Immigrant Social Policy in the American States: Race Politics and State TANF and Medicaid Eligibility Rules for Legal Permanent Residents

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Abstract

This article explains variations in the response of states to the devolution of authority in immigrant social policy in the context of the 1996 Welfare Reform. The passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA or Welfare Reform Act) allowed states to change their immigrant eligibility rules for both TANF and Medicaid. Specifically, I evaluate the importance of racial demographics in the formation of state Temporary Assistance for Needy Families (TANF) and Medicaid policies for legal permanent residents. By looking separately at TANF and Medicaid, the findings in this article break from previous research to show that the two policies are driven by different factors and considerations. My analysis shows that while immigrant TANF eligibility decisions where influenced by the majority/minority conflict dominant in the 1990s, immigrant Medicaid policy operated quite differently indicating a less racialized context and more pragmatic, evidence-based discourse and action.

I. Introduction

Since the formation of the United States, race politics has been at the heart of both immigration and social welfare policies at the federal and the state levels. Race has been an integral part of all U.S. policies that determine access to political, social and material privilege (Smith, 1997; Schneider and Ingram, 2005; Massey, 2007). The tools of the state have been consistently employed in defining and maintaining both racial categories and unequal treatment by race (Smith, 1997; Tichenor, 2002; Katznelson, 2006). Over the past century, immigration policy and social welfare policy have served as the means to maintain systems of racially-based preferential treatment and to discriminate against racial minorities (Haney Lopez, 2006; Daniels, 2004; Ngai, 2004; Fording, 2003; Tichenor, 2002; King, 2002; Gilens, 1999; Brown, 1999; Hero, 1998; Quadagno, 1994; Katz, 1989; Wright, 1976; Fox-Piven and Cloward, 1971; Bell, 1965). Although the influence of race on both immigration and welfare policies is well document, the effects of racial politics at the intersection of the two policy domains remains relatively unexplored.

The two policy domains intersected in 1996 when Congress passed the most expansive welfare reform in a generation. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA or Welfare Reform Act) introduced fundamental change to America's social welfare system by eliminating the welfare entitlement program which was established by the 1935 Social Security Act and expanding the autonomy of states in the establishment of welfare eligibility rules (Soss, et.al., 2001; Mettler, 2000). PRWORA was also a ground-breaking reform of American immigration law. The new legislation ignored more than one hundred years of federal exclusivity in immigration policy, and decentralized authority to states allowing them to decide on immigrant access to federally-funded low-income support

programs.[i]   As a result of the Act, states assumed responsibility for setting eligibility rules for legal permanent residents (LPRs) for both the Temporary Assistance for Needy Families (TANF) program and for Medicaid.   Despite concerns about the potential for wholesale immigrant exclusion from these programs (Fix and Tumlin, 1996), states in fact produced varied responses: some states chose to incorporate almost all LPRs into their public benefits and healthcare programs; other states were far more selective and restrictive in terms of eligibility and inclusion.[ii] Some states chose to exclude LPRs from TANF only, others from both programs.

This article seeks to explain variations in state responses to the devolution of authority in the immigrant social policy domain, and to evaluate the role that racial demographics played in state policy decisions. In contrast to previous research that has either focused exclusively on TANF (Graefe, et.al., 2008) or on a combination of social programs (Hero and Preuhs, 2007), this study analyzes state immigrant eligibility rules for TANF and Medicaid separately. PRWORA invited states to change their immigrant eligibility rules not only for TANF but also for Medicaid. Yet, little attention has been paid to this healthcare policy change. This is a major omission because, as will be discussed, not only does the incentive structure for state governments differ by program, but the two policy areas are politicized and racialized very differently in the public discourse. By looking separately at TANF and Medicaid, the findings break from previous research to show that the two policies are quite different, and to caution against analyzing "welfare reform" for immigrants as a unidimensional phenomenon.

II.   PRWORA and the Devolution of Immigrant Social Policy

The Welfare Act represented a substantial shift in American welfare and immigration federalism and a rather unique quasi-experiment for American politics. PRWORA dismantled the AFDC entitlement program, and replaced it with the TANF block grant. TANF was also

decoupled from Medicaid, the health insurance program for the poor, which continued life as a means-tested federal entitlement program.

With PRWORA, welfare reform and devolution was tied to immigration reform and devolution. States, for the first time in the history of the modern American welfare state, had to decide whether to exclude immigrants from their social programs. Although Medicaid eligibility rules did not change for citizen recipients, for immigrants, the new law specified that the same eligibility rules that applied for TANF also applied for Medicaid. According to PRWORA, states could choose to include or exclude from TANF and/or Medicaid any or all of the three groups of immigrants that the law created.[iii] If states chose to incorporate immigrants in their programs, Washington matched funds only for pre-enactment immigrants and those who had been in LPR status for more than five years. New immigrants were excluded from federal TANF and Medicaid funding. If states wanted to extend any benefits to this group they had to do so proactively by establishing state-funded initiatives.

