Abstract

In this thesis I investigate disparities in U.S. immigrants’ access to health insurance, a strong proxy for differential access to quality care in the American non-universalized health system. The United States is notorious among industrialized nations for its high proportion of uninsured residents—about 15% of the total population. U.S. immigrants, however, lack health insurance at a rate nearly double or triple the national average.

The immigrant uninsurance problem has been exacerbated by large-scale, deliberate economic and political adjustments to American health insurance institutions, and immigrants’ structural relations to these institutions. The two institutions I scrutinize in this thesis are (1) the employer-sponsored insurance system for immigrant workers, and (2) government-sponsored insurance systems for lower-income immigrants in need. Using a combination of primary and secondary data analysis, expert interviews, and a synthesis of multidisciplinary research, I map out the recent history and driving logic(s) of the immigrant uninsurance phenomenon, both for the United States in the 1980s-1990s and for the “case study” of Minnesota in the 2000s.

During the 1980s and 1990s, new immigrants to the United States in need of health coverage were “squeezed” by both of the largest health insurance institutions. First, immigrants were negatively affected by a polarized private labor market that increasingly limited its provision of health insurance benefits to those workers at the higher end(s) of the skill/income spectrum. Second, immigrants were actively targeted by a federal government that decided to explicitly exclude many of them from the protection of the national health insurance safety net. The end result of these negative “stresses” was that by the 2000s, immigrants’ chances of obtaining health insurance were at once increasingly “personalized” (i.e. dependent upon immigrants’ individual and community characteristics), and increasingly dependent upon localized economic, political, and institutional contexts. In Minnesota, for example, the immigrant uninsurance rate in the 2000s remained lower than the national average. This outcome was enabled, however, by specific demographic and institutional contexts unavailable in most other states. The health insurance system for immigrants in the 2000s, in other words, became increasingly geographically fragmented and contingent.
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1 Introduction: The alarming persistence of immigrant uninsurance

In the span of a single generation, the United States has experienced a massive demographic transition towards increased racial and ethnic diversity in nearly all regions, whether urban, suburban or rural. A significant proportion of this transition has resulted from differential birth rates between white and minority groups among the native-born population (Frey, 2011). The remainder has been the result of large and growing international migration flows. The 1990s marked a rapid acceleration in the pace of immigration to the United States. The nation’s foreign-born population grew by 57% during this decade (Singer, 2004), and by 2000 nearly 20% (60 million) of the national population were either foreign-born or 2nd generation immigrants, the largest proportion since the turn of the 20th century (Hirschman & Massey, 2008). In one of the most recent national counts (2009), first and second-generation immigrants moved up to slightly over 20% of the total population (U.S. Census Bureau Public Information Office, 2010).

New immigrants to the United States have been forced to adapt quickly to a bevy of the nation’s idiosyncratic systems and institutions of social reproduction—housing markets, job markets, education system(s), and so on. Because of the absence of significant explicit and organized support from the federal government, the contemporary integration of immigrants into these systems and institutions has been assisted by localized, ad-hoc programs and policies developed by local governments, civil society organizations, and immigrant communities themselves (Fix et al., 2001). But precisely because of this incomplete and/or differential integration, immigrants have suffered lower levels of wages, wealth, education, and other measures of socioeconomic well-being. Concerns over such disparities have intensified as the
geography of immigration has shifted. Since the 1990s, increasing numbers of foreign-born residents and citizens have migrated to locations away from traditional “gateway” states like New York, California, and Illinois, and towards “new destination” states like Colorado, Oregon, South Carolina, and Minnesota (Massey & Capoferro, 2008). While these new destinations offer some benefits to new immigrant communities that are unavailable in “saturated” gateway destinations, the former lack the latter’s robust institutional capacities for integrating and supporting new immigrants—capacities that traditional gateway communities built through collective action over decades.

This thesis examines the relation of new immigrants to one of the potential institutions of integration, the U.S. health care system. Specifically, it focuses on disparities in immigrants’ access to health insurance, a strong proxy for differential access to quality care in the American non-universalized health system. The United States is notorious among industrialized nations for its high proportion of uninsured residents—about 15% of the total population. U.S. immigrants, however, lack health insurance at a rate nearly double or triple the national average. The problem of immigrant uninsurance¹ is general across the fifty states, though measures of it vary depending on which definition(s) of “immigrant” are applied. This explains the wide variations in estimates of the uninsurance rate for immigrants. For example, persons who do not speak English as their primary language at home are uninsured at a rate roughly double the national average (33% compared to 15%).² In contrast, noncitizens who have resided in the country less

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¹ A broad term I will use throughout this thesis, referring to the generalized phenomenon of disproportionately high rates of uninsurance among different foreign-born groups (legal residents, refugees, undocumented residents, etc.) compared to native-born citizens.

than six years have an uninsurance rate closer to 50%.\textsuperscript{3} Naturalization is positively correlated with higher rates of insurance coverage: legally-present immigrants who are not yet citizens are “worse off” than naturalized citizens in terms of health insurance coverage, but remain “better off” than undocumented immigrants (Carrasquillo et al., 2000).

Immigrant uninsurance is geographically heterogeneous. \textbf{Figure 1.1} presents a map of uninsurance rates by state for noncitizens in 2009. They vary widely from state to state, from lows of 11% to 30% in northern and northeastern states to highs of 50% to 70% in (mostly) southern states. If it were the case that noncitizens and citizens were treated “equally” with respect to insurance and uninsurance in each state, the questions this map seemingly raise are why are uninsurance rates \textit{in general} so high in southern states (for example), and why do noncitizens reside in high-uninsurance states. However, census data shows that noncitizens are not treated equal to citizens in the health insurance system. On the contrary, geographic variations in immigrant uninsurance are exacerbated by large and (predictably) regular disparities between noncitizen and citizen populations in nearly every state. \textbf{Figure 1.2} plots immigrant uninsurance rates per state against insurance disparity rates between immigrants and native-born citizens per state. Very strong correlations between uninsurance rates and disparity rates appear, suggesting that patterns of very high immigrant uninsurance—in the south, for example—are not merely statistical artifacts of geographic patterns of general uninsurance. Native-born citizen populations almost \textit{always} fare better than noncitizen populations in terms of insurance coverage, \textit{especially} in states with very high rates of immigrant uninsurance—immigrants and natives are never “in the same boat” in any state.

Figure 1.1: Uninsurance rates for noncitizens by state, 2009. States are divided into five quintiles of uneven percent range. The middle 3/5ths of states fall into the 30%-50% range. Source: Calculations by author, data from U.S. Census Bureau (2010).

Large and widespread disparities in health insurance coverage lead to tangible (and well-publicized) consequences for immigrants’ access to health care. Unable to acquire access to first-rate hospitals and doctors, many poor and uninsured immigrants resort to unlicensed practitioners, makeshift pharmacies, and traditional healers for their care, often with deleterious or deadly effects. Without access to quality preventative health care, many of the same immigrants choose to (or are forced to) wait until their health problems reach critical or life-

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4 Some publicized examples: Kilborn (1999); Steinhauer (2000); Bernstein (2006); Sack (2008).
Figure 1.2: Immigrant group uninsurance rates vs. disparity between native-born and immigrant group uninsurance rates, measured by state, 2009. Data are displayed for the noncitizen populations, foreign born populations, and naturalized citizen populations of each state for comparison. Each dot represents data from one state, for one immigrant category. Example: the blue outlier in the upper right corner (70.8%, 55.8%) represents data from North Carolina’s noncitizen population. Of North Carolina’s noncitizen population in 2009, 70.8% were uninsured, a rate which was 55.8 percentage points higher than North Carolina’s native-born uninsurance rate (15%). Linear regression R-squared values are displayed in colors corresponding to the three immigrant categories. Strong positive correlations exist between high uninsurance rates and high immigrant-native disparities in insurance coverage. These correlations suggest that high immigrant uninsurance rates are not merely artifacts of states’ underlying average insurance rates. In a counterfactual case, if immigrants were insured at the same rates as native-born citizens in each state, the plot above would extend horizontally and would be clustered around the x-axis, as average differences in insurance rates between immigrants and natives would be close to zero. Source: Calculations by author, data from U.S. Census Bureau (2010).

threatening thresholds before seeking help in hospital emergency departments. These consequences, combined with the increased long-term financial risks of being uninsured, point to the same conclusion: the inadequate incorporation of new immigrants into the U.S. system of health insurance leads categorically to unequal access to the nation’s bedrock health care

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5 E.g. Kennedy (1999); Canedy (2002); Sack (2010).
institutions. More bluntly, uninsurance plays a large part in keeping immigrant populations close to the U.S. health care system’s “floor” (Portes et al., 2009).

In this thesis I argue that immigrant uninsurance is not an unavoidable malady; a *casus fortuitus* that may be fretted over empirically, but that will always be a part of the uniquely “American” immigration experience. On the contrary, the immigrant uninsurance problem has been exacerbated by large-scale, deliberate economic and political adjustments to American health insurance institutions and immigrants’ structural relations to these institutions. The “institutions” I examine are those of (1) employer-sponsored insurance (abbreviated ESI) for immigrant workers, and (2) government-sponsored insurance (abbreviated GSI) for lower-income immigrants in need. During the 1980s and 1990s, new immigrants to the United States in need of health insurance were “squeezed” by both of these institutions: first, by a polarized private labor market that increasingly limited its provision of health insurance benefits to those workers at the higher end(s) of the skill/income spectrum, and second, by a federal government that decided explicitly to exclude most new immigrants from the protection of the national health insurance safety net that all other citizens enjoyed. The end result of these negative “stresses,” I will argue, was that by the 2000s, immigrants’ chances of obtaining health insurance were at once increasingly “personalized” (i.e. dependent upon immigrants’ individual and community characteristics), and increasingly dependent upon localized economic, political, and institutional contexts. The health insurance “system” for immigrants in the 2000s, in other words, became increasingly geographically fragmented and contingent.

This thesis is divided into three chapters, and progresses across the recent history of immigrant uninsurance semi-chronologically (i.e. with timeline overlap between chapters). Chapter one explores the erosion of employer-sponsored insurance for immigrants in the United
States as a side-effect of economic restructuring, labor market polarization, and rising health care costs, and details immigrants’ structurally-disadvantaged relation to the ESI institution. Particular attention is paid to how the erosion of immigrant ESI (as a phenomenon in itself) fits within the broader framework of economic restructuring and shifting labor/employer dynamics in the American economy. ESI erosion attributable to systematic shifts in the economy began in the 1970s, and then accelerated in the following decades at the same period as accelerated immigration to the United States. Chapter one’s focus is therefore the events of the 1980s and 1990s, though reference is made to earlier and later periods. Also, as economic restructuring and ESI erosion are nation-wide phenomena, this chapter is largely confined to analysis at the national scale (though state-level geographic patterns of ESI are addressed).

In the American health care system, government health insurance programs act as safety-nets for many (though not all) individuals excluded from the private market for health insurance. Following chapter one’s discussion of private-sector insurance erosion, chapter two focuses on the government’s role in providing safety-net insurance coverage for immigrants. It revolves around the authorship and passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), more commonly referred to as “welfare reform.” PRWORA included sweeping changes to the federal government’s treatment of immigrants when determining eligibility for Medicaid; this chapter attempts to tease out the consequences of this state restructuring. Topics covered in this chapter are the relation(s) of PRWORA’s immigrant provisions to neoliberal welfare/workfare strategy, PRWORA’s effective “downloading” of immigrant welfare programming responsibilities to the states, and the ways in which different immigrant groups have become favored, excluded, or ignored by government GSI policy since 1996. The passage of PRWORA marked the beginning of a new era for
immigrant GSI in America, and represented a new form of institutional “squeeze” on immigrants, one that exacerbated the pressures created by the unraveling of the national ESI system. The temporal range of Chapter two is mostly limited to the late 1990s, though references are made to earlier “eras” of immigrant GSI policy. I also set the temporal “endpoint” of chapter two to be the early 2000s, as a set-up for a more in-depth discussion of (un)insurance trends in the 2000s in chapter three. Like chapter one, chapter two mainly deals with analysis at the national scale, though state-level government actions are cited during the discussion of GSI “downloading.”

Chapter three explores the following question: after the institutional erosion of ESI in the 1980s and 1990s, and after the federal government’s downloading of immigrant GSI responsibility to the states in 1996, how was immigrant access to health insurance experienced in the 2000s? Evaluating the dynamics of immigrant insurance/uninsurance across all or even several states is beyond the scope of this thesis, and I instead limit my analysis to a case study of one state: Minnesota. The single-state case study method sacrifices external validity with respect to understanding trends nationally in the 2000s, but it also provides a number of analytical advantages. First, it allows me to break away somewhat from the vague discussion of ESI and GSI “systems” present in chapters one and two. I am able to put these systems into the context of real, lived, place(s) in this chapter. Second, it allows me to explore the local contextual factors present in the state that expand or inhibit immigrant insurance coverage. Minnesota is a “new destination” state with respect to U.S. immigration, and it also boasts one of the lowest immigrant uninsurance rates in the nation. I argue that geographic contextual factors like Minnesota’s entrenched ESI system, state government commitment to immigrant GSI, and local
immigrant demographics acted in tandem to enable low levels of state immigrant uninsurance during the decade, and differentiated the Minnesotan experience from those of other states.

The U.S. legislature and the Obama administration passed the Patient Protection and Affordable Care Act during the research phase of this project. After summarizing my conclusions from chapters one through three, I will conclude the thesis with some comments on the possible ramifications of this new health-care reform on immigrant health insurance and health care disparities. It may very well turn out that the Affordable Care Act, if fully enacted, will render moot the use of insurance status as a proxy measure for immigrant access to health care. This does not guarantee, however, that disparities between immigrants and the native-born will disappear. A schematic representation of the organization of this thesis is shown in Figure 1.3.

A large portion of this thesis is dedicated to unpacking, analyzing, and synthesizing large amounts of quantitative and categorical statistical data on immigrants, health insurance, and the connections between the two. For these tasks I make use of publicly available data sets, such as the U.S. Census Annual Social and Economic (ASEC) supplement and the Minnesota Health Access Survey, as well as secondary data collected by other researchers. ASEC data in particular are used to produce maps of interstate insurance trends, run correlation tests between insurance-related variables, and produce various measures of inequality in immigrant health insurance over time. When possible I confine my comparative analyses to data sources that use consistent data/population definitions for the sake of consistency, though I often switch between statistical sources given the limited and fragmented nature of data on immigrant uninsurance. ASEC data, for example, only extend back to 2002. In order to investigate trends in the 1990s and earlier, I rely on secondary research and data analysis.
Chapter 1
Theme: Erosion of employer-sponsored insurance (ESI) and immigrants’ particular disadvantages in obtaining ESI
Time range: 1980s and 1990s, with context from Fordist era
Geographic scale: National economy

Chapter 2
Theme: Government role in providing/restricting government-sponsored insurance to immigrants
Time range: 1996 – early 2000s, with context from earlier era(s) of governance
Geographic scale: Federal government, state governments

Chapter 3
Theme: Minnesota state’s “system” for immigrant health insurance in an ESI-eroded, post-PRWORA era
Time range: 2000 – 2010
Geographic scale: State level, local levels

Conclusions
Theme: Conclusions plus possible future legislation
Time range: Post-2010

Timeline
1990 2000 2010

Figure 1.3: Chapter organization of this thesis.

Much of the data surrounding immigrant uninsurance comes from the late 1990s, unfortunately, and varies widely in the scope of immigrant sub-populations studied. One detailed study may evaluate the effects on low-income noncitizen LPR parents and children, while another study

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6 Following the passage of welfare reform, with no coincidence.
may use an aggregate measure of noncitizens that includes undocumented workers, and another may study a small-group sample from a particular region of the country. Faced with the inescapable variability of this collection of work, I do not attempt to present a single, comprehensive account of the “empirical” side of immigrant uninsurance, nor do I assign inordinate weight to specific quantitative magnitudes observed in the data. Rather, I use data primarily to illustrate the existence or absence of uninsurance disparities, for example, and the directionality of changes over time.

Statistics, of course, never speak for themselves. I have spent much time synthesizing and applying theory and research on labor market restructuring, neoliberal welfare reform, and associated contemporary economic and political trends to the problem of immigrant uninsurance in an attempt to better understand and explain its construction. As immigrant uninsurance is affected along multiple axes of difference, I have deliberately drawn from a multidisciplinary group of geographers, economists, health researchers, legal scholars, and political scientists in my research. Most sources cited in this thesis are publicly-available, though some (especially in Chapter 3) are more readily-accessible in Minnesota.  

Finally, during the course of researching this thesis I sought assistance from experts located in Minnesota in the fields of health economics and policy, state legislation, and local health care finance by carrying out interviews with them. Information gathered from interviews is of lower importance to this thesis, relatively, compared to data analysis and the synthesis of theory and research on immigrant uninsurance. The main purposes of these interviews were to fill gaps in scholarship, and to gather new knowledge about current and possible future trends in immigrant (un)insurance. Interviewees were chosen based on their relevant experience with the

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7 This being said, several sources I originally found as hard copies in library archives are also available online, thanks to the recent rise of archive digitization.
thesis’ (admittedly narrow) topic. For example, a health systems researcher at the State Health Access Data Assistance Center (SHADAC) was approached for an interview based on her previous and current work on immigrant-specific health economics and the potential effects of health care reform on uninsured immigrants. A state legislator, on the other hand, was approached based on his experience with GSI legislation. I cite experts such as these in the third chapter when appropriate.

