

**The Breast and Cervical Cancer Treatment
Program: Accepting Inequality for Undocumented
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INTRODUCTION

On January 1, 2002 the recently enacted California Breast and Cervical Cancer Treatment Program (BCCTP) began funding breast and cervical cancer treatment for low-income, uninsured, and underinsured women in California.¹ The new program expands the former Breast Cancer Treatment Program (BCTP) to include women with cervical cancer, and takes advantage of recently authorized federal matching funds for states that expand their Medicaid programs ("Medi-Cal" in California) to women with breast or cervical cancer.² Women's advocacy groups, cancer organizations, and health care providers, praised the legislation as "a great victory for all uninsured women in California."³

The BCCTP, however, provides two distinct levels of health care to California women, depending on their legal status. For women with breast or cervical cancer who meet federal citizenship and immigration criteria, the program provides full Medi-Cal benefits to address all of their health care needs for the duration of their cancer treatment.⁴ For women who

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1. The BCCTP is enacted in two different sections of the California Code: CAL. HEALTH & SAFETY CODE §§ 104160-104163 (West Supp. 2002) and CAL. WELF. & INST. CODE § 14007.71 (West Supp. 2002). The program covers uninsured and underinsured women with a family income at or below two hundred percent of the federal poverty level. CAL. HEALTH & SAFETY CODE § 104162(a)-(d).
2. CAL. HEALTH & SAFETY CODE § 104160(a); CAL. WELF. & INST. CODE § 14007.71(a).
3. *CWLC Secures New Hope for Uninsured Women with Breast Cancer*, CWLC NEWS (Cal. Women's Law Ctr., Los Angeles, Cal.), Fall 2001, at 4.
4. CAL. WELF. & INST. CODE § 14007.71(a).

do not meet these criteria, namely, undocumented women,⁵ the program only covers "medically necessary" cancer treatment for a maximum of eighteen months for women with breast cancer, and twenty-four months for women with cervical cancer.⁶

On the one hand, the program's inclusion of undocumented women appears to mark a significant accomplishment for advocates pushing to increase health care for undocumented individuals. The BCCTP's two-tiered structure, however, is at odds with basic liberal principles of equality, and raises fundamental questions regarding the future direction of liberal advocacy on behalf of undocumented individuals.

This recent development piece examines the BCCTP as it affects undocumented women and the legislation's role in the broader context of liberal advocacy regarding the expansion of medical coverage to undocumented individuals. Section I presents a brief background of recent health care policies toward immigrants. Section II provides an overview of the BCCTP's legislative history and services provided through the new program. Section III explores the politics surrounding the inclusion of undocumented women in the BCCTP and the underlying tension within the progressive ethos when it comes to advocating for the rights of undocumented people.

I. RECENT HEALTH CARE POLICIES TOWARD IMMIGRANTS

In 1994, the majority of California's voters approved Proposition 187, attempting to eliminate virtually all health care for undocumented individuals.⁷ The initiative also required health care providers to report individuals suspected of illegal status to the Immigration and Naturalization Service.⁸ Later struck down by a federal court injunction,⁹ Proposi-

5. Throughout this piece, the term "undocumented" shall refer to individuals living in the United States without government authorization. CAL. HEALTH & SAFETY CODE § 104162(a) requires only that an "individual is a resident of California," enabling undocumented women to qualify for such services. Some smaller groups, such as women over sixty-five and men, who do not meet the requirements for federal matching funds through the Medi-Cal expansion may also qualify for the state-only program. DEP'T OF HEALTH SERVICES, BREAST AND CERVICAL CANCER TREATMENT PROGRAM FREQUENTLY ASKED QUESTIONS 1 (2001).
6. CAL. HEALTH & SAFETY CODE §§ 104161(e) ("medically necessary" treatment services), 104161.1(a) (time limitations of medical care). "Medically necessary" treatment services have not been clearly defined. See *infra* text accompanying notes 52-57.
7. *Proposition 187: Text of Proposed Law*, CAL. BALLOT PAMPHLET GEN. ELECTION, NOV. 8, 1994, Aug. 16, 1994, at 91, 92. Section 6 of the initiative prohibits all publicly funded hospitals and health care clinics from providing any taxpayer financed services, other than emergency medical care, to people who are unable to prove that they are United States citizens, lawfully admitted permanent residents, or lawfully admitted temporary visitors.
8. *Id.* at 91. Section 7(c) of the initiative requires providers to verify the citizenship status of all patients before rendering non-emergency care, and to report individuals suspected of illegal status to the Immigration and Naturalization Service, the California Director of Health Services, and the California Attorney General's Office.

tion 187 nevertheless represents one of the most extreme measures taken against undocumented immigrants in recent United States history.¹⁰

On the federal level, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act¹¹ barred legal immigrants from access to federally-funded public benefits for the first time in United States history.¹² For "qualified aliens" who entered the United States after August 22, 1996, the law barred access to federally-funded Medicaid for their first five years in the country.¹³ In addition, the law excluded qualified aliens from Supplemental Security Income (SSI), a disability program for aged, blind, or disabled individuals unable to work.¹⁴ For undocumented immigrants, the 1996 law reaffirmed their ineligibility for federally-funded programs.¹⁵