III.   Immigration, Social Policy and the Politics of Race

Both immigration and social welfare policies have been theorized as the result of Americans' understandings and evaluations of social and racial categories. Racial classifications and their associated tropes have led to racially-based assumptions of who deserves access to privileges and who does not. The nexus between immigration, welfare and race is multidimensional. Concerns over welfare, or the likelihood that an immigrant may become a "public charge," serve as the basis for exclusion from immigration to the U.S as well as a limitation for naturalization. At the same time, since PRWORA, immigration status serves as the basis for exclusion from welfare programs.

a.   Race and Immigration Policy

Alone among areas of law, immigration policy is not subject to the same strict scrutiny that the Supreme Court has applied to cases involving race and minorities (Neuman, 1996; Chin, 1998). Given this extreme latitude, the federal government and the states have sought through immigration policy to "design" the racial make-up of the country by encouraging desired racial groups over others. Most notably, such policies precluded the arrival of specific undesirables who threatened to disturb the racial and ethnic distribution of the American population and unsettle the system of privilege constructed around whiteness (Zolberg, 2006; Haney Lopez, 2006; Daniels, 2004; Ngai, 2004; Tichenor, 2002; King, 2002). Especially threatening were those people at the intersection of race and class: poor non-white immigrants who were thought to have a higher likelihood of becoming wards of the state and a social burden (Katz, 1986). In the early part of the 20th century, courts used expansive and creative notions of being a "public charge" to deport immigrants (Alpert, 1939). For example, having spent time in county jail for a minor concern was interpreted as having received public support which could then be used by the federal authorities as grounds for deportation of undesirables as public charges. In the 1930s states and localities used public benefits as a guise in the "repatriation" of more than half a million Mexican immigrants and Mexican-Americans.

The use of racial factors in immigrant exclusion is not simply a relic of the distant past. The federal government can and does continue to use race as a factor in its immigration policy decision-making (Chin, 1998). Internal studies conducted by the U.S. consular services as recently as the late 1970s, noted that visa adjudicators used racial tropes in the use of public charge exclusions: Mexicans and others from Central and South America were more likely to be excluded on the basis of becoming a likely public charge than were Canadians or Chinese immigrants (Anderson and Gifford, 1978; Johnson, 1998). In general, public charge exclusions, which tie directly to the fear that immigrants will become "dependent" on the American welfare

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system, have had a disproportionate impact on minority applicants for permanent residence (Johnson, 1998). Similarly, from the recent Arizona SB1070 law which requires all state and local police to enforce federal immigration law, to California's Proposition 187 (1994) to state laws in the West targeting Chinese and other Asian immigrants in the late 19th and early 20th centuries, state immigration policies have sought to exclude on the basis of race (Provine and Chavez, 2009; Tichenor, 2002; Hero and Tolbert, 1996).

b. *Race and Social Welfare Policy for Immigrants*

Race has played an equally important role in the development of the country's social welfare system both at the federal and the state levels (Fording, 2003; Gilens, 1999; Brown, 1999; Hero, 1998; Quadagno, 1994; Katz, 1989; Wright, 1976; Fox-Piven and Cloward, 1971; Bell, 1965). State and federal welfare provisions have consistently discriminated against racial minorities: state mothers' pension programs excluded black mothers (Bell, 1965; Gooden, 1999) while the Social Security Act of 1935 barred most blacks through its exclusion of agricultural workers (Brown, 1999). Studies of AFDC and its successor program TANF have documented substantial differences in the generosity and stringency of the programs which scholars have attributed to racial factors (Soss, Schram and Fording, 2003). Among the earliest to discuss the role of race, Wright (1976) showed that AFDC benefit levels were strongly correlated with the racial composition of the state's population and with the degree of political inclusiveness of the state as measured through an index of civil rights liberalism. Post-PRWORA research confirms the importance of race: Soss, Schram, Vartanian and O'Brien (2003) found that stringency was higher in states where the welfare rolls included more minorities. Howard (1990), Johnson (2001) and Keiser, et.al. (2004) have also documented similar findings. Furthermore, there is strong evidence that prior to PRWORA, states with large black populations were more likely to request waivers from the federal government that allowed them to implement more stringent

welfare rules, and more likely to implement more stringent eligibility rules after PROWRA (Fellows and Rowe, 2004; Soss, et.al., 2001; Zylan and Soule, 2000). However, these findings did not extend to Latinos (Fellows and Rowe, 2004).