Although there are good political, social and even geographical reasons to undertake my thesis topic, the most immediate factor was in fact personal, a desire to enter the health care field in the future as an active practitioner. Also personal was the influence of my status as a (nearly) life-long Minneapolitan. Over the course of living in the Twin Cities I experienced first-hand a number of “waves” of immigrants: from Tibet, Somalia, Ethiopia, Bosnia and other countries. Immigrants have been my classmates, coworkers, and friends. The specific emphasis on health insurance and uninsurance was inspired by the teachings of the wonderful Professor Bob Evans at UBC (now retired). Evans was (and is) passionate about telling others of how seemingly-arcane aspects of the American health care system like health insurance and finance strongly shape (inequitable) distributional outcomes.

With respect to formulating this thesis, I have been lucky to attend a Canadian university: health insurance is usually presented as a purely financial instrument in American economic and political discourse. “Consumers” of health insurance, in this view, use it to mitigate their own risk of financial ruin in the event of an expensive trip to the hospital or an extended bout with a chronic condition. In the real-world, however, nearly no one pays exactly their “fair share” of insurance premiums —to paraphrase Professor Evans, those who are healthier and wealthier will inevitably cover the excess health costs of those who are less healthy and less wealthy. This is a
manifestation of health insurance’s second function: a means for redistributing risk across groups of individuals. It is the “redistributional” function of health insurance that I find most compelling, leading me to a number of questions that are pointedly ethical and political. For example: is the United States, as a country, comfortable with the fact that uninsured immigrants disproportionately shoulder their own health care cost risks, given that medical bankruptcy has grown as a major threat in recent years (Himmelstein et al., 2009)? What are we to make of the political economy of risk-transfer when the government makes or breaks a social contract regarding publicly-funded health insurance for immigrants? Will the newest health care reforms passed by the Obama administration really change the status quo of medical cost and risk for immigrants in the United States? Although I do not provide answers to these questions, I think the important point for all who are wed to the American health care system is that they be raised.
2 Perpetualized inequality in immigrants’ markets for employer-sponsored insurance

2.1 Introduction

In spite of voluminous work by researchers on health-systemic disparities between citizens and non-citizens, there exists a surprising lack of research on the proximate reasons why new immigrants disproportionately lack health insurance coverage (Buchmueller et al., 2007). A general comparison of the insurance trends among native citizens and non-immigrant groups reveals that the strongest disparity is in employer-sponsored insurance (ESI) coverage: the majority of native and naturalized citizens receive health insurance through their jobs, while only a minority of non-citizen immigrants receive the same benefit as a part of their total compensation (Figure 2.1).

![Figure 2.1: Health insurance coverage by citizenship status, 2002. Across citizenship classes, percentages of individuals covered by government sponsored insurance (Medicaid) and privately-purchased insurance (“Other”) do not vary significantly. Deficiencies in employer-sponsored insurance appear to translate directly into higher uninsurance rates among immigrant groups. Source: Alker and Urrutia (2004, p. 2).]
This gradient in ESI coverage rates, moving from relatively high rates among native citizens to relatively low rates among recent immigrant noncitizens, was documented in the early 1990s (Leclere et al., 1994) as well as in the 2000s (Alker and Urrutia, 2004; Goldman et al., 2006; Buchmueller et al., 2007), suggesting the disparity has remained relatively stable across time. Presented with this evidence, it appears that in order to begin explaining the immigrant uninsurance rate, it is essential to solve the mystery of why immigrants have such low levels of employer-sponsored coverage.

The purpose of this chapter is to explore this last question by turning it on its head. Low ESI rates among immigrants should not be interpreted as some sort of “failure” of immigrants to properly integrate themselves into the mainstream American economy. Rather, I argue that the American economy and ESI “system” have failed immigrant noncitizens, disproportionately shunting the majority of them into “restructured” (read: devalued) labor positions, while simultaneously abrogating responsibility for supporting them with their health costs—all in the name of labor cost-cutting at the margins of the workforce. Immigrants’ lack of employer-sponsored health coverage is, from this perspective, a casualty along the “low road” to profitability for American businesses (Peck, 2002a).

Yet it is not enough to say that the labor market has merely discriminated against immigrants in ESI. Broader shifts in the economy have led to differentially-eroding ESI rates among immigrant and native populations. Figure 2.2 plots noncitizen ESI rates per state in 2002 against the difference between noncitizen and native ESI rates for the same state (the same comparison used in Figure 1.2). Unfortunately, 2002 is the first year available for the U.S. Census Bureau’s Annual Social and Economic Supplement (ASEC), the most accessible source of disaggregated data available for comparing native vs. foreign-born and noncitizen insurance
rates. Nonetheless, a general picture is formed, both for the geography of immigrant ESI and the nature of ESI disparities between immigrants and natives. Geographically, noncitizen ESI rates vary in a way similar to general immigrant uninsurance rates: higher rates in northern states, and lower rates in southern states (with some important exceptions). Noncitizen ESI coverage in nearly every state lags behind the native rates. Geostatically, however, the relationship between ESI rates within a state and the disparity between natives and noncitizens is not as strong as the relationship between general uninsurance rates and native-immigrant disparity rates, as shown by comparing the linear regression R-squared value of Figure 2.2 (0.757) with that of Figure 1.2 (ranging from 0.85 to 0.94). This suggests an influence of wider shifts in the ESI system that positively or negatively affect the ESI chances of both immigrants and native citizens simultaneously, not just disproportionately affecting immigrant groups as in the case of
the general uninsurance rate (Figure 1.2). Put another way, the statistics suggest that immigrants and native-citizens are more “in the same boat” in some states, as their ESI insurance rates show less disparity. I will address both immigrant-specific and “wider” economic factors affecting ESI in this chapter.

The story of the failure of American ESI for immigrants since the 1980s is predicated on the interaction between a rapidly expanding immigrant labor force and a (relatively) gradual restructuring of labor relations nationally. In this chapter I will sequentially peel back layers of the “onion” that is immigrant ESI disparity, attempting at each level to gain further insight into how exactly this phenomenon remains entrenched in the American economy. I begin the chapter by establishing the importance of structural employment changes in effecting American ESI erosion. Next, I provide a proximate description of the relationship between American economic restructuring and the eroding ESI system without explicit reference to immigrant labor. In doing so I will capitalize on statistical and historical data on the ESI system as a whole in the 1980s and 1990s, and also draw from theory on the nature and logic of economic restructuring, labor market segmentation, and compensation/ESI polarization. After this, I will integrate the immigrant labor experience within the larger trends in American labor restructuring and ESI (non)provision, viewing the situation in terms of immigrants “encountering” the restructured ESI system and feeling the consequences. Finally, I will end the chapter by digging deeper, briefly exploring how a seemingly stable hierarchy of ESI entitlement and denial for immigrants may influence the success of business in a restructured U.S. economy. I will suggest that low ESI coverage among immigrants may not merely be a localized “market failure,” but rather one outwardly visible symptom of an entrenched “flexible” labor strategy that fuels profitability by
means of perpetuated inequality for certain parts of the population. This structural incentive, I argue, perpetuates low immigrant ESI coverage.

### 2.2 The erosion of ESI coverage in the 1980s and 1990s: a statistical overview

The overall distribution of insurance coverage among the non-elderly in the United States followed three trends in the 1990s and 2000s: (1) a cyclical fluctuation but overall decrease in the proportion of Americans covered by employer-sponsored insurance, (2) an overall increase in government-sponsored insurance with fluctuations mirroring those of ESI, and (3) a steady increase in the proportion of Americans without insurance entirely (Figure 2.3). As Farber and Levy (2000) point out, the erosion of coverage did not affect government workers: ESI coverage among workers in the public sector did not decline in the 1990s, and in fact grew very slightly (Figure 2.4). The problem of eroding ESI-coverage has thus been confined to the private sector.

The decline in ESI is, from one perspective, puzzling: the U.S. experienced strong economic growth in the 1990s, which theoretically could have led to a higher proportion of Americans being covered through their employers. Nonetheless, a closer look at the statistics over time shows a clear pattern: strong downward shocks to ESI rates during economic downturns, but only weak ESI increases during recoveries. Cutler (2003) breaks the “history” of ESI coverage in the 1990s into three periods: A period of ESI decline at the turn of the decade associated with slow employment growth; the period 1993-1998 associated with good economic growth but slow ESI recovery; and the turn of the century (1999-2000) when employment growth stayed strong and uninsurance rates began to decrease slightly. GSI programs like Medicaid appear to have played a mitigating function, increasing and decreasing enrollment reciprocally with the shifting national ESI rate.
Figure 2.3: Insurance coverage of the non-elderly U.S. population. Source: Cutler (2003, p. 30).

Figure 2.4: Public sector vs. private sector ESI coverage, 1979-1997. Source: Tabulated from Farber and Levy (2000).
The uninsurance rate, however, did not seem affected by either the GSI or ESI trends, and steadily increased throughout the decade. By 1999, 9.6 million children and 26.5 million adults (13% and 16% of total populations, respectively) lacked health insurance coverage (Zuckerman et al., 2001).

The effects of the overall decrease in insurance coverage in the 1980s and 1990s were not evenly-dispersed geographically, nor were they felt equally among all classes of Americans. Rural Americans were offered ESI at significantly lower rates than their suburban or urban counterparts (up to 10% less), and they were more likely to be uninsured (Larson & Hill, 2005). ESI coverage rates varied widely among states (Shen & Zuckerman, 2003) as well as metropolitan regions—for example: a worker living in El Paso, Texas in 1997 had only a 49% chance of being covered by ESI, whereas a worker living in Milwaukee, Wisconsin had an 84% chance of being covered by their employer (Marquis & Long, 2001). Within communities, several overlapping correlations were observed between socioeconomic and demographic characteristics and ESI coverage. Shen and Zuckerman (2003) produced a fairly-comprehensive statistical regression (years 1997-1999) of individual-scale factors that either increased or decreased the probability of being covered by ESI: being a woman, being married, or having at least a high school diploma, for example, were advantageous factors associated with higher ESI coverage, while being a racial minority, on the other hand, was negatively correlated with employer coverage.

The first few years of the 21st century did not appear to buck the trend set in the 1990s. Erosion of ESI coverage was documented in the 1999-2002 period (Shen & Long, 2006), and again in the overlapping period 2000-2006 (Schultz & Doorn, 2011). By 2006, the proportion of total Americans covered by ESI declined even further to 62.9% (ibid.), representing another large downward shock associated with economic recession, similar in magnitude to that of the period 1987-1994 (cf. Figure 2.3). I will return to the 2000s era in Chapter 3.

Aside from income status and immigration/citizenship status, which I will address shortly.
Presented with such statistical correlations, it is tempting to ask whether demographic and socioeconomic status changes in the makeup of the country—rather than fundamental changes in the economy or ESI system—account for the decline in coverage. Between 1988 and 1997, for example, there was a decrease in the percentage of the workforce that was white, male, and less than 25 years of age (Cubbins & Parmer, 2001). Is it possible that changes such as these somehow translated into a statistical “artifact” of declining private health insurance coverage?

There is little evidence to support such a claim. First, the influence of race and gender on the distribution of ESI benefits—and even the correlation between the two—is difficult to pin down statistically. Cubbins and Parmer (2001) conclude that gender and race significantly influence the pattern of ESI provision across industries, while Timmerman (2005) comes to the opposite conclusion, finding no significant statistical impact of race/gender on the likelihood that an occupation will offer ESI. It is difficult to favor one statistical conclusion over the other. There also remain stubborn questions that statistical regressions like these cannot address. Why did the economic expansion of the 1990s, which cut across many socioeconomic and demographic axes of difference, not change the general division of health insurance coverage in the nation (i.e. private vs. public and uninsured)? Why did it not significantly mitigate the overall erosion of private health insurance coverage? The explanation lies elsewhere, deeper than basic demographics.

“Employment characteristics” of the under-insured and uninsured—separable from socioeconomic or other individual-level characteristics of workers—offer an important clue

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10 Similarly, Cooper and Schone (1997) find that, besides a slight decrease in access rates for Hispanics in particular, there was no evidence that the changing racial and gender makeup of the workforce was correlated to the nationwide decline in ESI coverage.

11 Echoing Zuckerman et al. (2001, p. 175).
concerning the roots of ESI decline. Take, for example, a definition of the “working poor” in America, defined by Seccombe and Amey (1995). This group can first be described by their correlating socioeconomic and demographic characteristics: household incomes below the poverty line (by definition), disproportionately young, female, unmarried, belonging to a racial or ethnic minority, and so on. Beyond these, however, are characteristics related to the group’s workplaces: the working poor (in the early-1990s) were less likely to have full-time work, less likely to be union members, and more likely to be relatively “new” employees in their respective industries (ibid.). Seccombe and Amey correctly describe these employment characteristics—beyond SES factors—as the “critical antecedents” to ESI coverage among poor workers, and that variations in these characteristics translated into low insurance rates: the working poor in the early 1990s were only one-third as likely to receive ESI coverage as the non-poor, and five times as likely to be uninsured (p. 168). Shen and Long (2006) reach a similar conclusion about middle-income workers: measured reductions in ESI coverage were driven largely by changing characteristics of middle-income workers’ jobs, not their demographic and/or work preference characteristics. Finally, Shen and Zuckerman (2003) provide indirect evidence of the strength of employment characteristics in determining ESI coverage through their study of inter-state variations in employer coverage. The authors find that instead of reflecting the differences in people across the country, regional ESI variations represent the secondary effects of more primary variations in economic geography—the nature of employment opportunities offered in one state or one city compared to others.

Putting aside a discussion of ESI coverage variations along demographic and socioeconomic axes of difference—all very real to people’s lives—it seems logical to explore next the changing characteristics of American industries and employment. Cubbins and Parmer
(2001) present an overview of recent economic trends negatively correlated to the provision of ESI coverage. The authors cite technological change, the movement of manufacturing overseas, firm downsizing, changing labor management structures, a decline in union membership, the expansion of service and retail trade industries, and an increase in part-time work opportunities over full-time careers as relevant factors in ESI erosion. Interestingly, these conclusions closely echo Long and Marquis’ (1993) and Seccombe and Amey’s (1995) preceding work on ESI’s relation to the changing labor market at the turn of the 1990s. This suggests that a set of structural changes to the U.S. economy, set into motion in the 1980s or earlier, resulted in an associated shift in the system of compensation for American workers (especially ESI provision), the effects of which were still felt by the 2000s. During the course of research on changing labor market and ESI trends, I have found that (1) changes in industrial composition and average firm size, (2) changing labor management norms favoring “flexibility” in labor hours, and (3) an ongoing struggle between employees and employers with respect to responsibility for the cost of insurance premiums, all provide plausible proximate explanations for the deteriorating ESI rate in America (and not merely correlations to that rate). In the following sections I will describe the basics of each of these phenomena in preparation for deeper analysis of the logic of economic restructuring.

2.3 Economic (re)structuring (I): changing industrial mix and shrinking firm size

Inspection of the distribution of ESI benefits across industries in the United States reveals some striking patterns. A worker’s sectoral position—a qualitative variable not entirely reducible to other socioeconomic status locations, plays a considerable role in determining whether that worker is provided ESI. In the late 1980s, the “most insured” jobs existed in sectors like public
administration, manufacturing, transportation, and finance, while the “least insured” occupations were generally found in the agriculture, construction, and retail sectors (Figure 2.5).

The reasons for inter-sectoral differences in health insurance coverage are numerous. Labor economists, for example, point to human capital theories to explain why employers would seek to “invest” in a manufacturing laborer’s health and wellbeing more than, say, a service worker. Using this logic, manufacturing represents a capital-intensive industry that relies on both skilled and continuous labor. It is more advantageous from an abstract economic view for an employer to invest in the health of this type of worker to avoid turnover costs, as opposed to a service worker who may be replaced more easily if he/she falls ill (Cubbins & Parmer, 2001; Long & Marquis, 1993). From a human capital perspective, then, the goal of protecting the health statuses of employees is differentially “valuable” to employers in different sectors.

Explanations like these are grossly inadequate, as we shall see later in this chapter. At this point, however, it is enough to say that different sectors lie along a hierarchical spectrum of ESI coverage, and that this hierarchy remained relatively resilient over the course of the 1990s.