For undocumented individuals and qualified immigrants subject to the five-year bar, the federal government funds only services related to an "emergency medical condition."¹⁶ This is defined as "a medical condition . . . manifesting itself by acute symptoms of sufficient severity (including severe pain) . . ."¹⁷ For women with cancer, this means they are only covered at acute stages of their illness.¹⁸ Cancer is otherwise considered a

9. *League of United Latin Am. Citizens v. Wilson*, 908 F. Supp. 755 (S.D. Cal. 1995) (striking down Proposition 187's prohibition on non-emergency health care, public education, and other social services primarily on federal pre-emption grounds).
10. See Linda S. Bosniak, *Opposing Prop. 187: Undocumented Immigrants and the National Imagination*, 28 CONN. L. REV. 555, 557 (1996); see also Minty Siu Chung, *Proposition 187: A Beginner's Tour Through a Recurring Nightmare*, 1 U.C. DAVIS J. OF INT'L L. & POL'Y 267, 269 (1995) (citing Proposition 187 as the "latest chapter" in historical trends of anti-immigrant laws in California immigration history); Kevin R. Johnson, *Public Benefits and Immigration: The Intersection of Immigration Status, Ethnicity, Gender, and Class*, 42 UCLA L. REV. 1509, 1518 (1995) (discussing 1990s anti-immigrant policies in the context of historical trends of public concern over the receipt of benefits by immigrants).
11. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2260 (sections pertaining to immigrants codified as amended in 8 U.S.C.). 8 U.S.C. § 1613 bars "qualified aliens" who entered the United States after August 22, 1996 from receipt of Medi-Cal for the first five years after their date of entry. section 1631(a) provides that after the five-year bar expires, most sponsored future immigrants will remain ineligible for public assistance due to "deeming provisions," that attribute a sponsor's income to the immigrant for purposes of calculating eligibility for need-based programs.
12. CELIA GAYTÁN, & JOSÉ ATILIO HERNÁNDEZ, LATINO ISSUES FORUM, BEYOND A CULTURE OF FEAR: HOW WELFARE REFORM HAS FAILED IMMIGRANTS AND PUBLIC HEALTH IN CALIFORNIA 3 (1999) [hereinafter GAYTÁN].
13. 8 U.S.C. § 1641(b) (defining "qualified aliens" as (1) lawful permanent residents (LPRs), (2) refugees, asylees, persons granted withholding from deportation, conditional entry (in effect prior to April 1, 1980), or paroled for at least one year, (3) Cuban/Haitian entrants, and (4) battered spouses and children with a pending application).
14. 8 U.S.C. § 1612. In 1997 Congress amended § 1612, adding paragraphs (e) and (f), which granted eligibility to qualified immigrants who were lawfully residing in the United States on or before August 22, 1996.
15. 8 U.S.C. § 1611.
16. 42 U.S.C.A. § 1396b(v)(3) (West Supp. 2001).
17. *Id.*
18. See TERESA ZAK, ET AL., 2001 CALIFORNIA MASTER MEDICAID GUIDE 90 (2001).

chronic condition, and long-term treatment services, such as chemotherapy, are not covered.¹⁹

The 1996 federal cuts in social services for immigrants shifted increased costs onto California to meet immigrant health care needs.²⁰ For qualified immigrants barred from federal funding, California funds Medi-Cal regardless of the person's date of entry into the United States.²¹ For undocumented individuals, California funds health care through a disparate system of county public hospitals and clinics, which may or may not provide free indigent care.²² Undocumented individuals are also eligible for a few state-funded services, including services related to pregnancy and communicable diseases.²³

As the state with almost half of the undocumented population in the United States²⁴ and the largest number of legal immigrants affected by the 1996 federal welfare cuts, California's services for immigrant women ineligible for federally-funded health care are essential.²⁵ The BCCTP's inclusion of undocumented women stands in stark contrast to the recent decade of anti-immigrant legislation, and will provide critical services for undocumented women diagnosed with breast or cervical cancer.

II. OVERVIEW OF THE BCCTP

A. Legislative Background

The BCCTP responds to the gap in medical services created by federal and state programs that provide free breast and cervical cancer screening for low-income and uninsured women but fail to secure treatment options once women are diagnosed with cancer.²⁶ Senator Jackie