For most researchers, the explanation for these findings lies in state-level adversarial relationships between the white majority and various minority groups. Many have posited that the presence of large numbers of racial and ethnic minorities among welfare beneficiaries has led those in the dominant white group to object to social programs on the basis that they are racially driven and preferential in nature (Soss, Schram, Vartanian and O'Brien, 2003; Hero and Tolbert, 1996; Taylor, 1998). Furthermore, the relationship between race and policy outcomes is theorized to be the result of negative perceptions and negative media discourses which paint welfare recipients and immigrants as "undeserving," "dependent," or "lazy." Erikson, Wright and McIver (1993) have demonstrated that public opinion plays a key role in public policy outcomes. Analyses of survey data also show that American public opinion has been quite hostile to welfare since the late 1960s (Gilens, 1999) and there is a strong tendency to view welfare recipients as "undeserving" (Gilens, 1995; Katz, 1989). This negative frame of "undeservedness" which had been primarily associated with African-Americans was extended to Latinos and immigrants during the period of the welfare reform debate (Gilens, 1999). As a result, racial attitudes reflected in public opinion, especially white public opinion, are a key driver of public policy outcomes (Johnson, 2003).

Public opinion has been equally hostile to immigrants and immigration. Simon and Alexander (1993) have shown that American public opinion has consistently favored immigration restriction for decades. Negative media cues about the costs of immigration tend to increase negative views of non-white immigrants among white natives (Brader, Valentino and Suhay, 2008). Especially in areas experiencing high immigration growth rates, perceptions of

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economic and social threat are magnified. States that experienced high immigration growth in the 1990s may have been more likely to exclude LPRs from social programs out of fear of becoming "welfare magnets" (Borjas, 1999). During the Congressional debates on PRWORA, immigrants were portrayed as lazy, fraudulent and undeserving of state support (Yoo, 2008). The 'dependency" argument which portrayed low-income immigrants as "likely public charges" found support in many quarters in spite of several studies which showed that the use of public assistance among immigrants was significantly lower than among the native-born population (Tienda and Jensen, 1986). Recent findings on immigration indicate that the growth of immigration when combined with a salient national discourse that depicts immigrants as a threat can lead to the introduction of restrictive legislation at the *local* level (Hopkins, 2010).

Although the role of race in the context of public policy has typically been conceptualized in terms of a (white) majority/(black) minority dynamic, research shows that African-Americans use their political agency to their benefit.   In states where blacks have stronger political representation they have been able to thwart some of the more stringent proposals and secure better benefits for poor people (Fording, 2003). However, the relationship between blacks and immigrants, especially low income Latino newcomers, has not been easy. A number of studies have documented social and political conflict between blacks and Latinos (Bobo and Masagli, 2001; Vaca, 2004). Thus another explanation for stringency in immigrant welfare programs points to inter-minority competition for resources and access (Gay, 2006). African-American legislators in states where the African-American community is strongly represented may have pushed for the exclusion of immigrants from welfare programs in an effort to retain a larger piece of the diminishing pie.

Analyses of immigrant welfare eligibility at the state level have produced mixed results on the strength of the majority/minority hypothesis. Graefe, et.al. (2008) found that in states

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with high black TANF caseloads, immigrant welfare eligibility criteria tended to be more stringent. Interestingly, the same study did not find a statistically significant relationship between the percent of Latino TANF cases or the size of the Latino population and welfare stringency. Graefe, et.al. (2008) did find that states that are traditional immigration destinations and have a long history of immigration are more likely to extend TANF eligibility to immigrants than are new destination states. On the other hand, Hero and Preuhs (2007) found no statistically significant relationship between the overall size of the Latino, immigrant, or black population and eligibility rules. Immigrant Medicaid eligibility has not been studied to-date.

The intra-minority competition hypothesis has not been evaluated in the context of immigrant welfare reform at the state level.   This article sought to include an assessment of the intra-minority conflict hypothesis but due to data limitations (explained in the data section), I was unable to provide any robust conclusions.

c. Race and Healthcare Policy for Immigrants: Does the Majority/Minority Conflict Hypothesis Apply?

Access to health services, health insurance and resultant health outcomes are all correlated with race. Today 47 million people in the United States are uninsured, including 20 percent of all blacks and Asians and 30 percent of Latinos. Historical accounts indicate that public health programs systematically excluded racial minorities and immigrants based on beliefs that the diseases afflicting these groups were the result of behavioral choices or heredity (Painter, 2010; Beardsley, 1990; Katz, 1986). Equally well documented are the sterilization programs that targeted minorities and immigrants as well as certain poor white populations (Painter, 2010; Hanson and King, 2001; Lopez, 1987).   Studies of health insurance coverage show the existence of significant racial differences between whites and blacks going back to the 1950s and persisting to the current time (Olson, 2010; Thomasson, 2006). And studies of health

outcomes have documented significant discrepancies across racial groups, especially blacks and these differences are to a great extend the result of differential access to quality healthcare services (Olson, 2010; National Health Disparities Report, 2009, also see previous years). In the case of immigrants, health outcomes vary by ethnic/race group, income and by length of presence in the United States. Health experts have documented the "paradox of assimilation": consistent findings that show deterioration of immigrant health over time as they stay in the United States (see Fennelly (2006) for detailed literature review).