The general distinction between “high” and “low” ESI sectors and occupations remained in 2003, with jobs like engineer, (unionized) public safety and transportation worker, and administrator near the top of the list and food service worker, agricultural worker, and entertainer near the bottom (Timmerman, 2005). There was, however, a significant change in the relative proportions of “high” and “low” ESI sectors as fractions of the U.S. job market. Chollet (1994) took a “snapshot” of change occurring in the labor markets between 1988 and 1992 and found disturbing implications for the future of ESI: while a few sectors (e.g. professional services) were both adding jobs and providing at least some ESI coverage for their new workers, most high-growth sectors were not providing additional concomitant ESI. Most troublingly, sectors that
were former “bastions” of strong ESI coverage (e.g. manufacturing) were not only shrinking in employment, they were losing ESI coverage at an even faster rate. Employment growth in the 1990s seems to have followed a similar trajectory: retail trade and nonprofessional services grew at a fast rate, but also saw a steady decline in ESI, while other industries only experienced slight declines (Cubbins & Parmer, 2001). As Chollet (1994) observed in the early 1990s, “gap” coverage—in the form of government-sponsored insurance or insurance bought on the individual market—never entirely offset the effects of low-ESI coverage within a sector. If this inadequacy

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12 Meaning workers in these sectors who avoided dismissal faced the prospect of losing their ESI instead. Similarly, in sectors like retail trade and construction, many workers who once had ESI found themselves cut off from coverage, even as their industries expanded over the time period.
continued throughout the 1990s, the growth of tertiary industries likely contributed to the steadily increasing uninsurance rate.

The effects of a changing industrial base on ESI coverage were also exacerbated by an economy-wide shift to smaller firms beginning in the 1980s. Due to economies of scale and the underwriting practices of the insurance industry, smaller firms face larger difficulties organizing and purchasing group health insurance plans for their employees (Cubbins & Parmer, 2001). Firm-size reduction caused by the geographical re-scaling of divisions of labor in transnational corporations (Castree et al., 2004), for example, thus led to more firms unwilling or unable to secure group contracts for their workers, leading to even higher rates of uninsurance (Chollet, 1994; Long & Marquis, 1993).

To what degree did the changing nature of America’s industrial mix and average firm size impact the erosion of ESI in the 1990s? While some statistical analyses attempt to answer this question (e.g. Cubbins & Parmer, 2001), usually only the direction of the trend, not the magnitude, can be deduced. This being said, one of the findings of Shen and Zuckerman (2005) deserves special note: when comparing variations in ESI between different states in the late 1990s, “industry mix” was not a significant correlate (p. 248), implying that intra-sectoral economic changes across many industries played a significant role in re-shaping ESI, with perhaps an even stronger impact than inter-sectoral shifts. I now turn to one such “internal” economic change: the restructuring of terms of employment and renegotiation of health benefit cost-sharing as reactions to increasing U.S. medical costs.
2.4 Economic (re)structuring (II): increasing labor “flexibility” and health cost-shifting

A crucial element to the story of declining employer-sponsored insurance, often cited by health system researchers, is the impact of rising insurance costs. Payment for U.S. workers’ ESI premiums are almost always split between the employer and the employee—with the employers contribution usually ranging between 66 and 80 percent of the total bill (Banja, 2000). Insurance premiums, however, are necessarily positively correlated with average healthcare costs in the U.S., which have risen rapidly and consistently over the past few decades. The effect is at first a squeeze on employers: between 1987 and 1993, for example, health insurance premium costs rose 90% while average wages only rose 28% (Cooper & Schone, 1997). Employers in this situation were faced with an enormous percentage increase in total labor compensation costs from health insurance alone. In order to restore profitability, there emerged an incentive—perhaps even an imperative—for employers to use creative tactics to shield themselves from these inflating costs.

One available solution was to rely more heavily on both part-time work (measured in hours per week) and to increase turnover (in effect, to make jobs more temporary). The end effect was to reduce the number of employees that were eligible to receive ESI. This allowed a firm to decrease health insurance payments without dropping coverage of all employees (which could make the firm unattractive in the labor market) (Schultz & Doorn, 2011). The common labor practices of predating ESI eligibility on job tenure (only offering ESI after a set number of weeks/months on the job) and work-hour status (only offering ESI after a certain number of hours per week worked) were (and are) therefore useful cost-saving tools, provided that

13 The literature on rising medical cost trends is voluminous and too complicated to detail in this thesis. One example: between 1985 and 1998, there was a 113.3% increase in medical costs per capita, measured relative to the Consumer Price Index (Cubbins & Parmer, 2001).
employers strategically used these rules to their advantage in the 1980s and 1990s (ibid.). Seccombe and Amey (1995) accused U.S. employers of this very practice after evaluating the employment characteristics of the unemployed, while more recent analysis documents the trend quantitatively: measured nationwide between 1996 and 2004, a 1% increase in per-employee ESI costs resulted in an average 3.7% increase in the use of part-time employees at establishments that did not offer health insurance to part-time workers (Schultz & Doorn, 2011).

While it is difficult to pin down the aggregate effect of health care cost pressures on the total increase in U.S. part-time employment (compared to other factors), it is quite evident that as part-time employment grew, part-time ESI coverage fell during the 1990s. Farber and Levy (2000) elegantly documented this phenomenon by examining the U.S. workforce as separate, segmented classes defined by job tenure and number of working hours. Tracing the ESI coverage rates of each group separately over the period 1979-1997 produced dramatic and illuminating results: there was a strong, lasting hierarchy of ESI coverage, ranging at the high end from long-tenure, full time jobs (“core jobs”), down to full-time short-tenure (“new”) jobs, down further to part-time, long-tenure jobs (“peripheral jobs”), and at the very low end, part-time, low-tenure jobs (Figure 2.6). ESI in all classes of jobs were negatively affected by economic recessions, and each job class’ “ESI history” followed the same general shape of sharp decline and gradual recovery in the 1990s (cf. Figure 2.3).

Farber and Levy continued their analysis and found that the primary cause of reduction in ESI for “peripheral” (i.e. part-time and/or untenured) workers was a declining rate of ESI eligibility among workers, not a lack of part-time jobs offering ESI. The percentage of “peripheral” jobs offering ESI (again, upon fulfillment of any variety of eligibility tests) actually
**Figure 2.6:** Rates of private-sector ESI coverage by job class, 1979-1997. Sources: ESI statistics tabulated from Farber and Levy (2000); recession statistics from National Bureau of Economic Research (2010).

*increased* in the 1980s and 1990s, even as the actual coverage rates fell (ibid.).\(^{14}\) An increasing number of U.S. employees in the 1990s, therefore, worked part-time and temporarily in firms that technically offered insurance, but not to “peripheral” workers like them. Many workers may have taken up several part-time or temporary jobs throughout a year, perhaps accumulating as many work hours as their “full-time” counterparts, but remained uninsured due to ESI waiting lists or hourly requirements.\(^{15}\) Economic downturns, which increase employment volatility and slacken the part-time labor pool, are especially hard on the increasing number of “peripheral” workers, who are cut off from full access to ESI (Cubbins & Parmer, 2001).

\(^{14}\) A business strategy that, when viewed from such a macro-level perspective, seems almost cynical.

\(^{15}\) This trend is reflected in the statistics on employment volatility and ESI coverage: Andersson et al. (2010) find that the uninsured have the highest number of jobs per year on average, while ESI-covered workers have the lowest.
Exploiting differential ESI eligibility rules is one potential managerial strategy to avoid bearing the burden of increasing medical benefit costs; another is to shift some of the insurance premium costs onto employees. The employer-employee ESI contribution ratio is not fixed by law, and employers can manipulate it to increase the percentage paid monthly by their workers; in effect decreasing overall payroll costs, even if no one receives an actual “pay cut” per hour.\textsuperscript{16} There is strong evidence that employers did just this in the 1990s: between 1990 and 1995, the average ESI premium cost to employees increased 60%, much more than the growth rate of employer contributions (Banja, 2000). In dollar terms, a typical employee in the late 1980s contributed $150 annually for his or her ESI, while the same employee at the end of the 1990s paid $350 (Cutler, 2003). It is safe to say that very few employees also received a concomitant 133% nominal wage increase over this time period, given the general trend of “wage compression” at the middle and bottom ends of the income distribution during the 1980s and 1990s (Abraham & Spletzer, 2010).

The shifting of ESI costs onto employees produced a demonstrable impact on the ESI coverage rate, especially for certain groups of workers. Just as employers are sensitive to health insurance cost increases, employees are also sensitive to cuts in their take-home pay that accompany ESI premium increases. Unable to shift ESI costs onto another party, employees can choose to opt-out of ESI coverage instead. Employers are then relieved from paying ESI costs for that employee altogether, while the employee receives a (much smaller) savings via retained

\textsuperscript{16} A numerical example: if a hypothetical average worker’s ESI premium is 100 units, the employer-employee ESI contribution ratio is 80:20, and the employee’s wage is 300 units, the firm pays a total of 300 + 80 = 380 units per worker for wages and ESI. In the event of an ESI premium increase to 150 units, the employer would be faced with paying 300 + 120 = 420 units, a significant cost increase. If the ESI contribution ratio is changed, however, to 70:30 and wages are left unchanged, the firm is left paying only 405 units per worker—a successful deflection of costs towards the worker, who feels a larger indirect cut in his or her take-home pay.
wages. If this trend spreads across the labor force, it negatively affects the “take-up” rate of ESI insurance (separated from and contingent upon the preceding rates of ESI “offering” and “eligibility”). Data from the 1990s show that employees were, indeed, increasingly sensitive to price increases in ESI (Long & Marquis, 1993; Cutler, 2003; Okeke et al., 2010), but that this sensitivity led to different reactions among different job classes. Low and middle-income workers were more likely to decline ESI coverage in the face of premium increases, while high-income workers were more willing and able to absorb the cost increase(s) (Shen & Long, 2006). Ultimately, the effects of ESI cost-shifting upon the national uninsurance rate were mixed: very low-income workers could substitute forgone ESI coverage for public coverage, and higher-income workers had a greater chance of being able to switch to a spouse’s ESI coverage (providing consolidated cost savings)—low and middle income workers, on the other hand, ineligible for government assistance or insurance, tended to drop out of the insurance system entirely (Farber & Levy, 2000; Shen & Long, 2006). Firms seem to have had few problems washing their hands of these consequences entirely.

2.5 The longer view: structural logics of labor market flexibility and segmentation

Now that a number of proximate causal factors of ESI erosion have been identified, it is appropriate to shift to a deeper exploration of the reasons for structural shifts in the economy in the 1980s and 1990s. Why, for example, was the increased use of part-time and “flexible” work arrangements such a readily-available option for businesses to avoid or shift their growing health benefit costs? The short answer is that changes to ESI arrangements coincided with much larger structural shifts in the economy, driven by a multitude of logics separate from health insurance/care. Understanding these logics aids tremendously in explaining the seemingly
permanent state of labor market polarization in ESI coverage, and will aid further when evaluating immigrants’ positions within the ESI system.

Contemporary economic restructuring has its roots in profitability crises of the 1970s. Prior to the 1970s, the U.S. economy was dominated by the “Fordist” regime of accumulation, a collection of broad relationships between firms, government, consumers, and workers that manifested itself in stable, predictable product demand and market growth for firms (among other things) (Peck, 1996). These favorable market conditions provided the conditions of possibility for the growth of large domestic firms with stable workforces and life-long employment arrangements (as well as more stable ESI provision for long-term attached company men and women). A falling rate of profit in the 1970s, however, owing to domestic market product saturation, rapid new developments in technology, growing international price competition in product markets, restructuring in capital markets, and general global overcapacity, marked the beginning of the unraveling of the Fordist work regime (Peck, 2002a; Kalleberg, 2003; Rodriguez, 2004).

Reacting to this falling rate of profit, American managers strategically moved the U.S. economy into a restructuring phase that involved aggression against organized labor, changes in investment patterns from manufacturing to financial markets, and corporate reorganization and multinationalization.17 Labor market flexibility and segmentation can be seen as two crisis-containment strategies that emerged from this period.18 Both strategies altered the established

18 Another strategy was “deindustrialization,” which involved capital-switching between geographical regions (often outsourcing to lower-cost developing countries), as well as between industrial sectors. Deindustrialization diverted investment away from traditional domestic industrial output and towards professional, nonprofessional, and financial services (Peck, 2002a). This process influenced the economic shifts described in the “Economic (re)structures I” section above, but as labor market segmentation and
Fordist work-arrangement order. The Fordist regime of accumulation had articulated workers as (mostly) “fixed costs” of production; in order to better manage an economic environment of shifting, unpredictable product demand, managers soon sought ways of making labor costs more “variable” (Belous, 1989). Increased “functional” labor flexibility and “external”/“numerical” labor flexibility within firms became popular management options for achieving this task. “Functionally” flexible workers in a post-Fordist economy were highly-skilled, well-compensated, and able to perform multiple roles within a company with minimal (re)training time. “Numerically” flexible workers, on the other hand, performed less-complicated tasks less essential to the core functioning of the firm. As external demand shifted, the level of numerically flexible workers could be altered (i.e. more workers hired or fired quickly), in effect serving as a “buffer” for more valuable workers in managerial and functionally-flexible roles.19 In order for “numerically flexible” workers to be useful as profitability buffers in times of economic demand shock, their work arrangements and employment rights needed to be adjusted from the Fordist norm. While numerically flexible workers remained on the company payroll, their ties to the firm became increasingly weak, and they began to be hired on more temporary and contingent bases (Kalleberg, 2003).

The decision to make certain portions of U.S. firm workforces “contingent” and “flexible” in the 1980s was at first a largely ad-hoc one, executed by mid-level line and division managers faced with tough choices over the bottom line(s) of their companies (Belous, 1989). Flexibilization in general, therefore, ascended according to a variety of “local” logics, not to a universal corporate or managerial strategy (Peck, 1996). Despite an initial lack of coherent polarization seem to be more influential upon the erosion of ESI, I do not explore deindustrialization further.

corporate policy on flexibility, however, labor divisions like these soon evolved into an entrenched system of labor market segmentation between “core” and “peripheral” workers, the same as those described by Farber and Levy (2000) above (Kalleberg, 2003). Following Peck (1996), this segmentation can be described in terms of a division of “primary” and “secondary” labor groups. “Primary” labor are a firm’s “core” workers who must display competency in functional flexibility. “Secondary” labor refers to the part-time and contingent workers who must conform to their limited rights as numerically flexible assets (Castree et al., 2004). The increasing functional polarization between these two groups soon became the status quo for many firms’ hiring departments, once it became known that workplace segmentation produced significant cost-cutting benefits. By the end of the 1990s, evidence showed that between one half and one third of all firms in the U.S. had adopted some form of core-periphery labor strategy (Kalleberg, 2003).

Savings accrued from decreased labor costs alone were not the only reasons that labor flexibilization was embraced by corporate America. As Peck (2002a) describes, the strategy also coincided with the broader goal of devaluing labor and reducing the influence of collective bargaining:

After all, this is an employment strategy almost uniquely suited to the new times—its fluidity makes labor-organizing difficult, while holding workers in a continuous state of market-disciplined and insecure wage dependence; it permits the reduction in overhead and variable labor costs, while directly contributing to the circumvention and erosion of the social safety net; it allows labor to be scheduled and parceled flexibly, in line with short-term movements in demand, while externalizing many of the associated costs and risks (p. 190).

This theorization provides insight into the larger structural incentives for growing and maintaining segmented, polarized labor markets in the 1980s and 1990s. With reference to the previous section, increasing health insurance and care costs per employee, viewed as an external
threat to profitability, *were* a rationale for seeking more flexible work arrangements, but they should also be understood as being part of a much longer list of managerial pretexts for labor restructuring in the post-Fordist period. Structural incentives to preserving a segmented labor force ensured the longevity of bifurcation between “core” and “peripheral” workers.

2.6 The logic of labor reproduction risk-transfer and ESI polarization

Before returning to immigrants’ position in the American ESI system, one final theoretical point must be understood: the role of “reproduction” of the labor force, and struggles over who or which institution(s) should bear responsibility for this reproduction. Here “reproduction” describes the provision of a variety of necessities needed by workers to sustainably maintain their daily lives and labor potential. Adequate wages, housing, food, education, and health insurance/care are a few of the largest “goods” needed in the process of labor reproduction. Employers, as a general class, must make it their long-term goal to maintain adequate reproduction of their labor force, lest their future chances of profitability deteriorate with the health and wellbeing of their workers (Peck, 1996). This does not mean, however, that employers must bear *full* responsibility for labor reproduction. If a firm (or business leaders as a class) can successfully shift responsibility for providing workers’ necessities to another, outward “location” (workers themselves, the domestic sphere, the government sphere, etc.) it may choose

20 There is an opportunity for a useful cross-fertilization of ideas at this point between Geography and other disciplines. Work done by health economics researchers on the influence of ESI cost increases on corporate labor strategy can be added to geographers’ understanding of the rationales behind labor flexibility. Many economic geographers tend to emphasize rising *wages* as a primary target of management’s cost-cutting strategy, as opposed to growing *total* compensation, which is influenced by semi-independent trends in both the labor market and the U.S. health care system. Geographers’ wider appreciation of the social power-dynamics at play in the construction of labor markets and (re)negotiation of work environments, on the other hand, can inform more narrow empirical studies in other fields of why American ESI has eroded the way it has.
to do so as a way of slimming down the costs of compensation—in effect enhancing profitability (ibid.). A very recent example of this phenomenon applied to health insurance is the case of Wal-Mart, the largest “peripheral” employer in the nation, which was accused in the 2000s of “outsourcing” its worker’s medical costs to the government (i.e. paying sufficiently low wages for workers to qualify for Medicaid, and then recommending this option to employees) (AFL-CIO, 2006). We now turn to the shifting of labor reproduction responsibilities from businesses onto workers themselves.