19. Telephone Interview with Allison Breen, Medi-Cal Benefits Branch, Department of Health Services, (Feb. 20, 2002).
20. 8 U.S.C. § 1622 (authorizing states to determine the eligibility of qualified immigrants for their state Medicaid programs). See also GAYTÁN, *supra* note 12, at 3 (discussing the shift in cost to states).
21. See CAL. WELF. & INST. CODE § 14007.5 (West 2001) (providing that qualified immigrants are eligible for full scope Medi-Cal benefits, without imposing specific date-of-entry criteria).
22. See COMMUNITY HEALTH ADVOCACY PROJECT, IMMIGRANTS AND HEALTH CARE 9 (2001).
23. See *id.*
24. IMMIGRATION AND NATURALIZATION SERV., 1999 STATISTICAL YEARBOOK OF THE IMMIGRATION AND NATURALIZATION SERV., at <http://www.ins.gov/graphics/aboutins/statistics/illegals.htm> (last visited Jan. 31, 2002).
25. See GAYTÁN, *supra* note 12, at 3.
26. STAFF OF ASSEMB. COMM. ON HEALTH, S.B. 224 B. ANALYSIS, AS AMENDED JUNE 4, 2001, Sess. 2001-2002, at 6 (Cal. 2001) [hereinafter S.B. 224 B. ANALYSIS] ("[T]he intent of this bill is to expand treatment programs for low-income uninsured (or underinsured, in some instances) women who have been diagnosed with breast or cervical cancer under state or federal screening programs."). California operates two screening programs, the state-funded Breast Cancer Early Detection Program (BCEDP), and the federally-funded Breast and Cervical Cancer Control Program (BCCCP). In fiscal year 2002, the programs were estimated to provide a total of 230,000 breast cancer screens and 23,000 cervical cancer screens to uninsured and underinsured women

Speier (Democrat), one of the BCCTP's supporting legislators, argued that "California currently screens low-income women for breast and cervical cancer, but when they are diagnosed they often have no where to turn for treatment."²⁷

In 1999, California enacted the Breast Cancer Treatment Program (BCTP) as the first legislation to fund treatment for uninsured, low-income women diagnosed with breast cancer.²⁸ The state legislation built on previous breast cancer treatment funds established through private foundation grants.²⁹ The BCTP did not distinguish among individuals on the basis of legal status, providing breast cancer treatment equally to all residents of California.³⁰ The program covered treatment, that included, "but shall not be limited to, lumpectomy, mastectomy, chemotherapy, hormone therapy, radiotherapy, reconstructive surgery, and breast implant surgery" for a maximum of eighteen months.³¹

While supportive of state funding for treatment services, advocates of the BCCTP expressed concern that the original BCTP provided for treatment-only services, and did not fund the full extent of services needed by women undergoing cancer treatment.³² Furthermore, the BCTP cut off funding for services after eighteen months regardless of whether a woman completed her treatment.³³ Advocates designed the new program to provide women with full access to health care for the duration of their cancer treatment, describing the proposed legislation as "an effective and comprehensive proposal for breast and cervical cancer treatment."³⁴

The new BCCTP also takes advantage of the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, which authorizes

below 200 percent of the federal poverty level. These programs do not provide treatment funds for women diagnosed with cancer. *Id.* at 8.

27. *Id.* at 6.

28. Breast Cancer Treatment Program, ch.146, § 5, art.1.5, §§ 104160-104163, 1999-2000 Cal. Legis. Service (West 1999) (current version at CAL. HEALTH & SAFETY CODE §§ 104160-104163 (West Supp. 2002)). The new BCCTP repeals the BCTP.

29. CAL. HEALTH COLLABORATIVE, CAL. BREAST CANCER TREATMENT FUND, at http://www.healthcollaborative.org/programs/details.cfm?prg_programid=10 (last visited Nov. 10, 2001) [hereinafter CAL. HEALTH COLLABORATIVE]. In 1994, Blue Cross of California's Public Benefit Program (now the California Endowment and the California HealthCare Foundation) granted 12.4 million dollars to provide breast cancer treatment to low-income and uninsured individuals. In 1999, the private foundations granted an additional eight million dollars, which as supplemented by five million dollars in temporary state funding allocated by the legislature. In 2000, the state dedicated twenty million dollars, thereby institutionalizing the state-funded program. *Id.*

30. See Breast Cancer Treatment Program (BCTP), ch.146, § 5, art.1.5, § 104162 (providing treatment to "uninsured and underinsured women and men with incomes at or below 200 percent of the federal poverty level," while making no reference to immigration status).

31. § 104161. See also CAL. HEALTH COLLABORATIVE, *supra* note 29 (limiting services to 18 months).

32. See BREAST CANCER ACTION, ACCESS TO CARE, at <http://www.bcaction.org/Pages/LearnAboutUs/AccessToCare.html> (last visited Jan. 14, 2002) ("[The BCTP], while important, is limited to women diagnosed with breast cancer, and the scope of the care provided is also limited.").