The establishment of Medicaid in 1965 addressed some of the existing racial disparities in health service access by providing medical insurance coverage to low income families that met the criteria for AFDC. Over the next two decades, the scope of Medicaid was expanded to include a variety of non-AFDC eligible low-income populations. Even as states experimented with ways to reduce AFDC rolls and limit their welfare spending, Medicaid spending had *increased* through the 1980s and 1990s and states cost reduction efforts focused on changing reimbursement mechanisms, doctor pay-rates, and service delivery systems.   The goal was not to exclude people from the program; rather, new populations were added, especially pregnant women and young children, as well as elderly and disabled individuals (Schneider, 1998).

The implementation of PRWORA imposed limits on access to social programs and devolved to states the decision on immigrant eligibility for Medicaid. However, the program remained a jointly run and funded entitlement without spending caps. The only major change in Medicaid rules related to immigrant eligibility.   The immediate result of PRWORA was a substantial decline in the rates of public health insurance coverage among immigrants either because of ineligibility or out of fear and misinformation (Kandula et.al., 2004; Hagan et.al., 2003).

Although concerns about "undeservedness" have on occasion surfaced in relation to Medicaid, and the origins of welfare medicine are steeped in theories of individual responsibility for disease and punishment for sinful excess (Stevens and Stevens, 2004; Katz, 1986), the debate over deservedness has been limited in the post- World War II era (Olson, 2010; Stevens and Stevens, 2004). In 1995, 64 percent of Americans believed that the government should deny public benefits to all immigrants, including those legally in the country (Kaiser Family Foundation, 1995). However, these expressions of public hostility to public healthcare programs for the poor have been limited in scope. For one thing, Medicaid has received very little media attention except in cases of scandal and fraud (Olson, 2010). Furthermore, healthcare policy in recent decades has tended to be framed around issues of cost, access and public health rather than "deservedness" (Vilardich, 2009). Much of the analysis has been on the supply side, focusing on issues of managed care, fee-for-service schedules, reimbursement schemes, physician incentives and disincentives, service and drug tiering and other administrative considerations.

IV.   Data and Methods

As explained in section II, the federal government created three new categories of LPRs through PRWORA and enabled states to determine which of these groups, if any, they wish to include in their TANF and Medicaid programs. The analytical goal of this article is twofold: 1) to determine the factors that impacted state decisions to include immigrants in TANF or Medicaid; and 2) to identify differences between the two programs in terms of influential drivers of inclusion. To achieve these goals, a series of binary variables were created which were coded as "1" when the state offers a program to immigrants and "0" when the state does not include immigrants in the program. Following Hero and Preuhs (2007) and Graefe et.al. (2008), factor indices were estimated which provide continuous dependent variables.[iv]

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Factor analysis is a standard methodology that allows me to assess the degree to which states included immigrants in each of the two programs, instead of, simply, the odds that a state may include a certain portion of the immigrant population in TANF or Medicaid. Unlike Graefe et.al. (2008), this study focuses on the differences in the way states treat LPRs in the context of TANF and Medicaid policy regardless of the person's specific immigration classification (e.g., refugees, asylees).[v] Further, Hero and Preuhs (2007) combined the welfare and healthcare programs together with several other programs to compute a single factor score. However, the incentive structures and the politics of each the two types of policies (welfare, healthcare) differ; therefore, I contend that treating them separately leads to a better understanding of their social correlates. For that reason, TANF and Medicaid were analyzed as two different linear models and, correspondingly, two factor scores were developed.

The first dependent variable is labeled *TANF Eligibility Score* and it combines the three binary variables associated with TANF. The *TANF Eligibility Score* ranges from a minimum of -1.70 to a maximum of 1.93. The higher the factor score indicates more inclusive state eligibility rules for TANF. Analysis of eigenvalues shows that these policies can be combined into a single dimension: the eigenvalue of the first principal component has a numerical value of 1.4 and the second has 0.89. The Chronbach's A for this factor score is .72 indicating that the three variables do stand as a single factor. The second dependent variable is labeled *Medicaid Eligibility Score* and it includes the three binary variables associated with Medicaid eligibility. The *Medicaid Eligibility Score* ranges -3.52 to a maximum of 1.00. The higher factor score indicates more inclusive the state eligibility rules for Medicaid. Analysis of eigenvalues shows that these policies can be combined into a single dimension: the eigenvalue of the first principal component has a numerical value of 1.5 and the second has 0.89. The Chronbach's A for this factor is 0.69, which indicates that the score is somewhat less correlated but within acceptable

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limits. Descriptive statistics and source information on the dependent variables can be found in

Appendix A.