In the case of health insurance, ESI as a component of private-sector compensation had become a deeply entrenched and uniquely American “expectation” of the Fordist social contract in the decades after World War II (Blumenthal, 2006). During the period of economic restructuring, employers sought to break down this type of institutionalized arrangement through the general erosion of labor’s bargaining power (Peck, 2002a). As segmented labor markets evolved during the 1980s and 1990s, and as more laborers became dependent upon the polarized division between “core” and “peripheral” workers, American management increasingly deployed a cruder criteria for distributing ESI benefits: whether or not the ESI benefit was necessary to attract the required labor. If workers in one occupation had a firm expectation/demand of receiving ESI coverage as a part of their compensation, management was forced to oblige. If, however, health insurance was determined to be “not necessary to attract labor”—as was increasingly acknowledged in surveys of employers forgoing ESI in the 1990s—management could resort to new “flexible” tactics to avoid responsibility for their workers’ health costs.

Crucial to the new distinction of ESI as “necessary” or “unnecessary” was the erosion of organized labor power (i.e. unionization). In 1988, union coverage at work was the strongest

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positive statistical correlate to ESI access. By 1993, the correlation between unionization and ESI coverage fell, and by the turn of the century it no longer measured as significant (Timmerman, 2005). With less unionization, workers in many industries lost much of their power collectively to demand group-ESI coverage. In a sense, this was the transformation of what Peck (2002a) calls a “boundary institution”: that is, the distinction between optional and non-optional benefits in the labor market increasingly came under the discretion of profit-squeezed managers, instead of being negotiated between management and workers. Laxity in ESI regulations (another boundary institution) also enabled differential treatment of core and peripheral workers. Laws like the Health Insurance Portability and Accountability Act (HIPAA) and Title 26 of the U.S. tax code comprise the legal limits of what employers and insurers can and cannot do with respect to insuring employees. HIPAA, for example, protects workers from losing their health insurance if they lose or change jobs. It does not, however, require all firms to offer insurance to their employees, and thus allows employers legally to use part-time and tenure-requirement strategies to avoid ESI provision (Farber & Levy, 2000) and to cite “high costs” as an excuse for not offering coverage (Cubbins & Parmer, 2001). In sum, the decline of collective bargaining power and the lack of state-granted “entitlement” to ESI coverage acted together to facilitate the erosion of the Fordist ESI arrangement, and workers’ control over subsequent compensation arrangements.

The attrition of the Fordist ESI “contract” with workers, combined with the growth of perpetually-segmented labor markets, paved the way for increasing inequality among workers: ESI polarization between “core” and “peripheral” employees. To be clear, the primary functions

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22 The laxity of these laws was explicitly challenged by the Clinton health reform plan in 1994 (Skocpol, 1995). Resounding opposition from business and trade groups to Clinton’s proposal for an ESI mandate (and the swift defeat of the legislation through the action of lobbyists) provides evidence of the value of these lax boundary institutions to U.S. businesses.
of employer-sponsored insurance remain the same in the “post-Fordist” model: (1) the mitigation of medical cost risk among covered employees, and (2) the net transfer of medical care money from healthier and wealthier workers to unhealthier and less wealthy workers who require more care. However, an additional function has emerged as ESI increasingly is no longer a “standard” reward to employment: a recruiting tool for highly-educated and middle- to high-class labor.

When applied to the segmented labor market, the effect over time has been a bifurcation in the distribution of compensation benefits: upper and (most) middle-income workers receive either stable or growing ESI packages as “fringe” compensation, while peripheral workers find their ESI eroding as a function of wage and compensation stagnation (e.g. the hierarchy in Figure 2.6).  

The social determination of “skilled status” (Peck, 1996) is central to determining ESI chances in the contemporary workplace. Education and human capital, for example, can be used by workers to claim “skilled status” in labor market negotiations over compensation. “Level of education,” in fact, is one of the few remaining forms of leverage workers may use to gain and retain ESI benefits. ESI coverage has always increased monotonically with education level, and during the 1990s highly educated workers in “core” jobs experienced a much lower decrease in ESI coverage than their lower-educated co-workers (Farber & Levy, 2000). Using the terminology of labor market flexibility, education status could serve as a proxy signal of a worker’s “functional flexibility,” protecting them from downward mobility along the polarized ESI spectrum.

23 Compensation inequality, measuring wages and benefits such as health insurance, actually intensified faster than wage inequality in recent decades (Pierce, 2010).

24 This being said, even high education did not protect against ESI erosion in all cases—“peripheral” employers meted ESI cuts upon all of their workers, regardless of their education (ibid.).
In conclusion, then contemporary ESI distribution as a “system” works in accordance with a new valuation logic: whoever works in an occupation where labor has the power to compel employers to provide coverage (as in unionized occupations), or whoever works in an occupation where ESI coverage is an expected and institutionalized condition for “skilled status” employees, will receive insurance at the lowest cost to the employer. For those (expanding) industries in which labor can be procured without the inducement of ESI rewards, the restructured ESI system culls health coverage along both the edges of legal boundary institutions (barely within the bounds of labor law, tax law, and health insurance regulations) and down the gradients of human capital and core-periphery status, leaving more and more of the most vulnerable workers shut out of the system (and extending to parts of the middle class as well). In this way, health insurance status has become an increasingly strong proxy for socioeconomic status (Portes et al., 2009).

All of the consequences described in this section represent the tangible effects of a shift in labor reproduction responsibilities from the private sector “downwards,” mostly onto the backs of employees themselves.\(^\text{25}\) As long as under-insured peripheral workers keep returning to their jobs \textit{en masse}, management is satisfied, and ESI polarization remains entrenched. In fact, peripheral labor pools that are able and willing to submit to little or no ESI benefits are implicitly sought after in this system. This brings us back to the topic of immigrant labor and ESI.

\(^\text{25}\) These costs and responsibilities can, of course, be further transferred to other parts of society if workers cannot bear the additional burden (onto government insurance programs, public hospitals, charity centers, and the like). But the primary “responsible parties” remain uninsured workers.
2.7 “Playing by the rules and losing”: bringing immigrant ESI back into view

As cited at the beginning of this chapter, Buchmueller et al. (2007) established a crucial “starting point” for the analysis of immigrant uninsurance: the fact that immigrant uninsurance rates are mostly the product of lack of ESI coverage. Equally important, however, is another of Buchmueller’s key findings: immigrant ESI eligibility and take-up rates are nearly identical to those of native citizens, implying that immigrants simply have lower chances of working in a firm that offers coverage (ibid.). Characteristics of immigrants’ employment arrangements are, as we have seen, crucial antecedents to immigrant ESI coverage or non-coverage.

There is a level of consensus within the health economics and health services research literature (what little there is on the subject) that low ESI coverage among immigrants is proximally explained by immigrant laborers’ disproportionate inclusion into structural “gaps” in ESI coverage that have eroded since the 1980s. Immigrants as a group are disproportionately likely to work in jobs with at least one of the job characteristics negatively correlated with ESI coverage. A partial listing:

- Immigrants are more likely to work in low-ESI industries such as food and agriculture, personal services, textiles, construction, transport, and retail trade (Valdez, 1991; Goldman et al., 2005; Goldman et al., 2006; Buchmueller et al., 2007; Johnson, 2010).
- Immigrants are more likely to be self-employed or to work in smaller firms (Valdez, 1991; Buchmueller et al., 2007).
- Immigrants are less likely to work in unionized firms (Valdez, 1991; Buchmueller et al., 2007).

26 A portion of Seccombe and Amey’s (1995) article title.
• Immigrant workers are more likely to work part-time and/or have low job tenure (Carrasquillo et al., 2000; Goldman et al., 2005; Buchmueller et al., 2007).

Of course, not all immigrants are disadvantaged. Differentiating between immigrant groups reveals striking differences in ESI coverage outcomes. U.S. immigration in the 1990s was bifurcated, with two different streams of workers entering the country: first, a class of foreign professionals and technicians admitted to supply high-tech industries or healthcare, and a second, much larger class of less-skilled laborers that supply labor-intensive sectors like agriculture, construction, and personal services (Portes et al., 2009). In the restructured system of health insurance compensation and risk, the higher-skilled, higher-class of immigrants are more likely to succeed in obtaining ESI coverage as part of their compensation packages, while the much larger population of lower-skilled, peripheral immigrant workers are often shut out.

Measurable employment characteristics can be used to “explain” much of the immigrant ESI uninsurance rate. Buchmueller et al. estimates that two-thirds of the total percentage differential can be explained by these factors (2007, p. 286). Measurable employment characteristics also aid health economists and health system researchers in their respective explanations of the uninsurance rate, in that through their deployment it is possible to formulate the uninsurance problem as immigrants “encountering” the same labor market system as American workers, and losing out because they happen to have the misfortune to gravitate, as a collective group, towards jobs without health insurance. Policy prescriptions can subsequently be deployed with the aim of bringing immigrants’ work experiences closer to those of “average” American workers. This strategy, undoubtedly influenced by the statistical tools and body of knowledge at the hands of researchers, is essential and enlightening. However, it often leaves out a crucial factor: the extent to which an immigrant’s status as an immigrant—not simply as a sort
of statistically-disenfranchised variant of the generic “American worker”—translates to vulnerability, power/powerlessness, and class position within the American labor market.

Immigrants from different regions in the world come to America for different reasons, and some patterns can be seen in the rates at which some immigrant workers attain a less-peripheral status: 13% of Mexican immigrants in the late 1990s worked in agriculture, compared to 2% of native citizens (Carrasquillo et al., 2000). Agricultural jobs have always been on the low end of ESI coverage, and agricultural workers (especially foreign ones) have little to no bargaining power to demand better compensation. 34% of Filipinos, on the other hand, worked in health care (ibid.), a field with much higher rates of ESI, as well as unionization, collective bargaining, and more established expectations among workers regarding ESI coverage as a standard “right” of compensation. This example of the differences between Mexican agricultural and Filipino health care worker populations reflects a differential in the abilities of these two groups to assert their value as “skilled” or “unskilled” labor, whether through individual means or through collective action. The determination of “skilled” or “unskilled” is, of course, socially determined by the actions of both employers and employees. Immigrants are systematically disadvantaged on arrival to the U.S. as “skilled statuses” in other parts of the world are not equally-valued in America.27 The social structure of racism also exerts an autonomous influence upon the perceived skilled or unskilled status of immigrants (Peck, 1996; Castree et al., 2004).

The power of the “skilled” vs. “unskilled” bargaining position within the labor market is strong and lasting for many immigrants. It even often overtakes the competing influence of legal/documentation status in affecting immigrants’ employment outcomes. Undocumented

27 A common example is the plight of highly trained, experienced, and talented foreign doctors and other practitioners who, upon arrival in the U.S., cannot work in their specialties without first undergoing (often redundant) medical training to “prove” their skilled status to American employers.
immigrants are, without question, the most susceptible to exploitation by employers in America, and often work “off the books” in low paying jobs without benefits (Carrasquillo et al., 2000; Rodriguez, 2004; Prentice et al., 2005). In this way it makes a large difference whether an immigrant is a legal resident or undocumented. Often, however, legal immigrants follow the same employment paths as their undocumented counterparts: for example, owing to a lack of other work opportunities, and without additional leverage to claim “skilled status,” many legal immigrants from Central America work in the same peripheral occupations as undocumented migrant Central American workers, and thus share similar ESI (non)coverage rates (Carrasquillo et al., 2000).

This is the way in which the restructured ESI system affects immigrants differentially in America. The groups rewarded with higher wages and lower health cost risks are those immigrants that possess individual, human capital characteristics with better education and skills, those more familiar with America’s economic culture, and those who have access to labor market connections. The majority of immigrants, however, must contend with the (uniquely American) insurance rationing system that may reward or punish them based on their position along the lower ends of the spectra of socioeconomic status and bargaining power. The majority outcome determines the statistical average, and the immigrant uninsurance rate remains discouragingly high.

2.8 An aberration, or the new status quo? Immigrants’ experiences with the “booming” 1990s

Even armed with a richer understanding of the mechanisms underpinning immigrant uninsurance, a lingering question remains: was the convergence of expanding immigrant flows and deepening labor market segmentation/polarization entirely coincidental? If so, it could be
said that immigrant uninsurance owing to a lack of ESI during the “booming 90s” was an unintended (and perhaps unavoidable) outcome. I disagree with such a conclusion. Instead, I argue that the perpetuation of immigrant disparities in ESI served U.S. employers well during the 1990s, and that it in fact may have aided national economic expansion. This benefit to the business class helped to perpetuate ESI inequality between immigrants and native workers in the 1990s and beyond.

The logic of this argument is first derived from observed trends in high-ESI vs. low-ESI industries. In 1994, the health researcher Deborah Chollet published a set of grim conclusions regarding the future of ESI provision. Observing statistical trends from the 1980s and 1990s, Chollet observed that since the fastest-growing industries often lacked health insurance, and given the prevalence of “dependent coverage,” it was inevitable that some “ESI-heavy” industries would end up transferring ESI-benefits to the workers in industries without much ESI compensation. This, in turn, translates into a labor cost subsidy from one industry to another—an advantage for the new industries without ESI, a disadvantage for industries with firmly established ties to the “old” ESI institution. This has potential ripple effects: the availability of effective ESI subsidies from some generous industries, Chollet reasoned, probably would deter other employers from providing health benefits to their workers.29

These distortionary and competitive pressures may have had the effect of producing a new, semi-stable strategic solution (to borrow the parlance of economic game theory) to the question of whether to provide ESI coverage in certain industries. As time went by, some

28 The method by which an ESI-covered worker can extend his or her coverage to a spouse at extra cost.

29 “That is, in industries that import substantial amounts of coverage, firms that do not receive subsidies are best able to compete with firms that are subsidized only if they, too, do not offer coverage to their workers. Competition does not allow employers in such an industry to consider whether their workers are covered at all” (Chollet, 1994, p. 326).
industries would become so accustomed to *not* providing ESI coverage—instead allowing employees to either go uninsured or rely on a spouse’s coverage—that health care risk “free-riding” would become the new competitive standard. Again, this is an example of the transfer of labor reproduction responsibilities away from individual firms, this time one that may have greatly contributed to the boom of the 1990s.

The economic expansion of the 1990s was a respite from the Reagan years—real wages for median workers halted their decline, and actually began to slowly rise (Peck 2002a, p. 193). Wages and ESI rates, however, certainly did not rise as fast as GDP growth. The ESI rate at the turn of the century, in fact, was barely changed from the beginning of the 1990s (Figure 2.3). Peck (2002a) provides a “politico-institutional” explanation for the lack of substantial wage increases during the boom of the 1990s—an explanation that also applies to the lack of ESI coverage. First, the combined effects of deunionization, trade liberalization, and the erosion of social protections led to a new economic regime of “systemic insecurity” and harsher forms of labor controls (p. 209). This was not merely a side-effect of the economic era—according to Peck, it was essential to the 1990s expansion. “Old” economic regimes of regulation were simply no longer effective (or profitable) in the 1990s, and a new method of growing the economy, dependent upon controlling the costs and demands of labor through making labor markets more “flexible,” took precedence instead (p. 194). As labor costs were forcefully tamped down, economic growth resumed.

Peck (2002a) also touches briefly upon the effects of immigration upon the 1990s boom economy. In Peck’s estimation, structural “(ab)uses” of the immigrant labor force were useful to

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Marquis and Long (2001) speculate that this type of norm-based competitive pressure exists at the local level, and that employers look to the ESI practices of other employers in the same geographic area before making their own decision whether or not to offer coverage.
the managerial class in the 1990s insofar as the majority of immigrants represented a large
source of relatively vulnerable, chronically wage-dependent workers that slackened the lower
levels of the labor market (p. 194). I argue that the same can be said of immigrants’ effects upon
the restructured ESI market. If Chollet (1994) was accurate, and the “new” economic sectors of
the 1990s boom (expanding services, retail, etc.) owed part of their competitive edge to not
providing “flexible” workers with ESI, then the influx of immigrants may have provided a sort of
“enabling” role with respect to the continuation of labor market segmentation, ESI polarization.
Indeed, immigrants did not simply arrive in the United States to find vacant peripheral jobs
waiting for them. As Peck (1996) points out, the very existence of low-compensation peripheral
positions is often predicated on the prior existence of a suitable labor force that can be
“convinced” (sometimes exploitatively) to work in such positions. From a management position,
immigrants complemented peripheral positions and eroded-ESI: Rodriguez (2004) points out that
the majority of costs of labor reproduction for immigrants is borne (or at least perceived to be
borne) by another system, either by the immigrants’ home countries or by someone or institution
in the immigrant community network.\footnote{Drawing from the work of Michael Burawoy.}
The use of immigrant labor in the 1990s provided U.S.
employers with a fresh labor supply that was “self-recruiting, self-training, and self-
disciplining,” and, most importantly, willing to acquiesce to peripheral labor treatment
(Rodriguez, 2004). As long as immigrants in the 1990s took up a disproportionate amount of
jobs without ESI—\emph{and did not cause management a large headache about it}\footnote{Cf. American unions’ campaigns for ESI rights during the same period.}—the system of
immigrant employer-sponsored (un)insurance persisted.