33. CAL. HEALTH COLLABORATIVE, *supra* note 29.

34. S.B. 224 B. ANALYSIS, *supra* note 26, at 4.

federal matching funds for states that expand their Medicaid programs to women with breast or cervical cancer.³⁵ As of October 2001, California was one of thirty-four states to take advantage of this expansion option.³⁶ The state anticipates almost twenty million dollars in federal matching funds through the Medi-Cal expansion.³⁷ In addition, California has dedicated approximately seventeen million dollars to the program overall.³⁸

B. The BCCTP: Two Levels of Medical Services

The BCCTP's original goal was to provide "comprehensive care, not just cancer care, but the same benefits as provided in the Medi-Cal program" to California women diagnosed with breast or cervical cancer.³⁹ This goal included all women, regardless of legal status.⁴⁰

As enacted, however, the BCCTP provides two different levels of health care for women, distinguishing between women on the basis of legal status.⁴¹ For United States citizens and qualified immigrants, the legislation achieves its original goal and provides full-scope Medi-Cal benefits for the duration of their cancer treatment.⁴² If their cancer recurs, women may qualify for the program more than once, as long as the recurrence "is either a known or presumed complication of breast or cervical cancer."⁴³

The BCCTP coverage for women with legal status, in part, takes advantage of federal-matching funds available through the new expansion of Medi-Cal to women with breast and cervical cancer.⁴⁴ The federal government will match two dollars for every state dollar spent on women who are United States citizens or qualified immigrants, and not barred by the five-year-wait requirement for immigrants entering after August 22,

35. 42 U.S.C.A. §§ 1396a(10)(A)(ii)(XVIII), 1396d(b)(4) (West Supp. 2001) (authorizing state option to expand medical coverage to "certain breast and cervical cancer patients," and enhanced federal medical assistance percentage (FMAP) to fund services).

36. HEALTH CARE FIN. ADMIN., BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACTIVITY MAP, at www.hcfa.gov/medicaid/bcctp/bccpmap.htm (last visited Jan. 27, 2002).

37. E-mail from Kevin Collins, Budget Analyst, Department of Finance, to Sanna R. Singer, law student, Boalt Hall School of Law (Feb. 20, 2002, 08:53:11 PST) (on file with author).

38. *Id.*

39. S.B. 224 B. ANALYSIS, *supra* note 26, at 6.

40. *See id.* at 3 (proposing that eligibility for the program be contingent on California residency, and omitting specific immigration criteria).

41. *See supra* notes 4-5 and accompanying text.

42. CAL. WELF. & INST. CODE § 14007.71(a) (providing "medical assistance during the period in which [a qualified low-income individual] requires treatment for breast or cervical cancer").

43. HEALTH CARE FIN. ADMIN., BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000, FREQUENTLY ASKED QUESTIONS, at www.hcfa.gov/medicaid/bcctp/bccpfaq.htm (last visited Jan. 27, 2002).

44. *See* CAL. WELF. & INST. CODE § 14007.71(a) (adopting the option made available under the federal Breast and Cervical Cancer Prevention and Treatment Act to expand Medi-Cal for women with breast and cervical cancer for the duration of the treatment). Section 14007.71(e) authorizes the implementation of this program to the extent that federal matching funds are available.

1996.⁴⁵ For qualified immigrant women who are barred by the five-year wait period, California will support the full Medi-Cal benefits.⁴⁶ The state allocated approximately ten million dollars, and expects almost twenty million federal matching dollars, to support the Medi-Cal expansion.⁴⁷

For undocumented women, the new legislation falls short of its original goal of comprehensive medical care equivalent to benefits under Medi-Cal. The program narrows services to those "medically necessary to treat the covered condition," and limits care to eighteen months for women with breast cancer, and twenty-four months for women with cervical cancer.⁴⁸ After these time limits expire, women are cut off from the program regardless of whether they have finished their treatment.⁴⁹ In addition, unlike the Medi-Cal expansion, this program is not considered an entitlement, meaning once state funds are exhausted, services are no longer available.⁵⁰ Barred from federal matching funds, services for undocumented women are covered by 7.1 million dollars in state funds.⁵¹

To date, the BCCTP has not established specific guidelines for services that will be considered "medically necessary treatment of the covered condition."⁵² It is unclear the extent of services that will fall within the scope of this definition. Under the old BCTP, services were limited.⁵³ For example, the former program criteria for determining coverage for complications of treatment stated: "[t]he condition must be a legitimate, primary complication irrefutably related to breast cancer or its treatment."⁵⁴ The new program may have similar limitations. One advocate expressed concern that, for example, if a woman on pain medication falls and breaks her hip, the new program would not cover her broken hip.⁵⁵ In

45. See Federal Financial Participation in State Assistance Expenditures, 65 Fed. Reg. 69,560 (Nov. 17, 2000) (defining FMAP as 65.98% of state expenditures for California).

46. See CAL. WELF. & INST. CODE § 14007.71(b) ("Notwithstanding any other provision of law, an individual who is a qualified alien as defined in Section 1641 of Title 8 of the United States Code shall not be determined ineligible for services under this section solely on the basis of the individual's date of entry into the United States.").

47. E-mail from Kevin Collins, *supra* note 37.

48. CAL. HEALTH & SAFETY CODE § 104161(e) ("medically necessary" treatment services); § 104161.1(a) (time limitations of medical care).