Both the TANF Score and the Medicaid Score models were studied using OLS regression.

A total of seven independent variables were included in the base model. Demographic and

economic variables were lagged. Three predictors related to the racial/ethnic composition of

the state population: 1) percent of population that is black; 2) percent of population that is

Latino; and 3) percent of population that is foreign born. Interaction terms for these

demographic variables were also tested but yielded no significant results, so they were excluded

from the models. I also tested interaction terms for these variables with each other and with

public opinion liberalism. The population data were derived from U.S. Census sources. The

models also include two measures of the political environment of the state. These are Erickson,

Wright and McIver's (1993) measure of public opinion liberalism, and Rom, Peterson and

Scheve's (1999) measure of Democratic party control updated to include data from 1996-1997.

Also included are two lagged measures of the state's economic conditions, unemployment and

percent of population under poverty. The sources for the economic variables were the U.S.

Statistical Abstracts and the U.S. Bureau of Labor Statistics. Table 1 presents descriptive

statistics for all the variables included in the equations.

[TABLE 1- HERE]

 The final model was formalized as:

TANF/Medicaid Eligibility Score$_i$=α+β$_1$(Percent of population Black) + β$_2$(Percent of population Latino) +β$_3$(Percent Foreign Born) + β$_4$(Public Opinion Liberalism) + β$_5$(Democratic Party Control) + β$_6$(Controls) +error$_i$

Both the TANF and the Medicaid model were examined for normality, collinearity and

heteroskedasticity, using visual inspection of the data and standard formal tests. The TANF

model shows weak violation of normality (at the 10 percent level, using the Shapiro-Wilks test),

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while skewness and kurtosis are well within the acceptable norms for weak deviation from normality. No equivalent deviations appear in the Medicaid model. The model was re-examined excluding possible outlier states (California, Rhode Island, Utah and Maine) which resulted in approximately 6% change in the coefficient of determination and similarly small changes in the other diagnostic metrics. On the basis of these results, all states were included in the model. Collinearity diagnostics also fell within acceptable levels, while there is no significant evidence of heteroskedasticity from the residual scatterplots in the TANF model. There is, however, evidence of heteroskedasticity in the Medicaid model. For reasons of consistency, both models were run using robust standard errors procedures (Huber-White). Furthermore, using the feasible generalized least squares method (FGLS) for seemingly unrelated regression (SUR), to test the hypothesis that the two equations are correlated, I found no significant evidence of correlation in the error terms of the two regressions.

Table 2 summarizes the effects I expect to see in the models based on the theoretical discussion. The predictions are consistent with the literature on immigration and welfare. As noted earlier, I expect that the size of various minority populations correlates negatively with immigrant inclusion in TANF and Medicaid. Among the control variables, the two political variables, public opinion liberalism and Democratic party control are expected to correlate positively, while the two indicators of state-level economic conditions are expected to be negative correlates.

[TABLE 2- HERE]

Table 3 presents the results of the multivariate regressions for TANF and for Medicaid immigrant inclusion. The standard errors for each terms is included in parentheses below the relevant coefficient. Statistical significance is noted at the 99 percent confidence interval or the 95 percent level.

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[TABLE3 –HERE]

It can be seen that the two models resolve very different proportions of variance. Adjusted R^2 is 0.554 for the TANF model, but it is only about half of that (0.286) for the Medicaid model. In both models, the liberalism variable is a strong correlate (standardized b=0.375 for the TANF model; β=0.500 for the Medicaid model) and significant at the $p < 0.01$ level. There are, however some differences between the two models: the percentage of African American population is a negative correlate in the TANF model and a positive (but not significant) in the Medicaid model. Percentage of Latino population also correlates in opposite manner but is not significant in any model; the percentage of foreign born correlates more strongly and is significant in Medicaid; while percent below poverty correlates negatively in both models, but it correlates strongly and is statistically significant in the TANF model while it is close to zero (no effect) in the Medicaid model. I will discuss these findings in detail in the following Section.

V. Discussion

As expected given earlier research findings, estimates indicate that public opinion liberalism played a similar and significant role in the development of the immigrant eligibility rules for both programs, a finding consistent with previous research in immigration policy and in state politics writ large (Graefe, et.al., 2008; Hero and Preuhs, 2007; Erikson, Wright and McIver, 1993). States with a liberal public opinion were more likely to be inclusive of immigrants in both programs than were states with a more conservative public opinion. However, liberalism has a much stronger effect in the case of Medicaid than in the case of TANF, indicating that ideology played a more important role in that policy field. By contrast, TANF was more dominated by race factors. Furthermore, consistently with other research this analysis shows that legislative control by the Democratic Party is not a statistically significant correlate of immigrant inclusion

in welfare programs (Hero and Preuhs, 2007). In part, this is because welfare reform in the 1990s was supported by the Democratic Clinton Administration which sought to "end welfare as we know it." Also, there is important research indicating that when it comes to immigration, parties are split into pro-immigrant and anti-immigrant wings (Tichenor, 2003).