\footnote{Drawing from the work of Michael Burawoy.}
\footnote{Cf. American unions’ campaigns for ESI rights during the same period.}
This last point raises troubling ethical issues. Not only is it true, as Shah (2006) points out, that noncitizen immigrants suffer greater losses in ESI during economic downturns and enjoy smaller gains in ESI during economic expansions, it may also be true that recent economic expansion(s) have been fueled by their misfortune, if only partially. What of the U.S. government, the source of the largest health insurance safety net? What has its reaction been to this situation? I will turn to this question in the next chapter.
3 Policies of exclusion, policies of neglect: American GSI for immigrants

3.1 Introduction

While the previous chapter highlighted recent erosion(s) in U.S. private health insurance, the employment-based insurance “backbone” of the health care system has long been known to exclude certain segments of the population from its coverage. The elderly, children, and the disabled are a few of the most obvious populations deemed unfit to rely on working to pay for their own health care, and it has been long acknowledged that the poorest members of society are also disadvantaged by the ESI system. In response, the United States governments, at federal and state levels, have established a set of deeply-entrenched, parallel insurance systems (in this chapter referred to as government-sponsored insurance or GSI) over a span of several decades that provides coverage for many members of society—though not all—that fall through the cracks of the private insurance system.

With respect to the problem of immigrant (in)access to ESI, government-sponsored insurance appears to be a straightforward corrective. Hypothetically, the U.S. government could step in to provide insurance coverage as a supplement to immigrants (and others) who, by no fault of their own, work in occupations that either do not offer ESI or that pay too little to cover ever-escalating private insurance premiums. In reality, however, the U.S. government’s attitude(s) and policies towards providing GSI to immigrants are driven by an entirely different set of political logics, and have been subject to sporadic, extensive revisions over time. Instead of a technical debate over the shortcomings of ESI, the national debate over “immigrant GSI” is

For an excellent overview of America’s strategies in the 20th century for “dealing with” the challenge of health care for the very poor, see Engel’s Poor People’s Medicine: Medicaid and the History of American Charity Care since 1965 (2006).
often inextricably tied to larger political battles over immigration and the welfare state. Immigrants’ access to GSI is thus highly dependent upon politicians’ dominant attitudes and changes in the political wind.

This chapter explores one particular “moment” in the recent history of GSI for immigrants: the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996. This event marked a dramatic shift in the U.S. government’s approach to providing immigrants with GSI, and set in motion a series of politico-geographic reconfigurations that form the basis of immigrant GSI access up to the present. I will begin my analysis by first presenting a brief outline of the GSI system and the “old” standard of immigrant GSI, and then summarizing the immigrant-specific aspects of PRWORA. After this point, I will pause to take stock of the origins of the immigrant-specific provisions of PRWORA. Why was immigrant GSI reformed so radically in 1996? Was there a structural logic to the reform, or was it a more contingent process? I will then examine the geographic consequences of PRWORA on immigrant GSI by framing the legislation as a means of “devolving” government responsibilities and costs related to immigration to lower “scales” of government, and away from Washington D.C. Finally, I step back and attempt to evaluate the magnitude of PRWORA’s effects upon the immigrant uninsurance rate within the first few years of its passage. Although academic literature often presents the federal government’s adjustment(s) to the GSI safety net as playing a decisive role in affecting the balance of immigrant insurance and uninsurance generally, I conclude that this may not be the case, and that America’s GSI systems may be ill-calibrated to solving the health insurance problems immigrants experience, regardless of the consequences that PRWORA wrought.
3.2 Immigrant access to government-sponsored insurance prior to 1996

The two largest pillars of United States government-sponsored insurance are Medicare and Medicaid. Both federal programs were passed as “Great Society” programs within the Social Security Amendments of 1965. Medicare covers nearly all citizens age 65 and over, and acts as a single-payer health insurance system for the elderly. It receives revenue from federal taxation and distributes funds directly to health providers for care on a fee-for-service basis. Medicaid plays a similar single-payer insurance role for the very poor and disabled, though the eligibility rules are much more complicated. Most Medicaid recipients must have incomes under a certain threshold, which is annually adjusted based on the government’s calculated “federal poverty line” (FPL), whereas pregnant women, children, and disabled working-age adults receive Medicaid on the basis of their vulnerable group status. Medicaid’s revenue and payment structure is more “progressive” than Medicare’s in that states and the federal government split the costs of payment to health care providers, and the relative share of a specific state’s contribution is inversely proportional to its per capita income (Committee on Ways and Means, 2004). Together, these two programs provide insurance to a large proportion of the American population: in 2004 Medicare covered 42 million Americans, and Medicaid another 52 million, together paying $602 billion in enrollee health care claims (Kaiser Family Foundation, 2005).

Motivated by concerns over the growing size of working-class uninsured populations, several states operate smaller, secondary GSI programs for their residents that are roughly modeled after Medicaid. These programs are funded through state taxes, and provide free or low-cost insurance coverage to citizens that fall outside the eligibility requirements for Medicaid.

34 In practice, the “richest” states pay close to 50% of their total Medicaid bills, while the poorest states pay closer to 17%, with the federal government covering the remainder (Committee on Ways and Means, 2004, Ch. 15, p. 28). This represents a tax expenditure transfer from wealthier states to poorer states.
(usually meaning slightly higher-income adults, families, and children). Examples of state-run GSI programs include Vermont’s Catamount Health and Minnesota’s MinnesotaCare. Because states are forced to bear the full costs of this type of non-Medicaid GSI program, and because states have fewer options for raising revenues than the federal government, there is an incentive to shift as many uninsured cases as possible into the federal system instead of state systems (Committee on the Consequences of Uninsurance, 2003).

One additional type of government sponsored “insurance” is Disproportionate Share Hospital (DSH) expenditures and Emergency Medicaid. Federal law (specifically, the Emergency Medical Treatment and Active Labor Act, “EMTALA”) requires hospital emergency departments to provide examinations and “stabilizing treatment” to all incoming patients, regardless of insurance status or ability to pay. “Stabilizing” treatment is defined as attending to “any severe medical condition (including labor and delivery) for which the absence of immediate medical attention could place an individual’s health in serious jeopardy, seriously impair bodily functions, or result in serious dysfunction of any bodily organ or part” (Fremstad and Cox, 2004, p. 14). This statute results in large uncompensated costs at the point of service for many hospitals, but later assistance from government sources eventually make up for much of these losses: 75-85% of uncompensated hospital costs are covered by public sources, with 60% of this amount paid for by the federal government (the rest by lower levels of government) (Committee on the Consequences of Uninsurance, 2003). While these systems are not technically insurance schemes in the same sense as ESI or Medicare/Medicaid, which work on the basis of covering specific individuals, they represent retroactive, de facto payment mechanisms for poor and uninsured emergency room patients collectively.
Government-sponsored health insurance programs must be offered on the same terms to all citizens, following the U.S. Constitution’s 14th Amendment requiring equal protection under the law. Immigrants who either have not yet or will not become U.S. citizens, however, cannot automatically rely on this protection. Their eligibility or ineligibility for GSI is contingent upon the “alienage” laws of the United States. Alienage law governs the treatment of non-citizen immigrants during their time in the country; it is separate from immigration law, which governs the conditions for entry or expulsion from the country (Motomura, 2006). As it is not tied to the Constitution, alienage law has been built, eroded, and re-built over the course U.S. history, and has been highly sensitive to contemporary political sentiments regarding immigrants and immigration.

Historically, alienage law governing immigrants’ eligibility and use of government-funded health insurance has been strongly influenced by U.S. society’s popular attitudes towards immigrants’ receipt of welfare. In turn, this has often been influenced by the racial perceptions and prejudices projected on new immigrants by natives (Motomura, 2006). Welfare laws for immigrants early in U.S. history were generally exclusionary, based on the general principle of keeping poor immigrants out of the country. As could be expected, the implementation of these laws waxed and waned according to long boom and bust cycles of the U.S. economy, though they were not entirely economic in their logic. Exclusionary immigrant welfare laws with specifically racist undertones (against the Chinese, for example) were usually carried out with greater enthusiasm (ibid.).

The shifting scale of regulation of alienage law (federal versus state and local) has greatly impacted immigrants’ legal standing for welfare and GSI eligibility. Before the mid-1800s, alienage law was largely constructed at the state level. States managed the affairs of migrants—
citizen and noncitizen alike—and generally targeted criminals, the sick, or the indigent for discrimination (Motomura, 2006). This changed in the mid-1800s, however, when the federal government stepped up its power over immigration and immigrant affairs. By 1890, immigration affairs were almost entirely decided at the federal level (ibid.). With the shift towards federal command of alienage law, there eventually emerged three basic legal precedents regarding the treatment of immigrants, each of which extended into the late 20th century: (1) the “plenary power” doctrine, which holds that federal immigration and alienage laws are largely immune from judicial review; (2) that the Constitution grants individual states no such judicial immunity; and (3) that noncitizens are still “persons” subject to the equal protection clause of the 14th Amendment (Wishnie, 2001). The palimpsest set of alienage laws in the 20th century contained both positive and negative implications for immigrant rights to government assistance—on the one hand, “plenary power” implied that the federal government was in a position to pass any discriminatory welfare restriction it saw fit, with very little fear of the Supreme Court overturning its legislation; on the other hand, states could not pass similar discriminatory laws, and which if they did would be the subject of judicial scrutiny for fairness.

This regulatory regime worked to the benefit of immigrants during the formation of the modern government-sponsored health insurance system after 1965. For example, when the state of Arizona imposed a 15-year residency requirement for welfare eligibility, effectively barring immigrants from receiving government assistance (including Medicaid), the Supreme Court intervened, ruling that the state had no right to make such a law and that legal immigrants were to receive equal access to benefits. This was a manifestation of the second and third legal

35 Each legal precedent the product of specific court cases at different historical moments, each usually initiated by immigrants arguing for their civil or economic rights.

doctrines listed above (Varsanyi, 2008). Through precedents set in similar court decisions, noncitizen access to Medicaid, Medicare, and other GSI programs nearly converged with those of native-born citizens nationwide near the end of the 20th century (ibid.).

Immigrant use of GSI benefits in the last decades of the 20th century nearly matched that of native citizens. In 1994, low-income legal permanent resident families enrolled in Medicaid at the same rate as low-income native citizen families (both 47% of families), while low-income naturalized citizen immigrant families relied on Medicaid much less (only 27% of families) and refugees more (66% of families) (Capps et al., 2009). However, due to the differing composition of immigrants in the 1990s (i.e. more low-income immigrants, elderly immigrants, and refugees eligible for Medicaid), the aggregate level of medical benefits for immigrants increased compared to earlier decades (Fix et al., 2009). Many elderly immigrants, unable to qualify for Medicare, were also forced to fall back on Medicaid insurance, slightly inflating the perceived total “magnitude” of immigrant GSI usage (Ku, 2009).

Government-sponsored health insurance in the late 20th century, when viewed through an institutional and legal lens, was thus relatively generous to new immigrants. As the modern federal GSI system solidified in the decades following 1965, immigrants were granted equal eligibility and access as citizens by the Supreme Court. Uninsured immigrants entering hospital emergency rooms were subject to the same EMTALA regulations as citizens, and states and

37 Even immigrants of disputed legal status were granted access to GSI via the PRUCOL (Permanently Residing Under Color of the Law) doctrine. If an immigrant was deemed to be PRUCOL, he or she was sometimes granted access to Medicaid benefits. Unlike legal protections of legal immigrants, however, PRUCOL rights varied across states (Zimmerman and Tumlin, 1999). Medicaid implemented an official policy to check for verification of legal immigration status prior to granting eligibility after 1986, dampening GSI access to undocumented immigrants (Rosenbaum, 2000).

38 Medicare usually requires a recipient (or a spouse) to have worked 40 quarters of employment that paid taxes into the Medicare fund over his or her lifetime before qualifying. Recently-arrived elderly immigrants, therefore, are often excluded based on this requirement (Ku, 2009).
localities were forbidden to discriminate between citizens and noncitizens in their distribution of GSI benefits. The enabling factor for these positive outcomes was the trend towards centralized, federal control of GSI standards, combined with the declaration by high-level courts that noncitizen immigrants nationwide were persons granted equal protection under the law (despite the fact they were not formally established as such within the Constitution). The set of conventions that defined the scale(s) of regulation in the “old” regulatory GSI regime—that is, orchestration at the federal scale and equal protection of citizens and noncitizens regardless of geographic location across the country—was not inevitable or transcendentally determined; it was produced through the actions of legislators, courts, and specific legal claimants across the country over many years. The contested nature of this regime, however, also rendered it vulnerable to further (re)negotiation and redefinition. Such a redefinition occurred in 1996 with the passage of welfare reform, producing long-lasting consequences for immigrants’ eligibility, access, and use of government-sponsored insurance.

3.3 PRWORA: Redefining the contract with (new) Americans

The 1990s ushered in a new era of bitter partisan politics at the national level. Two years after Bill Clinton defeated George H.W. Bush to win the 1992 presidential election, Republicans swept the U.S. House of Representatives, picking up 54 seats to become the majority party (Carle, 1995). Republican legislators won the House from Democrats thanks in large part to a lackluster national economy (Teixeira, 1996) and the public promotion of the “Contract With America,” a manifesto of conservative economic policy proposals that Republicans promised to act upon if elected to office (Peck, 2001b).

The Republican “Contract With America” movement reached a crescendo with the authorship and passage of the Personal Responsibility and Work Opportunity Reconciliation Act in August of 1996. PRWORA was foremost a welfare reform act—the culmination of several years of political attacks on the traditional, entitlement-based welfare state. The most trumpeted feature of PRWORA was its promise to combat “welfare dependency” on the part of America’s poor: post-enactment welfare recipients were required to continuously work or seek employment in exchange for state and federal cash assistance (Peck, 2001b). PRWORA did away with the old cash welfare system (Aid to Families with Dependent Children or AFDC) and introduced the new TANF (Temporary Aid for Needy Families) system, which was to be administered on a state-to-state basis and funded by the federal government through block grants (ibid.). The Act also imposed federal caps on welfare spending, and an individual limit on welfare eligibility (five years per recipient) (ibid.). Bill Clinton, who had promised in his 1992 presidential campaign to “end welfare as we know it,” initially rejected the Republicans’ welfare reform and the “Contract With America” generally, but eventually signed a compromise bill under political pressure in the run-up to the 1996 presidential election, after PRWORA had spent many months moving through drafting phases in the House and Senate (Agrawal, 2008).

PRWORA radically restricted welfare benefits for immigrants, under the discursive banner (produced behind the scenes) of “No More Welfare for Noncitizens and Felons” (U.S. House of Representatives, 1996). The bill’s immigrant-specific provisions were prefaced by a set of bluntly normative theses and political economy aims:

The Congress makes the following statements concerning national policy with respect to welfare and immigration:

(1) Self-sufficiency has been a basic principle of United States immigration law since this country's earliest immigration statutes.
(2) It continues to be the immigration policy of the United States that—
(A) aliens within the Nation's borders not depend on public resources to meet their needs, but rather rely on their own capabilities and the resources of their families, their sponsors, and private organizations, and (B) the availability of public benefits not constitute an incentive for immigration to the United States.

(3) Despite the principle of self-sufficiency, aliens have been applying for and receiving public benefits from Federal, State, and local governments at increasing rates.

(4) Current eligibility rules for public assistance and unenforceable financial support agreements have proved wholly incapable of assuring that individual aliens not burden the public benefits system.

(5) It is a compelling government interest to enact new rules for eligibility and sponsorship agreements in order to assure that aliens be self-reliant in accordance with national immigration policy.

(6) It is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits.

(104th Congress, 1996)

As a means of promoting such “self-sufficiency,” the old regulatory frameworks guaranteeing legal permanent residents (LPRs) equal access to benefits (as well as the heterogeneous PRUCOL rules for immigrants of ambiguous legal status) were dissolved and replaced by a new, explicitly differential system based on the classification immigrants as either “qualified” or “unqualified” to receive welfare benefits. This new classification system was not a simplification of older doctrines; on the contrary, the “qualified vs. unqualified” eligibility criteria were, in the words of Rosenbaum (2005), “uncommonly complicated, with exceptions, caveats, and limitations piled onto a murky, basic immigration law” (p. 5). At its core, PRWORA set up three classifications of immigrants:

1. “Qualified” aliens who entered the U.S. before August 22, 1996: This group, consisting of LPRs, asylees, refugees,40 and a few other small categories of

40 Traditionally defined as persons who, out of a demonstrable expectation of persecution based on ethnicity, religion, political affiliation, or other social membership, are unwilling to return to their home countries.
immigrants living in the country at the time of PRWORA’s passage, were considered “long-term entrants.”