49. Telephone Interview with Allison Breen, *supra* note 19.

50. CAL. HEALTH & SAFETY CODE § 104163.

51. E-mail from Kevin Collins, *supra* note 37.

52. Telephone Interview with Allison Breen, *supra* note 19.

53. See e.g. CALIFORNIA BREAST CANCER TREATMENT FUND PROGRAM, CONSENT TO THE RELEASE OF MEDICAL AND OTHER INFORMATION I (2000) ("The Treatment Fund covers certain services to treat breast cancer It is important that you know that certain kinds of treatment cannot be paid for by the Treatment Fund. For example, bone marrow or peripheral stem cell transplants, wigs, social worker services, hospice services, nutrition services, alternative or other complementary treatments, home health care, and treatment of refractory disease are not covered by this program.").

54. AM. MED. ASSOC. INT'L CLASSIFICATION OF DISEASES, CAL. BREAST CANCER TREATMENT FUND PROGRAM 14 (2001).

55. Interview with Mehl Kavanaugh-Lynch, Director, California Breast Cancer Research Program, in Berkeley, Cal. (Jan. 25, 2002).

addition, the new program may not cover psychological counseling, nutrition, or physical therapy.⁵⁶ The interpretation of "medically necessary" services will likely depend on physicians' interpretation of this definition and their willingness to advocate to obtain this coverage under the program.⁵⁷ By contrast, all of these services are covered for women with legal status through the Medi-Cal expansion.⁵⁸

The new BCCTP also does not include patient care coordination.⁵⁹ The California Health Collaborative administered the former BCTP and relied on an intensive system of case-by-case patient care coordination to fill in the gaps of medical services not covered by the program, as well as to assist with services such as transportation, child-care, and translation.⁶⁰ Medi-Cal eliminated this assistance under the new program.⁶¹ Because benefits under the Medi-Cal program will be comprehensive, legislators did not consider additional patient care coordination necessary.⁶² The deletion of this assistance, however, may be especially problematic for undocumented women who are still only eligible for limited services.⁶³ Not only may obtaining necessary medical care be difficult, but undocumented women will also likely face significant barriers, such as language as well as fear of revealing their illegal status.⁶⁴

III. ACCEPTING INEQUALITY?

Advocates call the BCCTP a "great victory for all uninsured women in California."⁶⁵ It is a partial victory, but it leaves undocumented women with unequal services.⁶⁶ Although advocates originally aimed for comprehensive care for all women, they compromised this goal for undocumented women in order to achieve services under the program as a whole.⁶⁷

For the immediate services that the BCCTP provides, the legislation may be viewed as a success. The California Women's Law Center (CWLC), an organization that supported the legislation, explained in its Fall 2001 newsletter, "CWLC advocated for broader coverage for all women; however, there is no doubt that this new program will save

56. *Id.*

57. Telephone Interview with Allison Br en, *supra* note 19.

58. *Id.*

59. Telephone Interview with Dottie Mazurek, Patient Care Coordinator, California Health Collaborative (Jan. 29, 2002).

60. *Id.* See also CAL. HEALTH COLLABORATIVE, *supra* note 29 (patient care coordination).

61. Telephone Interview with Dottie Mazurek, *supra* note 59.

62. Interview with Mehl Kavanaugh-Lynch, *supra* note 55.

63. Telephone Interview with Dottie Mazurek, *supra* note 59.

64. See, e.g., GAYTAN, *supra* note 12, at 9.

65. See CWLC Secures New Hope for Uninsured Women with Breast Cancer, *supra* note 3, at 4.

66. See discussion *supra* Part II.B.

67. See discussion *infra* Part III.C.

countless lives."⁶⁸ Indeed, the BCCTP expands the former BCTP to include women with cervical cancer, takes advantage of the federal Medical expansion, and provides medical care for many low-income women diagnosed with breast or cervical cancer who have few other options.⁶⁹ For undocumented women, the program stands in stark contrast to an environment of anti-immigrant policies and appears to mark a significant advancement in liberal advocacy to expand medical care for undocumented individuals.

When analyzed from a perspective based on equality, however, the BCCTP's two-tiered structure illustrates a fundamental tension in liberal advocacy on behalf of undocumented individuals. On the one hand, organizations supporting the legislation call for "equality and justice for all women,"⁷⁰ the elimination of "institutional and systemic causes of . . . oppression,"⁷¹ "freedom from discrimination,"⁷² and representation of "the voices" of women affected by cancer.⁷³ The BCCTP's two-tiered structure, however, is at odds with these fundamental principles of equality. As a piece of liberal legislation, how did advocates ultimately accept such inequality for undocumented women?

A. The Politics of Inclusion

Advocates prioritized the inclusion of undocumented women as one of their most important goals for the program.⁷⁴ "From the start," Marj Plumb, a consultant to the California Breast and Gynecological Cancer Treatment Task Force (Task Force),⁷⁵ a coalition of organizations supporting the legislation, explained, "we were committed to comprehensive coverage for all women."⁷⁶ In their goal to address the gap in medical

68. See *CWLC Secures New Hope for Uninsured Women with Breast Cancer*, *supra* note 3, at 4.

69. See discussion *supra* Part II.A.

70. CAL. WOMEN'S COMM'N, VISION AND MISSION STATEMENT, at <http://www.statusofwomen.ca.gov> (last visited Jan. 27, 2002).