The role of race in the development of immigrant eligibility rules is more complex and nuanced, and it differs substantially across programs. In the case of TANF, the size of the black population in the state served as a significant negative correlate to inclusion of immigrants. States with large black populations were more likely to exclude legal immigrants from TANF than were those with smaller black populations. In contrast to TANF, the size of the black population had no statistically significant effect on legal immigrant eligibility for Medicaid. Conversely, there is no statistically significant relationship between the size of the foreign-born population or the size of the Latino population and legal immigrant inclusion in TANF, but the size of the foreign born population is a significant positive correlate for Medicaid inclusion.

The TANF finding is consistent with the literature that analyzes the racialization of welfare reform, indicating that the discourse focused on the black-white divide (Fellows and Rowe, 2004; Fording, 2003; Soss, et.al., 2001; Zylan and Soule, 2000; Gilens, 1999). The size of the Latino population was not significantly correlated with TANF immigrant eligibility suggesting that states with large Latino populations were as likely to include LPRs in TANF as states with smaller Latino populations. My results indicate that the negative focus of welfare policy did not extend to the Latino population, in agreement with previous studies (Fellows and Rowe (2004). Although Latinos were also negatively portrayed as "undeserving" poor, this was not to the same extent as blacks (Gilens, 1999). Thus in the case of immigrant welfare policy, immigrants became collateral damage to the majority/minority conflict in states with large black populations.

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The alternative hypothesis of an intra-minority conflict could not be fully evaluated with

the data at hand. This hypothesis posits that in states where blacks had some political power

compared to immigrants and Latinos, black legislators may have supported immigrant welfare

exclusion in order to maintain a larger portion of a rapidly shrinking pie for their constituents. I

created a variable for the relevant legislative cycle which indicated the number of state

legislators in each state who were black. However, the correlation between this variable and

"percent of population black" was .90, making it impossible to independently assess the two

hypotheses. A more complete assessment would require an examination of the legislative

record for all 50 states to identify the position that black legislators took at the time of the

passage of welfare reform in their states. This analysis is beyond the scope of this article but a

point that deserves further investigation given existing literature on the intra-minority conflict.

TANF immigrant eligibility was also influenced by the economic conditions in the state,

especially the poverty level. States with a lower percentage of the population under poverty

were more likely to include immigrants in their TANF programs than were states with a higher

percentage of the population under the poverty line.   The block-granting of TANF explains why

poorer states may have been more eager to exclude immigrants from the program. PRWORA

set the total amount of funding available for TANF to what was spent in 1995. This meant that

through immigrant exclusion, states with high poverty rates could provide a slightly higher

stipend for more native-born and naturalized low income residents.

In the case of Medicaid, a very different pattern emerged suggesting that the two

policies operate quite differently. In this model, neither the presence of a large black population

nor the presence of a large Latino population was statistically significant in the model though it

is worth noting that the coefficient for Latino population is negative. However, in contrast to

TANF, there is a strong and highly significant positive correlation between the size of the foreign

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born population and immigrant inclusion in the program, indicating that immigrant gateway states were more likely to offer Medicaid access to this population. Equally interesting, in the case of Medicaid, there is no statistically significant correlation between the economic control variables and immigrant inclusion in the program, whereas a higher poverty rate correlates negatively with immigrant inclusion in TANF.

Why is it that the size of the foreign-born population was a statistically significant driver of immigrant inclusion in Medicaid but not TANF? And why did racial and economic factors also play very divergent roles in the two programs? In part, these differences are an indication that Medicaid was not racialized in the same way as welfare. Indeed, as noted earlier, researchers in healthcare have argued that the political discourse on healthcare has been less centered on issues of "deservedness" or race and more on issues of cost and access (Olson, 2010; Viladrich, 2008; Stevens and Stevens, 2004). The racialized "deservedness" discourse reappeared in the public scene in recent years, as part of the debate over access of undocumented immigrants to subsidized health insurance under President Obama's healthcare reform. However, in the context of the 1990s when the focus was on legal permanent resident access to welfare programs, the issue of deservedness was not central to the debate.