2. “Qualified” aliens who entered the U.S. after August 22nd, 1996: This group, categorically identical to the “long-term entrants” but entering the country after the passage of PRWORA, were deemed “new entrants.”

3. “Unqualified aliens”: This group was defined negatively as not falling into the qualified category. This included undocumented immigrants. (Rosenbaum, 2000)

Eligibility for “federal means-tested benefits” (Medicaid, cash welfare, Social Security Insurance, and so on) was to be determined by one’s status as either “qualified” or “unqualified.” “Qualified” aliens entering the country before PRWORA’s passage were eligible for all federal benefits, including Medicaid. “Unqualified” aliens were barred from nearly all federal benefits except for emergency Medicaid (usually used for emergency care). “Qualified” aliens that entered after PRWORA’s passage were barred from nearly all federal benefits, including Medicaid, for five years after their date of entry.41

As intimated in PRWORA’s “statement of principles,” the decision to bar new immigrants from welfare was partially rationalized by a new “sponsor deeming” law: sponsorship of new immigrants by an existing U.S. resident (a long-standing prerequisite for entry) subsequently required an Affidavit of Support, holding sponsors responsible for the financial well-being of their sponsored immigrants and thereby (theoretically) shifting responsibility for immigrant welfare away from the federal government. If an immigrant suddenly became in need of cash assistance or Medicaid, they could be deemed ineligible for

41 Rosenbaum (2000). PRWORA set up a short list of “qualified new entrant” categories excluded from the 5-year ban, including refugees and asylees, honorably discharged veterans of the U.S. armed forces and their spouses/dependents, Amerasian immigrants, and American Indians born in Canada (ibid.).
benefits if the sum of his or her financial resources plus the resources of his or her sponsor exceeded their state’s calculated eligibility ceiling (Fix et al., 2009). In practice, this meant that the five year bar for noncitizens could be “extended” in a sense, if the deeming requirement was strictly enforced by the states for all new non-citizens (Motomura, 2006).

PRWORA allowed individual states to provide replacement welfare benefits for immigrants excluded by PRWORA provisions at a “state option,” meaning states would have to raise 100% of the funding for such programs without federal assistance (Zimmerman and Tumlin, 1999). This was presented as a means of providing states with more flexibility in regulating their own immigrant welfare programs. This flexibility was tempered, however, by new restrictions upon which benefits could be provided to “qualified” and “unqualified” immigrants at the state level, as well as new protocol requiring states to ascertain the legal statuses of all applying immigrants before distributing almost any type of benefit (ibid.). A virtually-identical “qualified/unqualified” standard was also applied to SCHIP (State Children’s Health Insurance Program), a federal-state partnership GSI program established in 1997 (Fremstad and Cox, 2004) (Table 3.1).

After signing PRWORA, President Clinton explicitly stated his desire to undo the embedded restrictions on immigrant eligibility for federal benefits. Within three years of PRWORA’s passage, after further partisan shifts in Washington D.C., legislation was enacted to roll back parts of PRWORA’s immigrant restrictions: for example, cash payments and food stamps to elderly and disabled immigrants and immigrant children were partially restored, and the definition of “means tested federal benefits” was narrowed (Zimmerman and Tumlin, 1999). The main thrusts of PRWORA’s anti-immigrant restrictions, however—the five-year ban on federal benefits for legal immigrants and the downloading of responsibility to the states—were
<table>
<thead>
<tr>
<th>Immigrant Status</th>
<th>Eligible for Medicaid</th>
<th>Eligible for SCHIP</th>
<th>Eligible for Emergency Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal permanent residents who have resided in the U.S. more than 5 years – “Qualified”</td>
<td>Yes</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Legal permanent residents who have resided in the U.S. less than 5 years – “Qualified”</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Refugees and other humanitarian immigrants – “Qualified”</td>
<td>Yes</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Pregnant immigrants who are (1) legally in the country less than 5 years, (2) “lawfully present” immigrants who were receiving SSI at passage of PRWORA, or (3) undocumented – “Unqualified”</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>“Lawfully present” immigrants who are not pregnant – “Unqualified”</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Undocumented immigrants who are not pregnant – “Unqualified”</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 3.1: Federal eligibility rules for Medicaid and SCHIP, established by PRWORA and subsequent federal legislation. Included are PRWORA’s designations of each immigrant category as either “qualified” or “unqualified” for federal means-tested benefits. Sources: Adapted from Fremstad and Cox (2004, p. 10), and Zimmerman and Tumlin (1999, p. 15).

left in place. The message sent to immigrants lacking health insurance was simple: in case of medical hardship, the federal government was no longer inclined to offer its assistance, and that access to insurance benefits would be contingent upon the decisions of state governments, with no guarantees of equal protection.

3.4 A “serendipitous” pairing: neoliberal ascendency and the genesis of PRWORA’s immigrant restrictions

Within a matter of months, the normative and regulatory regime surrounding government-sponsored insurance for immigrants had been radically redefined. Instead of treating immigrants as if they were granted equal protections as citizens under the law, Republican legislators had specifically targeted them for exclusion from a wide range of government services—in spite of the fact that immigrants still paid taxes to pay for these services.
PRWORA’s restrictions were labeled as tools to solve an immigration issue (“Self-sufficiency has been a basic principle of United States immigration law since this country's earliest immigration statutes,” quoted above). This strategy implicitly invoked the “plenary powers” granted to the federal government when dealing with alienage law—powers that might not have withstood judicial scrutiny if the legislation was formulated as merely a “welfare” issue. The question arises, then, of how an immigration regulation tool made its way into bill that touted itself as a reformation of the domestic welfare state. With respect to this question, the historical details of PRWORA’s drafting are revealing. They show that the idea of immigrant exclusion from welfare and GSI did not arise as a natural application of neoliberal welfare reform’s inner logic. Rather, the ascendancy of neoliberal reformists to Washington D.C. in the 1990s produced the conditions of possibility necessary for the (much older) idea of immigrant non-dependence from welfare to be enshrined into law. Only as PRWORA took its final shape were immigrant exclusion and neoliberal welfare reform “merged” to form a unified policy platform.

Welfare reform of the 1990s was the product of a multi-decade neoliberal movement towards “welfare-to-work,” also known as “workfare” (Peck, 2001b). “Workfarism” as an ideological project began with a set of normative beliefs regarding the causes of and solutions to poverty in the United States. Americans depending on cash welfare, food stamps, Medicaid, and other government supports were constituted by workfare supporters in a specific way: namely, in terms of a pathological “dependency” upon government aid that inhibited individual responsibility and entrepreneurship—a deficiency that could only be cured through “tough love” behavioral correctives (Peck, 2001b, p. 57). Workfarism as a political project, in turn, emphasized: (1) mandatory participation in programs to modify the work behavior of welfare recipients (e.g. learning “employability” skills) as a condition of cash assistance; and (2) a
systemic orientation towards work and labor-force attachment (requiring welfare recipients to seek employment continuously while on welfare, even if the only available jobs are of low quality) (ibid.). Such a depiction of the domestic welfare “maladies” of the United States, including prescribed correctives, represents one facet of neoliberalism as a hegemonic ideological project. That project was represented as a coherent set of ideas and images of the U.S. welfare state, its problems, and how these problems could best solved (England & Ward, 2007).

By the time of PRWORA’s passage, workfarism as a neoliberal ideological and political was already several decades old (Peck, 2001c). Significantly, workfarism up to the 1990s did not typically address immigrant affairs at all. Welfare recipients were defined ideologically without reference to citizenship status; that is, all individuals of working age were presented as equally susceptible to “welfare dependency.” Furthermore, after PRWORA was passed, workfarism continued to spread as political orthodoxy to Canada and Western Europe (Peck, 2001b) without the same explicitly discriminatory polices aimed at denying immigrants from welfare. Immigrant exclusion from welfare as a political end in itself, therefore, was not a natural culmination of the hegemonic ideological precepts of the workfarist movement that had been cultivated prior to PRWORA’s authorship, and it did not become a central tenet of workfarist theory and practice after PRWORA’s passage.

How exactly, then, did immigrant exclusion from GSI get wrapped up in a fundamentally neoliberal project? Ron Haskins’ (2009) account of the PRWORA drafting process shows that the idea of immigrant exclusion from GSI and welfare, far from a well thought-out and principled policy decision, was instead hastily decided upon behind closed doors in the interests of incidental cost savings. It was only later presented to the House of Representatives as a goal-
driven policy, justified using the language of “traditional” immigration regulation (Agrawal, 2008). Haskins, a senior staffer in the House Ways and Means Committee in the early 1990s and a supporter of the immigrant exclusion provisions of PRWORA, provides his candid recollection of the genesis of the idea:

…a few days after the first meeting of the Republican welfare reform task force, a group of House Republicans invited Doug Besharov of the American Enterprise Institute to talk with them about welfare reform. During that meeting…the issue of welfare for noncitizens came up. I was annoyed as the discussion proceeded because I knew very little about the basic facts of welfare for noncitizens, other than that many noncitizens received welfare benefits. Two facts emerged from that brief 1993 discussion. Nearly every Republican in the room was against giving welfare to noncitizens, and no one had any idea of how many noncitizens were receiving welfare nor how much it cost the government to pay for the benefits. (Haskins, 2009, p. 47)

After conducting a single week of research following this meeting, Haskins distributed a memo to Republican legislators summarizing the basic facts of welfare use by noncitizens. Haskins describes the next meeting:

When the issue of welfare benefits came up at the next meeting of the welfare reform task force, everyone was astounded that noncitizens could apparently participate in most welfare programs on the same basis as citizens and that the estimated cost of paying for the benefits…could be as much as $2 or $3 billion per year. There was virtually no controversy about ending some or all of the benefits, and the staff began immediately drafting provisions to achieve this end. (ibid., p. 48)

Assuming Haskins’ recollection is accurate and representative of the motivations of other key authors of welfare reform, the genesis of PRWORA’s immigrant exclusion provisions can be described as the chance outcome of the back-room machinations of ill-informed conservative reactionaries. Serendipitously presented with the facts of the “old” system of welfare for immigrants, neoliberal authors in Congress reacted swiftly and punitively against their future access to safety net institutions. This is especially troubling, since immigrants in the United States hardly fit the profile of the entrepreneurially-deficient, welfare-dependent subjects
typically scrutinized by workfarists. On the contrary, U.S. immigrants are generally characterized by comparatively low welfare use (controlling for socioeconomic status), high work levels, and a significantly greater likelihood of living in intact families than the native-born poor (Fix et al., 2009). The bar on immigrants from GSI and welfare even contradicts the basic logic of workfarism itself: government benefits are re-formulated as inducements to seek employment for the majority of workfare’s subjects, but for immigrants employment status (or any other behavior) is not a factor. Immigrants are simply excluded (Zimmerman & Tumlin, 1999).

The idea of immigrant exclusion from welfare, seized upon by Ron Haskins and other republican legislators, does, as PRWORA’s language suggests, trace its roots to much earlier eras in America’s history (Motomura, 2006). But it reflects two lines of reasoning that are almost entirely separate from workfarism. First, immigrant exclusion is predicated upon the moral notion of the “immigrant bargain” (Agrawal, 2008). In this view, immigrants can come to America and eventually enjoy the benefits of citizenship (including welfare or GSI), but they are morally obligated to first work hard, pay taxes, and support themselves. This is a small price to pay in the eyes of PRWORA’s supporters (e.g. Haskins, 2009). Restrictions on welfare for immigrants are also rationalized as means of improving the “quality” of immigrants and counteracting the “welfare magnet” effect (Fix et al., 2009) (it is implicitly assumed, incorrectly,

42 These are, of course, the “high minded” justifications for immigrant exclusion from welfare. A more base justification was also presented: incidental cost savings accrued by excluding immigrants, (questionably) valued at $23 billion (Agrawal, 2008).

43 The “immigrant bargain” was used as the greater justification for immigrant exclusion in PRWORA (see the 104th Congress’ statements 1, 2A, and 5 in the quoted PRWORA preface text above).
that new immigrants are particularly prone to the “welfare dependency” affliction).\textsuperscript{44} These logics, primarily ideological in nature, remained at the center of justifications for immigrant exclusion as enshrined by law. Agrawal (2008), reflecting upon the discursive techniques used to push immigrant welfare exclusions into law, remarks that “the broad lesson [of PRWORA’s formulation] is that members of Congress operationalize legislation and the debate around that legislation with reference to perceived national ideologies and values—even in opposition to technical data and measurable fact if necessary” (p. 669). This is certainly true, but there is a wider lesson to be learned from the connection between workfare’s ascendancy and the inclusion of immigrant exclusion. The workfarist program was driven by the more general project of neoliberalism, and was used as a sort of (re)regulatory arm of business interests committed to dismantling the Fordist social contract (Peck, 1999). The election of a broad base of conservatives to the U.S. legislature, most of which were committed to a radical, workfarist reform strategy, set the conditions of possibility for a vitriolic policy platform like “No More Welfare for Noncitizens and Felons” to be passed without significant resistance. Bill Clinton strongly disagreed with the immigrant exclusion provisions of PRWORA, but was caught in a trap both by his earlier political promises to “reform welfare as we know it” and his adherence to the prevailing neoliberal political zeitgeist (Peck, 2001b). Given the popularity of neoliberal concepts among elite policymakers and private stakeholders in Washington, Clinton determined the political consequences of not passing PRWORA to be much greater than any potential political fallout from excluding immigrants. The government’s official stance towards immigrant GSI was thus sealed.

\textsuperscript{44} Combating the “welfare magnet” effect was enshrined as the \textit{lesser} justification for immigrant exclusion within PRWORA (104\textsuperscript{th} Congress’ statements 2B and 6 above).
The path of immigrant GSI exclusion into law was, in conclusion, tortuous and contingent. Nevertheless, after its passage, PRWORA served as a powerful tool for a new brand of immigration affairs. Relations between immigrants, the state, and society were re-imagined and re-defined by those in the centers of power in Washington. They also initiated a new geographic pattern of devolution for immigrant GSI/welfare costs and powers, and a re-definition of the relations between different geographic scales of government safety nets (e.g. federal vs. state). I will now explore the dimensions of this restructured state form as it relates to GSI for immigrants.

3.5 Devolution of welfare authority and its implications for immigrant access to GSI

As PRWORA ushered in the state block-grant system for welfare programs, and as it granted individual states the option of providing “replacement” welfare for immigrants excluded from federal benefits, it redefined part of the American federalist relationship. Federalism, broadly defined as the relationships of power, responsibility, and legal authority between the federal and state scales of government, has always been subject to periodic contestation and redefinition since the coalescence of the United States (Delaney & Leitner, 1997); PRWORA, therefore, can be seen as one of a long series of refinements. Generally speaking, welfare reform changed the federalist relationship by “hollowing out” the old federally-centralized welfare system and “devolving” most of the powers to organize welfare programs to the states.

“Hollowing out” did not imply the disappearance of the federal government’s powers over welfare; rather, it implied the deconstruction of the older, historically and geographically specific institutionalization of welfare and its replacement by another reorganized federal-state welfare apparatus (Peck, 2001a, p. 447). This restructuring of welfare involved complex changes in the
relations between different scales of the state welfare apparatus—in regulatory responsibilities, administrative capacities, financial control, and so on—such that the functioning of welfare systems (as well as their experienced effects among welfare recipients) tended to change along with their geographic "relocation" away from Washington (ibid.).

Although many powers and responsibilities were devolved “downwards” towards the states in the new welfare system, much of the regulatory regime constraining these powers remained anchored at the federal level (Peck, 2002b). This is sometimes referred to as “thin” policy within geographic discourse on neoliberal restructuring (Peck, 2001a). “Thin” policymaking underpins the devolution of Medicaid for immigrants: states were granted more flexibility for operating their GSI systems, but Washington did not cede its powers of direction entirely. It still held the purse-strings via the cost-sharing mechanism of Medicaid, and it still dictated the rules regarding which immigrants were eligible or ineligible to receive health benefits.

In terms of the geography of cost-devolution, the PRWORA model for immigrant GSI generally conform to Handler and Hasenfeld’s (1997) description of the scalar dichotomy that tends to emerge in American government when dealing with the “deserving” and “undeserving” poor (p. 208): “deserving” immigrants can receive federally-funded benefits on par with citizens, while benefit programs for what PRWORA defines as the “undeserving” immigrants—new immigrants and undocumented immigrants—are left to states and localities to organize, fund, and distribute (or not). The additional costs of “replacement” GSI programs at the state

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45 The “old” system of cash assistance (AFDC), for example, could be described in federalist terms as centrally-funded and federally-centralized, whereas the new system of devolved welfare (TANF) could be described as more flexibly funded at different scales (state and national), and more unstable and multi-scalar in its organization (Peck, 2001b).
government scale are the most visible consequences of this welfare model (Zimmerman & Tumlin, 1999).