71. CAL. WOMEN'S LAW CTR., GUIDING PRINCIPLES, at <http://www.cwlc.org/about.html> (last visited Jan. 27, 2002).

72. CAL. NAT'L ORG. FOR WOMEN, MISSION STATEMENT, at <http://www.canow.org/> (last visited Jan. 27, 2002).

73. BREAST CANCER ACTION, MISSION STATEMENT, at <http://www.bcaction.org/Pages/LearnAboutUs/MissionStatement.html> (last visited Jan. 27, 2002) ("Breast Cancer Action carries the voices of people affected by breast cancer to inspire and compel changes necessary to end the breast cancer epidemic.")

74. Interview with Mehl Kavanaugh-Lynch, *supra* note 55.

75. Members of the Task Force include: American Cancer Society (California Division), Breast Cancer Action, Breast Cancer Early Detection Program Advisory Council, Breast Cancer Early Detection Partnerships, Breast Cancer Alliance of California, California Breast Cancer Organizations, California Breast Cancer Treatment Fund, California Health Officers Association, Latino Coalition for a Healthy California, The Breast Cancer Fund, Women's Information Network Against Breast Cancer. CAL. BREAST AND GYNECOLOGICAL CANCER TREATMENT TASK FORCE, FACT SHEET, at http://www.cancerlynx.com/breast_gynecological.html (Sept. 2, 2000).

76. Telephone Interview with Marj Plumb, Consultant, California Breast and Gynecological Cancer Treatment Task Force (Feb. 1, 2002).

services created by the screening programs, advocates included undocumented women who are also screened through these programs.⁷⁷ In addition, in their broader goal to advance universal access to health care, the Task Force viewed access to health care regardless of legal status as integral to this principle.⁷⁸

In the politically anti-immigrant environment, however, advocates viewed an open stance on the inclusion of undocumented women as an impossible political goal that would jeopardize the entire program.⁷⁹ Like other legislation that includes undocumented individuals, only the intentionally broad term "resident of California" signals their inclusion.⁸⁰ Advocates avoided a direct stance, anticipating that legislators would sooner eliminate than approve a program that vocalized the inclusion of undocumented individuals.⁸¹

B. The Evolution of the Two Tiers

Concurrent to activities at the state level, Congress enacted the federal Breast and Cervical Cancer Treatment Act of 2000, which authorized states to expand their Medicaid programs to women with breast or cervical cancer for the duration of their cancer treatment.⁸² While funneling funds into California's proposed program, the federal legislation also introduced specific immigration eligibility criteria.⁸³ The legislation enabled Medi-Cal benefits for citizen and legal immigrant women, but left out undocumented women.⁸⁴

While securing medical care for women with legal status, the federal legislation made advocates' work to obtain services for undocumented women even more precarious.⁸⁵ They feared that critics would question the need for a program beyond the Medi-Cal expansion, especially if it would primarily serve the needs of undocumented women.⁸⁶ During a year of significant budget cuts, advocates were "surprised" that the Medi-Cal expansion and the additional state-only program even made it through the legislature.⁸⁷

77. Interview with Mehl Kavanaugh-Lynch, *supra* note 55.

78. *Id.*

79. Telephone Interview with Barbara Brenner, Executive Director, Breast Cancer Action (Feb. 4, 2002).

80. CAL. HEALTH & SAFETY CODE § 104162(a).

81. Telephone Interview with Barbara Brenner, *supra* note 79.

82. 42 U.S.C.A. § 1396a(10)(A)(ii)(XVIII) (authorizing the state option) & 42 U.S.C.A. § 1396a(10)(G) (providing services for the duration of the cancer treatment).

83. 8 U.S.C. § 1613 (barring certain qualified immigrants from federally funded full-scope Medicaid); § 1611 (barring undocumented immigrants from federally funded full-scope Medicaid).

84. *Id.*

85. Interview with Mehl Kavanaugh-Lynch, *supra* note 55.

86. *Id.*

87. *Id.*

When it came to dedicating funds, however, the legislature divided the program into two distinct levels of services. Under the Medi-Cal expansion, the federal legislation required that women receive full Medi-Cal benefits for the duration of their treatment.⁸⁸ In addition, the legislation dedicated federal matching funds that would cover sixty-six percent of the cost of care.⁸⁹ The federal legislation infused the proposed program with a significant portion of funding and prevented the state from cutting services.⁹⁰