Another reason for the differences between the drivers of eligibility for TANF and Medicaid is that exclusion from Medicaid does not represent a clear-cut benefit to the state the same way that exclusion from TANF does. Removal from welfare rolls represents a net fiscal gain for the state. The cost of losing income support is shouldered by the immigrant who has little political power or electoral significance, and low-income legal immigrants are concentrated in city neighborhoods while more affluent voters live in suburbs and exburbs. Therefore, the decision to exclude legal immigrants from TANF, especially when the state has fiscal difficulties, has few political costs from the perspective of political leaders. This is not the case for

Medicaid: excluding individuals from healthcare programs has direct economic costs for the state. Uninsured, low income individuals –and much of the foreign born population falls into this category—may resort to costly emergency services. Federal law prohibits states and localities from excluding any person, regardless of immigration status, from accessing emergency healthcare services.

Furthermore, the differences between the drivers of TANF and Medicaid immigrant eligibility reflect differences in the incentive structures that shaped the two programs. In the case of TANF, not only were states allocated a fixed amount of monies as a result of block-granting, but the success of the program was measured in terms of reduction in welfare rolls, with inducements for high-performing states. Immigrant exclusion provided a way to reduce welfare rolls and cut expenditures. The social costs of excluding legal immigrants from TANF were mostly borne by the immigrant families themselves and by the communities within which they lived, but these costs were less visible to the general public. Some of the cost may be incurred by the state in the form of urban blight, higher crime and the need for additional police in certain poor neighborhoods, but the median voter is less aware of this association (Weir, 1997). Policymakers could thus score political points by claiming that immigrant exclusion from TANF encouraged immigrant self-sufficiency and prevented immigrants from becoming "dependent" on the state (Yoo, 2008).

The Medicaid political calculus was different. Not only did the program remain a jointly run and funded entitlement but Washington did not block-grant the program the way it did with TANF in 1996. Furthermore, the program has been set up to create incentives for high poverty states to include more people. Medicaid operates with a formula that is based on a state's poverty level. Thus states with higher poverty levels receive a higher match from the federal government for each individual they cover through Medicaid. Federal rate of reimbursement

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ranges from 50 to 80 percent depending on the state's poverty level.   It is thus not surprising that, even as states experimented with ways to reduce AFDC rolls and limit their welfare spending, Medicaid spending had *increased* through the 1980s and 1990s and states cost reduction efforts focused on changing reimbursement mechanisms, doctor pay-rates, and service delivery systems (Schneider, 1998).   The goal was not to exclude people from the program; rather, new populations were added, especially pregnant women and young children, as well as elderly and disabled individuals (Schneider, 1998).   Thus the incentives to exclude legal immigrants from Medicaid were lower than those for TANF because of the differences in funding structure.

Immigrant inclusion in Medicaid made sense especially in high immigration states. The federal requirement that all noncitizens have a right to emergency healthcare meant that exclusion from Medicaid could lead more immigrants to the emergency room (ER). Since the cost of unreimbursed ER services is covered by states and localities, Medicaid exclusion could come at a heavy price, especially since emergency care is significantly more expensive than routine care. These types of cost considerations prompted states to offer Medicaid access to "medically needy" individuals (mostly seniors) who did not meet the income specifications of AFDC (Grogan, 1994). Similarly, immigrant access to prenatal care programs can save states money related to caring for premature or under-weight U.S. citizen newborns. In fact, throughout this period, states and the federal government introduced a number of programs to meet the healthcare needs of pregnant women and their children (Schneider, 1998). Some states even provided funding for the prenatal care of undocumented pregnant women recognizing that they were investing in the health of an American citizen child.

States recognized that the cost of immigrant exclusion could be high for American citizens as well: health problems associated with the lack of prenatal care are particularly acute

and expensive. Citizen children born to uninsured immigrant parents are more likely to be born prematurely, be underweight and require expensive neonatal care. In North Carolina, 80 percent of immigrant-related healthcare costs borne by the state involved child-birth and post-natal care (Committee on Future of Emergency Care, 2007). Since the children born to immigrant parents are American citizens by birthright and thus immediately eligible for state benefits, states have an incentive to provide preventative care to immigrants in order to minimize the costs associated with neonatal services.

The emergency care costs shouldered by states and localities did not end with prenatal care. The Congressional Budget Office (CBO, 1995) in its assessment of the PRWORA legislation warned that immigrant exclusion could shift the immigrant healthcare burden from the federal government to local emergency rooms and clinics, both the exclusive responsibility of sub-national governments. The CBO estimated that federal savings from immigrant exclusion from Medicaid would be approximately $7.7 billion between 1996 and 2000 but the costs would shift down burdening states and local governments (Congressional Budget Office, 1995). More recently, the CBO issued similar warnings when arguments surfaced for the exclusion of legal immigrants from the Obama healthcare reform law (Capps, Rosenblum and Fix, 2009). Furthermore, evidence based on a study of undocumented immigrants, a population that is eligible *only* for emergency benefits, indicates that exclusion of legal permanent residents from Medicaid does lead to higher healthcare costs. Specifically, a comparison between California, which in the 1990s provided some funding for non-emergency care of undocumented immigrants, and the other states which did not offer similar programs, shows that the per capita healthcare cost of undocumented immigrants in California was 60 percent of the average resident spending while in the rest of the country it was 223 percent of the average (Ku and Kessler, 1997). More recently, in 2009, a Massachusetts bill which set to revise immigrant

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eligibility rules and exclude all legal permanent residents from the state Medicaid program was estimated to provide $130 million in cost savings but would add at least $87 million to the unreimbursed emergency care costs of local public hospitals and clinics (Capps, Rosenblum and Fix, 2009).

