented immigrants. Health-care reform has received significant attention under the Trump administration; both states and Capitol Hill have proposed various changes to the health-care system.¹⁷² Broadly, these proposals recognize tensions between individual and public-health systems yet repeatedly continue to miss the consequences of a society with large uninsured and underinsured populations. Despite early calls for attention, the ACA's exclusions of undocumented immigrants left enduring consequences.¹⁷³ While the federal government is unlikely to pay for the costs of undocumented immigrants' access to health-care services any time soon, state and local governments will still be left with financial burdens. Health-care reform proposals must address undocumented immigrants, rather than focusing merely on gradients to which individuals are "entitled" to be included and creating borders across bodies, by including an unborn fetus while excluding the pregnant noncitizen from health-care benefits.

Following the confirmation of Justice Brett Kavanaugh, anti-abortion advocates see potential to limit *Roe v. Wade* through cases and policies advancing

170. See "State Children's Health Insurance Program," note 107, at 61,969 (describing that coverage is only available "during the period from conception to birth"); Elisabeth H. Sperow, "Redefining Child under the State Children's Health Insurance Program: Capable of Repetition, yet Evading Results," 12 *American University Journal of Gender, Social Policy & Law* 137, 152 (2004) (explaining the absurdity of this policy by highlighting how "the patient to whom the doctor owes his or her duty of care is clearly the unborn child and not the pregnant woman.").

171. See e.g. *Burton v. State*, 49 So. 3d 263, 266 (Florida District Ct. of Appeals 2010) (reviewing an order compelling a pregnant woman to submit to the physician's treatment decision and holding that "the test to overcome a woman's right to refuse medical intervention in her pregnancy is whether the state's compelling state interest is sufficient to override the pregnant woman's constitutional right to the control of her person, including her right to refuse medical treatment."); see generally Michele Goodwin, "Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield," 102 *California Law Review* 781, 781 (2014) (exploring "maternal policing" and examining new challenges throughout various states).

172. See e.g. American Health Care Act of 2017, H.R. 1628, 115th Congress (2017), <https://perma.cc/9WYT-P2SG>; Cara M. Passaro, "Using the State Innovation Waiver to Fill Obamacare's Coverage Gaps in Connecticut," 16 *Connecticut Public Interest Law Journal* 299 (2017).

173. See e.g. Janet M. Calvo, "The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP," 17 *Annals of Health Law* 175, 175-77 (2008) ("[T]he restrictions to health care access wreak havoc on the administrative and fiscal underpinnings of health care programs and frustrate medical and health administration professionals. Determining eligibility for care on the basis of immigration status requires difficult analysis and shifts a significant amount of resources away from providing health care.").

fetal personhood.¹⁷⁴ By legitimizing and advancing fetal personhood, advocates may broadly limit access to reproductive health care. Accepting the “unborn persons” language allowed under CHIP’s state amendment plan would advance fetal personhood arguments. Given the new makeup of the Court and uncertainty concerning *Roe*, reproductive health advocates must remain cautious of the looming potential to advance the fetal personhood framework. Even if health policies may have well-intentioned benefits for vulnerable populations, advocates must carefully assess potential detrimental limitations to abortion access.

CONCLUSION

The Trump administration has demonstrated that the CHIP exception may be the only path for securing expanded prenatal care at the federal level. Yet states still retain significant control over protecting reproductive and public health. States should use this opportunity to create narrowly tailored legislation, refraining from encroaching on women’s reproductive privacy, to ensure adequate promotion of public health by expanding prenatal care funding for local immigrant populations. Such proposals must address noncitizen members and avoid creating gradients for which individuals are “entitled” to be included. Difficulties in securing health care for undocumented immigrants impact not only individual families but also the greater community.¹⁷⁵ While discussions surrounding immigration and health care occur at the national level, it is essential to assess whether existing barriers to health care for vulnerable patient populations are appropriately serving public health goals.

Advocates for expanded access to reproductive health and prenatal care for undocumented immigrant women may find a sympathetic pathway through CHIP’s unborn provisions. However, these advancements should proceed with caution. Ultimately, the pursuit of immediate CHIP protections may undermine long-term health care goals of undocumented immigrant populations by advancing fetal personhood arguments. The difficulties undocumented women confront in securing prenatal care illustrate how immigration status should be a key concern for reproductive health policy advocates.

174. See e.g. Alice Miranda Ollstein & Rachel Roubein, “Here Come the *Roe v. Wade* Challenges,” *Politico* (8 Nov. 2018), <https://perma.cc/6S7F-V2W4> (detailing state-level efforts to contest abortion at the ballot); Elizabeth Nash et al., “Laws Affecting Reproductive Health and Rights: State Policy Trends at Midyear, 2018,” *Guttmacher Institute* (31 July 2018), <https://perma.cc/YGQ8-JT6S> (exploring “trigger” laws in several states that would outlaw abortion if *Roe* were reversed); Mary Ziegler, “The Movement That Could Reshape the Abortion Fight,” *The Washington Post* (20 Mar. 2018), <https://perma.cc/6K6N-DTE8> (noting that personhood proponents are likely to “stand a better chance in the Supreme Court” without Justice Kennedy’s vote).

175. I explore this topic more in a separate work: Cleek, see note 46.