Under the state-only program, the California legislature limited services to medically necessary treatment for a maximum of eighteen months for women with breast cancer and twenty-four months for women with cervical cancer.⁹¹ In contrast to services under the federal Medi-Cal expansion, the costs of medical services would fall entirely on the state.⁹² At one point, the legislature considered removing cervical cancer from the state-only program entirely, a proposal that advocates adamantly opposed and successfully prevented.⁹³ In addition, to avoid a division of the program, advocates proposed cutting services under the Medi-Cal expansion and reallocating funds to the state-only program to raise the state program to an equivalent level.⁹⁴ The federal requirements for the Medi-Cal expansion, however, prevented this transfer.⁹⁵ Finally, despite advocates' budget projections of the feasibility of a state-only program equal to Medi-Cal, the governor's budget did not include this expansion.⁹⁶

Shaped by the federal legislation that excludes undocumented women, the legislature's budget imperatives, and a political environment endorsing the exclusion of undocumented individuals from health care and other public programs, advocates' original goal of comprehensive care for all women eventually eroded into the program's two tiers. As Marj Plumb explained, the broader political forces shaping services for undocumented women "were bigger decisions than us."⁹⁷

C. The Dilemma of Inequality

Discontent with the two-tiered structure of the program, advocates considered their choices to accept or protest the program's inequality.⁹⁸

88. 42 U.S.C.A. § 1396a(a)(10)(G).

89. Federal Financial Participation in State Assistance Expenditures, *supra* note 45.

90. Telephone Interview with Marj Plumb, *supra* note 76.

91. CAL. HEALTH & SAFETY CODE § 104161(e) ("medically necessary" treatment services); § 104161.1(a) (time limitations of medical care).

92. See *supra* text accompanying note 15.

93. Telephone Interview with Marj Plumb, *supra* note 76.

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

The "political reality" of a stance on the program's unjust subordination of undocumented women, however, confronted advocates with a dilemma.⁹⁹ If they came out directly on the issue, they risked achieving a program at all, both in services for undocumented women, as well as services under the Medi-Cal expansion for women with legal status.¹⁰⁰

Advocates struggled between advocating on behalf of the life-threatening needs of women diagnosed with cancer and standing up for the rights of undocumented individuals. "In the politics of life-threatening illnesses," one advocate explained, "we're talking about people's lives, not an abstract political discussion [of remote policy issues]."¹⁰¹ Advocates confronted a decision of risking not only services for undocumented women, but services for women with legal status as well. Marj Plumb explained, "advocates were in the untenable position of either standing up for what is right and not getting anything at all, or continuing to accept what is helpful, even though it is ethically unfair."¹⁰² Dr. Mehl Kavanaugh-Lynch, director of the California Breast Cancer Research Program, summarized that advocates were faced with the questions: "Where do you draw the line? When do you compromise equality for the sake of services? What's more important, being principled, or taking what you can get?"¹⁰³

Barbara Brenner, Executive Director of Breast Cancer Action and a member of the Task Force, explained that advocates faced the dilemma that "if you push for care for undocumented individuals, then you will jeopardize care for others."¹⁰⁴ Brenner added that: "[Risking a program for women with life-threatening illnesses] makes decisions that much harder. But even though this may be politically true, this is not the way that advocates should be thinking. How do we change the political reality so that we are not confronting the same issues each time?"¹⁰⁵ Although unsatisfied with the two-tiered structure of the program, advocates eventually moved forward with what they could, saving the battle of equality for another day.

D. The Struggle in Liberal Advocacy

The struggle between equality and advocating on behalf of the rights of undocumented individuals is not a new one. In her article, *Opposing Prop. 187: Undocumented Immigrants and the National Imagination*, Professor Linda Bosniak examines a similar tension in progressive argu-

99. Telephone Interview with Barbara Brenner, *supra* note 79.

100. *Id.*

101. *Id.*

102. Telephone Interview with Marj Plumb, *supra* note 76.

103. Interview with Mehl Kavanaugh-Lynch, *supra* note 55.

104. Telephone Interview with Barbara Brenner, *supra* note 79.

105. *Id.*

ments opposing Proposition 187.¹⁰⁶ Bosniak points out that progressives almost “instinctively” opposed the measure.¹⁰⁷ Yet arguments condemning the injustice of the measure and invoking the rights of undocumented individuals, were largely absent from liberal critiques.¹⁰⁸ Instead, opponents strategically chose arguments that emphasized the negative consequences for Americans’ self-interest, such as potential public health problems created by people afraid to access medical care, increased future costs to the state, and the measure’s failure as an illegal immigration deterrent.¹⁰⁹

Bosniak acknowledges the “political tightrope” in the context of an extremely anti-immigrant political climate as limiting the freedom of liberal arguments.¹¹⁰ She suggests, however, that the absence of arguments invoking more fundamental notions of injustice runs deeper than controversial politics alone.¹¹¹ Traditionally committed to advocating on behalf of oppressed, marginalized and excluded groups, Bosniak points out the curious lack of liberal arguments “robustly” articulating the rights of undocumented individuals.¹¹² She poses the questions: “What, precisely, do the critics understand to be wrong with Prop. 187? And how far does their aversion to such measures extend?”¹¹³

Since Proposition 187, the BCCTP takes a step in the opposite direction and attempts to expand health care for undocumented individuals. Yet, as in their opposition to Proposition 187, advocates promoting the BCCTP again failed to base arguments on the rights of undocumented immigrants themselves. Instead, the term “resident” neutrally disguises the controversial issue of including individuals regardless of legal status.