Additionally, immigrant exclusion from Medicaid could result in significant spillover costs for public health. Unlike exclusion from TANF, which affects the lives of individual immigrants and their families, immigrant exclusion from Medicaid can have a serious impact on the larger population. Public health programs covered through Medicaid, such as access to immunization, are beneficial to everyone in society. Not only are citizens and immigrants in increased danger of various communicable diseases but lower immunization rates have real economic costs as well. According to the U.S. Department of Health and Human Services, every dollar spent on immunizations represents future costs savings of $27 in healthcare (U.S. Department of Health and Human Services, 2000). Insured individuals are more likely to be vaccinated for contagious diseases while a cluster of unvaccinated immigrants can have serious implications for public health.

VI. Conclusion

Racial factors have played important roles in the shaping of public policy towards vulnerable minority populations, but the centrality of racial considerations differs by policy area. The story of immigrant eligibility for TANF and Medicaid shows that the debate over welfare/TANF policy in the 1990s was more racialized along the traditional black/white divide. The shaping of TANF was informed by notions of "deservedness" and it included efforts at behavior modification which have been strongly tied to race (Fording, 2003; Gilens, 1999). Beliefs about the "laziness" and state dependency of black and (to an extent) Latino low income women guided both the discourse and policy prescriptions. State-level immigrant eligibility for TANF was also affected by this majority/minority racial division as states with large black

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populations were more likely to exclude immigrants from TANF than were those with smaller such populations. More research is needed to assess the intra-minority conflict hypothesis: did black legislators in states where they wielded substantial electoral power vote against immigrant inclusion in TANF and Medicaid? What does the state legislative record reveal about the way immigrants (most of whom are Latinos) were perceived by black leaders in the 1990s? A more historical, qualitative approach could provide clues about the position of black legislators on immigrant welfare eligibility.

This study does show that the healthcare/Medicaid policy operated quite differently from welfare/TANF indicating a less racialized context and more pragmatic, evidence-based discourse. Traditionally, the discourse over healthcare has focused on cost and public health issues with a lesser emphasis on deservedness. In this case, states with large foreign-born populations were more likely to include immigrants in their Medicaid programs, a decision that reflected the reality that exclusion of immigrants from Medicaid would result in cost shifting from the insurance program to public hospital emergency rooms and local clinics.

Another aspect of this story deserves more close scrutiny too. There is strong indication that interest groups played a significant role in pushing for immigrant inclusion in Medicaid, another factor that differs between the two programs. The American Medical Association, the American Hospital Association, and senior citizen groups argued for expansion of Medicaid services and, in the process, shifted the debate away from inclusion to issues such as the desirability of managed care, the type of payment schemes for doctors and the reimbursement schedules. By contrast, welfare policy has never enjoyed the support of such powerful and well-organized constituencies. The data available for this study did not allow me to quantitatively assess the role of interest groups in the development of immigrant TANF and Medicaid eligibility rules, but this is an important topic for future research.

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[i] In the 1880s, the Supreme Court determined that immigration policy and all policies relating to non-citizens fall under Congress' plenary power. In a number of subsequent decisions, the Court determined that "*Over no conceivable subject* is the legislative power of Congress more complete than it is over [immigration and naturalization]" *Oceanic Navigation Co. v. Stanahan* 214 US 320 (1909). For a discussion of immigration federalism see: Newton and Adams (2009), Spiro (2001), Skerry (1995).

[ii] States could not offer differential programs to LPRs, for example they could not provide smaller benefits or less comprehensive insurance. Only full inclusion of full exclusion was at play with PRWORA.

[iii] The law created three new categories of LPRs: those who were granted permanent residency prior to August 22, 1996 (pre-enactment LPRs), those who were granted LPR status after August 22, 1996 and have been LPRs for fewer than

five years (new immigrants) and those who received residency status after August 22, 1996 but have been in LPR status for more than five years.

[iv] The approach that I use is conceptually identical to the one used by Hero and Preuhs (2007) and Graefe (et.al, 2008).

[v] Graefe, et.al. (2008) created factors based on primary and secondary legal classifications of immigrants (e.g., asylum-seekers, battered spouses, new LPRs) on the assumption that states would treat various immigrant groups differently. The focus here is with LPRs in the context of TANF and Medicaid.