Many scholars feared that this brand of downward cost-shifting would mark the beginning of a “race to the bottom,” with states limiting social service access to immigrants as much as possible either to comply with federal law or to make up from a loss of federal funding (Zimmerman & Tumlin, 1999). PRWORA legally allowed states to be more restrictive than the federal government in denying welfare eligibility for new immigrants (Fremstad & Cox, 2004), and decentralization of welfare policy theoretically increased the incentive for states with limited resources to find the cheapest welfare “recipe” that produced positive, politically viable short-term results (Peck, 2001b, p. 71). Because state lawmakers and program directors often construct their welfare programs in reaction to the regulatory actions of other states with which they “compete” (Lieberman & Shaw, 2000), one state’s decision to provide immigrants with benefits after PRWORA could be viewed as a “high cost” and “uncompetitive” welfare strategy compared to another state’s decision to provide only the bare minimum of benefits to immigrants mandated by the federal government. The expedient option in this case would be to not provide additional benefits at all.

After a few years, however, the results remained ambiguous. Judging by programs approved after PRWORA, most states seemed willing to provide substitute benefits to new immigrants facing the federal five-year bar. Many of these programs, however, also carried restrictions that disproportionately affected immigrants, effectively excluding them a second time from equal access. Sheer geographical unevenness soon emerged as the defining feature of the substitute programs: full benefits offered in one state might be partially offered in another state, or not offered at all in another (Zimmerman & Tumlin, 1999).
Zimmerman and Tumlin’s (1999) survey measured the extent of immigrant-specific state substitute programs for four benefits: food stamps, Social Security Insurance, cash assistance, and Medicaid. 28 out of 50 states opted to provide at least one of the four substitute benefits, 15 states offered at least two, 10 offered at least three, and only 2 offered all four. Cash assistance was the most-offered substitute benefit, with 19 out of 50 states providing TANF to new immigrants, followed by food stamps (17 states), Medicaid (14 states), and SSI (5 states) (ibid.). California and Maine were the most proactive providers of substitute benefits for federally-barred immigrants, while states in parts of the South, Southwest, and West were less generous (Figure 3.1). Even if substitute programs were offered to excluded immigrants in a state, the actual efficacies of the programs were less-than-ideal. Many programs were targeted at mothers and children, for example, but did not address working-age adults, the largest immigrant group barred from access. Many substitute benefits were temporary or carried residency requirements, both effectively limiting immigrants to particular time windows for access. Finally, following the federal model, many states imposed sponsor-deeming clauses, even on GSI (Fremstad & Cox, 2004).46

In general, the only states initially to provide substitute GSI benefits to federally-barred immigrants were those that had established state-run health insurance programs prior to the passage of PRWORA (e.g. MinnesotaCare, created in 1992). Unfortunately, only 23 states maintained such state-funded health insurance programs near the time of PRWORA’s passage, and most of these programs were targeted towards children, pregnant women and parents, or the elderly.

46 This being said, some states refrained from enforcing sponsor-deeming rules on substitute Medicaid programs on the stated assumption that even middle-income sponsors could face great difficulties paying unforeseen health care costs (Zimmerman & Tumlin, 1999, p. 27).
In 1998, only 14 states offered Medicaid-substitute insurance to federally-barred immigrants (Table 3.2) (Zimmerman & Tumlin, 1999). In the period of economic expansion following PRWORA, however, most states experienced relative budget surpluses. In this time, eight more states decided to fund Medicaid-substitute eligibility for immigrants, raising the total number of states to 22 by 2004 (Fremstad & Cox, 2004) (Figure 3.2).

States’ chances of offering substitute welfare benefits were not necessarily correlated to the size of their immigrant populations. Some states with small immigrant populations (like Washington D.C.) also introduced similar immigrant eligibility during this time (ibid.).
Maine) provided generous benefits, while some states with larger immigrant populations (like Texas) provided relatively few. The growth rate of states’ immigrant populations did not seem to be a determining factor either, given that of the ten states with the fastest-growing immigrant populations in the 1990s, only two (Nebraska and Colorado) offered substitute GSI by 2004 (Fremstad & Cox, 2004). Wealthier states (measured in terms of per capita income) offered more assistance, with the possible implication that states with poorer populations (immigrant or otherwise) might provide the least amounts of assistance (Zimmerman & Tumlin, 1999).

Hero and Preuhs (2007) conclude that demographics, combined with a states’ political “orientation,” influenced the distribution of substitute welfare benefits nationwide. Politically “liberal” states were more likely to offer eligibility to immigrants, but the magnitudes of included benefits were negatively-correlated with the immigrant proportion of the population. That is, liberal states would often offer substitute benefits immigrants, but would be more

<table>
<thead>
<tr>
<th>State</th>
<th>Limited immigrant eligibility (e.g. to children or pregnant women)</th>
<th>Sponsor-deeming requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td></td>
<td>X</td>
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<tr>
<td>Connecticut</td>
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<td>Washington</td>
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<td>X</td>
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</tbody>
</table>

Table 3.2: List of states providing substitute-Medicaid programs for federally-barred immigrants in 1998, with attached conditions to eligibility. Source: Adapted from Zimmerman and Tumlin (1999, p. 64).
generous with their benefits if the immigrant share of the state population was small.

Zimmerman and Tumlin also conclude that the size and political strength of a state’s immigrant advocacy community, as opposed to simple demographics, played a large role in policy differences between states (Zimmerman & Tumlin, 1999).

Even as GSI-replacement programs expanded across the country in the years following PRWORA, immigrant communities were left in a state of increased political vulnerability.

Welfare reform’s renegotiation of the roles and responsibilities between the federal and state governments for immigrant welfare also implied a redefinition of the “scale” of scrutiny aimed at immigrant groups—that is, the politically-mediated geographic scale at which population(s) have the greatest ability to make legal and legislative actions to the benefit or detriment of immigrants. Before PRWORA, this scale was set at the national level: plenary power allowed the federal government almost unlimited powers of legislation over alienage laws, while restricting states.
from discriminating. PRWORA’s devolution of welfare programming authority, however, tilted the legislative scale to which immigrants are politically vulnerable much farther towards the state and local levels (Varsanyi, 2008). Trends in “inclusionary” versus “exclusionary” political sentiments do, of course, change at the national level, but they are likely to be more volatile at smaller scales (i.e. within smaller groups of people in distinct geographically bounded areas) (Ellis, 2006). Localized bias or dissatisfaction against immigrant communities, therefore, could be more easily translated into discriminatory legislation after PRWORA’s passage (Wishnie, 2009).

One possible consequence of this “localization” of political vulnerability, predicted by scholars like Zimmerman and Tumlin (1999), is that immigrants would face the brunt of state spending and benefit cuts in times of economic insecurity—even if the same states were relatively inclusive and generous in their welfare provision during periods of economic strength. This is partially a factor of the imbalanced flow of taxes and services to/from immigrants: the majority of tax dollars paid by immigrants flow to the U.S. treasury in the form of income taxes, while many of the most visible services used by immigrants are paid for by local governments (public schools, for example). In general, this means that immigration generates a net “surplus” for the federal government, a net deficit for local governments, and mixed results at the state level, depending on state tax structures (Fix & Tumlin, 1997). This imbalance—applicable to many different U.S. sub-populations, not just immigrants—can be easily combined with racial politics and fundamental prejudices against immigrant communities to form a (false) “taxpaying citizen” versus “non-taxpaying immigrant” dichotomy in the minds of voters and state legislators (Fujiwara, 2006), with discriminatory legislative consequences in times of socioeconomic distress.
Fortunately, this increase in political vulnerability did not seem to translate into large cutbacks in GSI during the recessionary periods of the early 2000s. Only a few states—Washington, Massachusetts, Connecticut, and New Jersey—cut back or eliminated their state-replacement programs for immigrants in the face of budget deficits, and many of these cuts were quickly restored in following years (Fremstad & Cox, 2004). Some states even expanded their GSI offerings to immigrants during periods of fiscal distress (ibid.), presumably due to the resilient efforts of health advocates in local legislatures. The threat of localized vulnerability remained the status quo, however, and PRWORA’s redefinition of the relationships between federal and state governments and the immigrant communities they serve remained entrenched.  

In the next chapter I will evaluate one case study, Minnesota, with respect to the local dynamics of this vulnerability.

3.6 Estimated effects of PRWORA on the immigrant uninsurance rate

Determining the effects of welfare reform and GSI devolution upon the uninsurance rate of immigrant communities is exceedingly difficult for at least two reasons. First, changes to the GSI system are only one of several interacting factors affecting uninsurance rates in general. As discussed in Chapter 1, shifts within the economy and ESI systems—for example, shifts in incomes within populations, or a trend towards more ESI coverage in certain growing industries—affect the insured and uninsured populations significantly. A change to the GSI “regime” like PRWORA must subsequently be mediated by the private labor and ESI markets.

48 It remained entrenched throughout the 2000s, in fact, following the defeat of comprehensive immigration bills in 2006 and 2007 (Johnson, 2010).
before it can be felt in terms of insurance/uninsurance outcomes.\textsuperscript{49} Without taking such considerations into account, observations of reduced outlays for immigrant GSI, or increases in ESI among immigrants formerly-receiving GSI, or a change in the broad immigrant uninsurance rate could be inaccurately ascribed to PRWORA when they in fact owe more to a changing economy.\textsuperscript{50} Second, PRWORA’s (intentional and unintentional) institutionalization of differential treatment for different immigrant groups\textsuperscript{51} implies that PRWORA’s impacts on “immigrant uninsurance” as a group characteristic are \textit{heterogeneous}, a significant factor for reasons that will become apparent in Chapter 3.

Unfortunately, research on the after-effects of PRWORA varies widely in the scope of immigrant sub-populations studied: one detailed study may evaluate the effects on low-income noncitizen LPR parents and children (the subject of certain SCHIP protections), while another study may use an aggregate measure of noncitizens that includes undocumented workers (intentionally excluded from GSI programs altogether). Both studies are useful, but they are difficult to compare directly in order to find some “unified” result of policy. For the sake of brevity, I will present a small number of surveys on the impact of PRWORA upon immigrant GSI, and attempt to weigh the results with respect to the broader immigrant uninsurance rate.

Research conducted within the first ten years following PRWORA indicates that the federal reform at first drastically limited access and take-up of Medicaid to low-income immigrants. Fix and Passel (2002) recorded a 15% drop in legal immigrants’ use of Medicaid

\textsuperscript{49} This is analogous to Peck’s (2001b) observations on the “workfare regime”—the outcomes of welfare-to-work programs inextricably depend on the quality and quantity of private-sector work available to welfare recipients (p. 16).

\textsuperscript{50} Echoing Capps et al. (2009, p. 127).

\textsuperscript{51} E.g. “qualified” pregnant women vs. “qualified” but barred LPRs.
nationally between 1994 and 1999, and this result was confirmed by the Kaiser Commission on Medicaid and the Uninsured (2003) and Rosenbaum (2000). Carrasquillo et al. (2003) estimated the number of immigrant children and parents excluded from GSI due to PRWORA in the hundreds of thousands, while localized surveys of Los Angeles County (Fix & Zimmerman, 1999) and Texas (Hagan et al., 2003) each reported immigrants dropping Medicaid coverage by percentages in the double digits. Fix and Passel (2002), pointed out that in the majority of cases, if immigrants left Medicaid between 1994 and 1999 they did so not because they had acquired alternative insurance options but because they simply joined the ranks of the uninsured.

Several researchers have also argued that PRWORA’s immigrant restrictions produced a number of additional, unintended effects on immigrant GSI. A variety of spillover effects acted to discourage otherwise eligible uninsured immigrants from using Medicaid, intensifying the magnitude of immigrant exclusion. For instance, the application and case processing system for Medicaid recipients became much more complicated following PRWORA in ways that disproportionately affected immigrants (owing to the fact that caseworkers now had to verify immigrant eligibility using the much more complicated system of “qualified vs. unqualified” plus exemptions) (Kandula et al., 2004). Consequently, this placed the burden mainly on immigrants themselves to prove their identity as one or more of the sets of eligible and exempted groups (Rosenbaum, 2000), possibly hindering enrollment.

A more widely-favored spill-over effect of PRWORA’s immigrant restrictions was the “chilling effect” of welfare reform’s outward message, i.e. that the United States government officially expects immigrants to provide for themselves, no matter what. Much of this “chilling effect” was the product of rumors following welfare reform that the U.S. government would make it harder for non-citizens receiving Medicaid to receive citizenship, or even deport
immigrants who took “too much” in welfare benefits (Ku and Matani, 2001). This threat never materialized, but the rumor, combined with PRWORA’s discursive tone and other anti-immigrant legislation such as California’s Proposition 187, sent a signal that legal immigrants should avoid Medicaid, even if they were uninsured and eligible (ibid.; Rosenbaum, 2000). Hagan et al. (2003) found evidence of this type of chilling effect through interviews with immigrants in Texas communities. Even though many Texan immigrants dropped their Medicaid (and other benefits) due to fears of hurting their chances at naturalization, their withdrawal from the system could be misleadingly described as “voluntary” by a researcher examining only trends in welfare rolls.

Fortunately, after a number of years of Medicaid declines following 1996, the national GSIC system recovered and began to enroll needy immigrants in higher numbers. Aside from the benefits provided by state-run replacement Medicaid and SCHIP, a number of enrollment-enhancing factors emerged. First, the government clarified its stance on Medicaid receipt and naturalization, allaying earlier fears among immigrants hesitant to ask for welfare. Second, local outreach efforts aimed at immigrants (especially immigrant parents) successfully enrolled harder-to-reach eligible populations (Fix & Passel, 2002). Improvements in the caseload system, e.g. a streamlined application process and the addition of more foreign language support, also improved access for uninsured immigrants who were otherwise eligible for Medicaid (Holcomb et al., 2003). Third, structural aspects of the Medicaid program mitigated the erosion of immigrant enrollment after PRWORA: Medicaid, unlike other benefits like food stamps or cash welfare, acts as a direct payment from the government to third parties (doctors and other healthcare professionals) in exchange for their services. These third parties in the health care sector have a strong incentive to keep as many of their Medicaid-eligible uninsured patients
(citizen or noncitizen) enrolled in GSI programs as a means of stabilizing compensation for their services (Fix & Passel, 2002). Immigrants seeking medical care therefore likely received substantial assistance from such third parties to ensure that any pre-existing GSI was not lost, or even that “new” GSI was acquired.

A table and maps of Medicaid coverage rates for noncitizens in 2003 is displayed in Figure 3.3. Patterns exist in the distribution of Medicaid coverage in 2003, though they do not seem to follow a strong geographic gradient. Most notably, all states with replacement GSI programs (Figure 3.2) tend to have noncitizen Medicaid rates of 6% or higher, and states with next-to-nonexistent noncitizen Medicaid coverage did not offer replacement GSI for immigrants (with the notable exception of Virginia). Unfortunately, the data set that this map is derived from (the Current Population Survey Annual Social and Economic Supplement, CPS-ASEC) does not extend to years past 2002-2003, making a state-by-state comparison of noncitizen GSI before and after the passage of PRWORA difficult. It does, however, show evidence of the effect of geographic context upon the distribution of GSI coverage nationally at the beginning of the 2000s.

As Medicaid and nearly all other state-organized GSI programs are means-tested, it would be plausible that the distribution of GSI coverage mapped above would be covariate with the distribution of poverty among the noncitizen population (the higher the poverty rate, the

52 This, unfortunately, marks the boundary between the CPS-ASEC collection and an earlier set of surveys, the Annual Demographic Survey. The two types of survey have different methodologies, and produce different levels of data disaggregation. Another problem with the ASEC data is its apparent failure to distinguish between state-provided GSI and federal Medicaid. It appears that state and federal GSI coverage are both recorded as simply “Medicaid” in these samples.