Advocates anticipated that a direct stance on the inclusion of undocumented individuals would risk the program entirely.¹¹⁴ As Barbara Brenner emphasized, this is the “political reality . . . but we must find a way to change [it].”¹¹⁵ By not advocating directly on the issue of including undocumented individuals, advocates incorporated this political reality into their own arguments. Without arguing for equality, they anticipated their defeat from the start. Although they did not shape the two tier structure of the program—in fact, they fought hard against it—the weakness was in the foundation of their arguments.

106. Bosniak, *supra* note 10, at 557.

107. *Id.* at 558.

108. *Id.* at 567.

109. *Id.* at 559-566.

110. *Id.* at 573.

111. *Id.* at 573.

112. *Id.* at 559.

113. *Id.* at 557.

114. Telephone Interview with Barbara Brenner, *supra* note 79.

115. E-mail from Barbara Brenner, Executive Director, Breast Cancer Action, to Nicola Pinson, law student, Boalt Hall School of Law (Feb. 28, 2002, 09:28:00 PST) (on file with author).

What would have happened if advocates had taken a direct stance on the inclusion of undocumented individuals? While it may be true that such a stance could have triggered intense political opposition, it also would have generated and articulated the arguments of those who believe in equality. The decision to stay silent subverts this political dialogue. While the BCCTP accomplishes some services for undocumented women, it does not advance the broader arguments of equality.

The BCCTP's inclusion of undocumented women also raises the tension between advocating for the rights of undocumented women and risking services for women with legal status. This tension is compounded by the fact that women receiving services through the BCCTP have life-threatening illnesses and few other options to obtain medical care.

In advancing the rights of undocumented individuals it is unclear why their rights are considered separate from the advancement of other liberal agendas. Bosniak explores the "national political imagination" that is at odds with liberal notions of equality and justice.¹¹⁶ Embedded in many liberal critiques of social inequalities is the presumption of a "national community."¹¹⁷ Unlike race, class, ethnicity, and other forms of discrimination, legal status is rarely viewed as a category of oppression.¹¹⁸

Adding legal status to the list of oppressions, Bosniak argues, will require liberals to confront important tensions in their own commitments to equality and the significance of national borders.¹¹⁹ Even if liberals consider undocumented individuals as part of the national community, they must still confront their more fundamental endorsement of the exclusion of undocumented individuals from American society by virtue of national borders.¹²⁰ Nevertheless, Bosniak believes liberals could still issue:

powerful criticism . . . that—*notwithstanding the circumstances of their entry—those undocumented immigrants who live and work among us are entitled to the basic rights of (national) membership by virtue of their contributions to our society . . . and to deny them such rights is both a formalist lie and a means of ensuring their continued subordination . . .*¹²¹

In the case of the BCCTP, however, advocates failed to address the fundamental issue of how national borders should affect the rights of undocumented individuals to health care. Without taking a stance on the inclusion of undocumented individuals, arguments articulating the nature and extent of these rights are absent from the debate. Despite the goal of

116. *Id.* at 558.

117. *Id.* at 561.

118. *Id.* at 577.

119. *Id.* at 580.

120. *Id.* at 572.

121. *Id.* at 583.

equality, the absence of this discussion fractured the program from the start.

CONCLUSION

The current anti-immigrant environment, federal devolution of fiscal responsibility to states to meet immigrant health care needs, and a tightening California budget all make it extremely difficult to advocate on behalf of the rights of undocumented individuals. The BCCTP advocates accomplished an unprecedented program compared to the broader inequities in health care for undocumented individuals, providing critical treatment services that otherwise would not have been available. This critique does not call into question the commitment of advocates to obtain medical care for all women, but rather the strategies employed and the long-term ramifications.

Looking towards the future, the BCCTP does not pave a more permanent solution to address the inequities and injustice in our health care system for undocumented individuals. How can we change the political reality of anti-immigrant policies if we do not articulate the issues that we are challenging? Furthermore, to what extent is advocating on behalf of undocumented individuals a separate issue from advocating on behalf of individuals with legal status? And to what extent are advocates willing to risk services for women with legal status?

The fact that the United States does not consider health care a fundamental right for its own citizens makes achieving the goal of equality that much harder. But this reality does not eliminate the need to carefully examine the strategies defending the rights of undocumented individuals.

Beyond the BCCTP, many liberal advocates would like to push toward universal access to health care, which would include all people, regardless of legal status.¹²² The BCCTP's original goal of equality, and the subsequent inequitable result, calls for careful examination of strategies employed to reach this goal. While the BCCTP will provide valuable services to women in the short-term, addressing the issue of including undocumented individuals will be critical for more permanent and longer term advancement.

122. See CAL. BREAST AND GYNECOLOGICAL CANCER TREATMENT TASK FORCE FACT SHEET *supra* note 75.