53 A meta-analysis of data from the ASEC and earlier data sets is theoretically possible, but beyond the scope of this thesis.
<table>
<thead>
<tr>
<th>State</th>
<th>Noncitizens</th>
<th>% Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Coverage (&gt;15%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>98,000</td>
<td>22.45%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>465,000</td>
<td>21.94%</td>
</tr>
<tr>
<td>Alaska</td>
<td>23,000</td>
<td>17.39%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>58,000</td>
<td>17.24%</td>
</tr>
<tr>
<td>New York</td>
<td>2,131,000</td>
<td>16.71%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>186,000</td>
<td>16.13%</td>
</tr>
<tr>
<td>California</td>
<td>5,725,000</td>
<td>15.88%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>83,000</td>
<td>15.66%</td>
</tr>
<tr>
<td>Vermont</td>
<td>13,000</td>
<td>15.38%</td>
</tr>
<tr>
<td><strong>High-Middle Coverage (15% - 9%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>7,000</td>
<td>14.29%</td>
</tr>
<tr>
<td>Michigan</td>
<td>264,000</td>
<td>14.02%</td>
</tr>
<tr>
<td>Washington</td>
<td>334,000</td>
<td>13.77%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>177,000</td>
<td>13.56%</td>
</tr>
<tr>
<td>Nebraska</td>
<td>56,000</td>
<td>12.50%</td>
</tr>
<tr>
<td>Arizona</td>
<td>615,000</td>
<td>11.87%</td>
</tr>
<tr>
<td>Ohio</td>
<td>254,000</td>
<td>10.63%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>838,000</td>
<td>9.90%</td>
</tr>
<tr>
<td>D.C.</td>
<td>51,000</td>
<td>9.80%</td>
</tr>
<tr>
<td>Utah</td>
<td>117,000</td>
<td>9.40%</td>
</tr>
<tr>
<td><strong>Middle Coverage (9% - 6%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>182,000</td>
<td>8.79%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>82,000</td>
<td>8.54%</td>
</tr>
<tr>
<td>Iowa</td>
<td>113,000</td>
<td>7.96%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>129,000</td>
<td>7.75%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>93,000</td>
<td>7.53%</td>
</tr>
<tr>
<td>Florida</td>
<td>1,746,000</td>
<td>7.39%</td>
</tr>
<tr>
<td>Colorado</td>
<td>320,000</td>
<td>6.88%</td>
</tr>
<tr>
<td>Kansas</td>
<td>102,000</td>
<td>6.86%</td>
</tr>
<tr>
<td>Maine</td>
<td>15,000</td>
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</tr>
<tr>
<td>Pennsylvania</td>
<td>256,000</td>
<td>6.64%</td>
</tr>
<tr>
<td>Oregon</td>
<td>207,000</td>
<td>6.28%</td>
</tr>
<tr>
<td>Delaware</td>
<td>32,000</td>
<td>6.25%</td>
</tr>
<tr>
<td>Texas</td>
<td>2,518,000</td>
<td>6.04%</td>
</tr>
<tr>
<td><strong>Low Coverage (6% to 1%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>88,000</td>
<td>4.55%</td>
</tr>
<tr>
<td>Idaho</td>
<td>48,000</td>
<td>4.17%</td>
</tr>
<tr>
<td>Illinois</td>
<td>977,000</td>
<td>3.99%</td>
</tr>
<tr>
<td>Alabama</td>
<td>57,000</td>
<td>3.51%</td>
</tr>
<tr>
<td>Missouri</td>
<td>110,000</td>
<td>2.73%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>375,000</td>
<td>2.67%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>40,000</td>
<td>2.50%</td>
</tr>
<tr>
<td>Georgia</td>
<td>337,000</td>
<td>2.37%</td>
</tr>
<tr>
<td>Maryland</td>
<td>479,000</td>
<td>1.88%</td>
</tr>
<tr>
<td>Nevada</td>
<td>232,000</td>
<td>1.72%</td>
</tr>
<tr>
<td><strong>Nonexistent Coverage (&lt;1%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>405,000</td>
<td>0.99%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>68,000</td>
<td>~0%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>39,000</td>
<td>~0%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>35,000</td>
<td>~0%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>23,000</td>
<td>~0%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>8,000</td>
<td>~0%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>9,000</td>
<td>~0%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>7,000</td>
<td>~0%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>6,000</td>
<td>~0%</td>
</tr>
</tbody>
</table>
higher the Medicaid enrollment rate by some function). When a linear correlation test is performed between “% noncitizens covered by Medicaid” and “% noncitizens in poverty” confined to 2003 ASEC data, the result is astounding: measured state to state, there is no observed relationship between noncitizen poverty rates and noncitizen enrollment rates in Medicaid ($R^2 = 0.007$). Additional variables appear to have driven GSI rates for each state in the years following PRWORA, and a proper explanation for the geographic distribution seen in Figure 3.3 is impossible without knowledge of these geographically-specific contextual factors. The next chapter will deal with some of the contextual factors present in Minnesota.

### 3.7 The (in)effectiveness of Medicaid in remedying immigrant uninsurance, 1990-2000

Overarching the highly-researched and documented trends in eroding and rebounding GSI coverage for immigrants in the wake of PRWORA, there exists one stubborn trend: over the course of 1990s and into the 2000s, the uninsurance rate for immigrants as a whole remained alarmingly stable. The work of George Borjas provides an outline of this trend. Borjas (2003) takes a much broader approach than most other health researchers to measuring insurance status, including a comparison of the ESI, GSI, and uninsurance rates of all noncitizens (LPRs, refugees, etc.) against those of all native citizens over the time period 1994 – 2000. This particular comparison obliterates the differences in insurance outcomes between immigrant groups that other health researchers take pains to disentangle, but it also uncovers some illuminating facts: namely, while Medicaid receipt unquestionably declined in the 1990s, the
national uninsurance rate stayed relatively stable, and the ESI rate among noncitizens actually slightly increased (Figure 3.4). One further piece of statistical evidence bears noting: when enrollment rates in Medicaid per state are compared against rates of noncitizen uninsurance (for the year 2003, ASEC data), a linear correlation test indicates the two variables move independently \( (R^2 = 0.040) \). Higher rates of Medicaid coverage in some states do not seem to significantly impact overall uninsurance rates.

![Uninsured and Covered by ESI](image)

**Figure 3.4**: Comparison of non-citizen vs. citizen rates of Medicaid coverage, uninsurance, and employer-sponsored insurance (ESI) coverage, 1994 – 2000. Source: derived from Borjas (2003, p. 937).

These facts call into question the magnitude of government-sponsored insurance’s impact on the immigrant uninsurance rate *in general*, a point that most researchers studying the effects of PRWORA omit. Other, larger forces appear to have been dominant in determining the
uninsurance rate nationally. The percentage increase in ESI coverage among immigrants nearly perfectly coincides with the nation-wide ESI expansion towards the late 1990s (cf. Figure 2.3), suggesting economic effects overshadowed policy-level changes. That is, sharp declines or rebounds in the GSI rate attributable to welfare reform were confined to a relatively small population (those immigrants with incomes falling within Medicaid eligibility limits), while even a small percentage increase in ESI affected a much larger proportion of the immigrant population. The two forces cancelled each other out in the measured uninsurance rate in the 1990s.54

Figure 3.5 provides more evidence that economic shifts—in this instance shifts in immigrants’ income levels—may have had a strong influence on the uninsurance rate. Levels of poverty among different classes of immigrant families significantly declined between 1994 and 2000, and remained steady throughout the first years of the 2000s (Capps et al., 2009). Since eligibility for GSI is means-tested, a reduction in poverty (as measured by federal guidelines would have likely resulted in fewer noncitizens qualifying for Medicaid or Medicaid substitutes, whether or not alternate insurance options were available.55

Economic research suggests that if ESI expansions continued after 2000, they are likely to have been modest or even anemic for immigrants. After a brief economic dip in 2000-2001,

54 It is highly unlikely, contrary to what Borjas (2003) suggests, that the same immigrants that dropped Medicaid coverage were (on average) the same immigrants who enjoyed expanded ESI coverage during the same period in the late 1990s. This would imply that former-Medicaid recipients somehow “leap-frogged” over other working, uninsured immigrants to acquire the limited number of new ESI offerings. It is more likely that those immigrants exiting Medicaid disproportionately entered the ranks of the uninsured (as supported by the more detailed empirical work of Fix and Passel (2002)), and that other working, uninsured immigrants enjoyed the lion’s share of (slightly) expanded ESI coverage. There is no way of confirming either narrative with total certainty, though, given data limitations.

55 Note that this reduction in poverty would affect the entire-nation rate of eligibility for Medicaid. It says nothing of the actual patterns of Medicaid enrollment in different states, which as mentioned above is highly variable (indeed, unpredictable).
the U.S. experienced a “jobless recovery,” with most employment growth occurring in low-pay service sectors and real wages declining in non-supervisory positions (Morgen et al., 2006). Following the evidence presented in Chapter 1, this is hardly an indicator for strong ESI growth among low and mid-level workers, whether citizen or noncitizen. Indeed, Kaushal and Kaestner (2005) attribute poor job quality among their surveyed immigrant population (low-educated, unmarried women) as a barrier to health insurance in the late 1990s and early 2000s, regardless of PRWORA’s effects.

In sum, PRWORA initially produced a negative effect on health insurance access for a large number of low-income noncitizens, but this effect was partially mitigated through the efforts of state-funded programs, local outreach and enrollment efforts, and the effect of a dissipating “chilling effect” within immigrant communities. This being said, the uninsurance rate among immigrants as a whole seemed to be affected more by broader changes in the economy, the ESI system, and shifting demographic trends within the immigrant population (e.g.}

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**Figure 3.5:** Percentages of U.S. families with children living in poverty (under 200% of federal poverty line), 1994-2004, divided by legal status. Source: Reproduced from Capps et al. (2009, p. 128).
proportions of refugees to LPRs or even undocumented workers\textsuperscript{56}). The uninsurance rate among new noncitizen immigrants remained stubbornly and structurally “fixed” around 50% throughout the 1990s and into the 2000s (Leclaire et al., 1994; cf. Alker & Urrutia, 2004).

3.8 Conclusions: A policy of exclusion, a policy of neglect

Perhaps the best way to describe the federal government’s policy on immigrant uninsurance in the 1990s is that it took a bad situation for working immigrants—disadvantage and hardship stemming from an ESI-eroded labor market—and made it slightly worse. Instead of making any factual consideration of why new immigrants may require GSI to supplement their compensation (that is, to evaluate low-income and uninsured immigrants by their structural economic position), PRWORA’s authors and supporters treated the issue as one of immigration control. All of the arguments used to justify immigrant exclusion were based on conservative morality tropes of “self reliance” and the “immigrant bargain.” Immigrants did not deserve government assistance \textit{on principle}, the argument went, and therefore they would not receive it at all, regardless of whether they conformed to any of the target work behaviors promoted in PRWORA’s broader “workfarist” aim.

The 5-year bar on Medicaid for legal immigrants, combined with the devolution of GSI authority and costs to the states, most likely increased the number of low-income uninsured immigrants, at least in the short run. In the long-run, it produced a highly complicated and geographically-variable patchwork of policies and programs across the country. Even if low-income immigrants were able to receive “replacement” Medicaid through the efforts of states or other non-Medicaid GSI expansions, they were shifted into a position of political and economic

\textsuperscript{56} Ku (2009).
vulnerability at state and local levels, and became increasingly dependent upon the generosity and financial stability of local governments.

Despite the abundance of literature on the effects of PRWORA, welfare reform’s restructuring, devolution, and cuts to GSI only put a relatively small “dent” in the total national immigrant uninsurance rate. This is because ultimately the government-sponsored insurance institutions of the United States are neither calibrated nor responsive to the needs of most uninsured immigrants working in an ESI-eroded, post-Fordist economy. The most deeply-entrenched GSI programs in America—Medicare and Medicaid—have always been designed to cover only certain sub-populations deemed “vulnerable” and “deserving” by the network of actors that forge federal policy. Standards of vulnerability and deservingness in the purview of American GSI, in turn, remain oriented to the historically-specific economic and social contexts that were present in the era of these institutions’ establishment (i.e. the mid-1960s). Medicaid, for example, began as a relatively minor piece of legislation buried within the larger set of policy re-alignments in President Johnson’s “War on Poverty.” Its original purpose was to combat the most severe forms of medical indigence and/or isolation from modern medical treatment (Engel, 2006). Summarizing the zeitgeist surrounding Johnson’s anti-poverty initiatives, Engel writes: “[the new domestic programs] responded to a growing public awareness in the early 1960s of the depth and magnitude of poverty in America, as well as to a sort of jingoistic optimism which gave many planners and activists the confidence that poverty could be conquered given the proper leadership and commitment” (ibid., p. 56). As time went on and Medicaid expanded, extreme medical indigence faded from prominence as a progressive political target, but the primary function of Medicaid remained the same: preventing Americans at the lowest levels of
the socioeconomic strata, especially the chronically unemployed or underemployed, from forgoing medical care.

The dilemma for uninsured immigrants encountering the American GSI system in the 1980s and 1990s is that, before and after PRWORA’s restructuring of welfare programs, the majority of immigrants fell into socioeconomic positions outside the eligibility boundaries established for Medicare and Medicaid’s politically-favored groups. The majority of immigrants are not chronically under-employed or unemployed; on the contrary, they work as many hours (if not more) than the average native-born U.S. citizen. The potential for gainful employment, after all, is the leading reason for immigration to America. Average immigrant incomes are significantly lower than those of native-born citizens—on the order of thousands of dollars per year per capita (Kochhar, 2008)—but are still much higher than the low income ceilings set for most GSI programs. Programs like SCHIP aimed at children and mothers are unquestionably helpful, but they leave out much larger populations of working immigrants without children. In sum, Medicaid-like programs simply lack the ideological and historical orientation to serve as commonplace supplements to increasingly inadequate working class incomes. If there is any collective political will to assist less-visible uninsured workers in an ESI-eroded economy, it has not materialized.

The federal government’s (in)actions on the immigrant uninsurance problem either do nothing to mitigate the impact of local socioeconomic and political contexts upon immigrants’ insurance outcomes (in the case of working immigrants outside the range of GSI), or they actually exacerbate such geographically-contextual impacts (for those immigrants dependent upon geographically re-centered GSI institutions). As the federal government remains

57 Which would be, in essence, very different institutions than “anti-poverty” programs.
(ostensibly) opposed to health insurance assistance for immigrants, and as state governments replace coverage for only some immigrant groups in a piecemeal fashion, the fates of immigrants are tied more closely to their local contexts. Just as the gradual erosion of the employer-sponsored insurance institution implied a medical cost-risk shift away from private sector employers and onto working people themselves, the federal government’s actions in the 1990s implied another form of cost and risk shifting. The burden was shifted onto immigrants themselves as posited in the language of PRWORA, and also on to state and local governments that were forced to “pick up the pieces” of the uninsured populations that “Contract With America” Republicans intentionally targeted for exclusion.

In the following chapter, I investigate the local context(s) of health insurance coverage for immigrants in one state: Minnesota. A state-level analysis is insightful, as states in PRWORA’s devolved welfare state have become “laboratories” for experimental safety net designs. In this system, “successful” safety net programs become models for other states to emulate (Peck, 2001b). This strategy for promoting “innovation” in the welfare state assumes that programs built successfully in one state will work with similar success in other states. Many geographers have questioned this assumption, arguing that local contexts (economic, social, political, institutional, or otherwise) strongly influence the success or failure of government institutions like GSI, as well as the “path” of neoliberal governmentality as experienced by individuals (Cope & Gilbert, 2001; Brenner & Theodore, 2002). With this in mind, I will attempt to evaluate how PRWORA has affected Minnesota’s GSI system for immigrants, and determine whether these effects are influenced by Minnesota’s institutional context(s). I will also take into account demographic factors, such as the local relative proportions of different legal status groups (e.g. LPR vs. refugee), that affect the uninsurance rate. The insurance status “fates” of
immigrants in Minnesota are quite different from those of immigrants in other states, due to a number of geographically-specific factors. The importance of geographic context, in turn, generates a number of implications for the future of U.S. immigrants’ access to health insurance.
4 Context matters: Minnesotan immigrant (un)insurance in the 2000s

4.1 Introduction

This chapter explores the broad question of what drove variations in immigrant uninsurance at the state level in the 2000s. As explained in Chapter 1, immigrant-native disparities in ESI remained firmly entrenched within the American economy throughout the boom of the 1990s. As explained in Chapter 2, the contemporaneous implementation of PRWORA in the late 1990s left states to devise their own approaches to providing GSI programs for new immigrant populations. The 2000s, then, held the potential to be new era for the American health insurance system for immigrants. Further changes in the economy and labor markets could have had novel effects upon immigrant ESI rates, and the “patchwork” of GSI policies established by states following PRWORA created conditions ripe for interstate divergences in the treatment of low-income uninsured immigrants (Zimmerman & Tumlin, 1999). The sum of these influences, in theory, could have either diminished or exacerbated the national problem of immigrant uninsurance and influenced geographic uninsurance disparities on a state-to-state basis.

I explore the topic of state patterns in immigrant uninsurance in the 2000s by departing from the methodological “scope” used in the first two chapters of this thesis. Instead of attempting to evaluate changes in immigrant uninsurance at the national-scale, over a collection of states, I utilize a single-state case study: Minnesota. The single-state case study approach offers a number of benefits for my analysis of immigrant uninsurance. First, it grounds the phenomenon “in place,” allowing me to better demonstrate the variegated ways in which “immigrant uninsurance,” ESI and GSI, are experienced by diverse immigrant populations in the
United States. Second, it allows for a simplified, bi-directional analysis of the ways in which state and local governments interacted in the 2000s with respect to GSI and PRWORA. Most importantly, a case study of Minnesota allows for a detailed exploration of some of the geographically-specific contextual factors that affect immigrant health insurance access and coverage. In this chapter I argue that geographic variations in immigrant uninsurance (cf. Figures 1.1, 2.2, and 3.3) are, in part, attributable to interstate differences in political, economic, institutional, social, and demographic contexts, and that these contexts have become more important since the introduction of PRWORA. Though it is impossible in this thesis to describe all fifty states’ myriad institutional, political, and social contexts, by examining those contexts and their effects in just one state I show how geography mediates the construction of immigrant uninsurance.

Let me begin by clarifying “geographically-specific contextual factors,” admittedly a fuzzy term. As an example, let me use the case study of Garcia, Pagán, and Hardeman (2010). Between 2007 and 2008, Garcia et al. carried out a survey of two groups of uninsured Latina mothers, one located in rural Minnesota and the other in rural Texas. Participants were asked questions about their level of satisfaction with their local health care system: whether they received timely and appropriate care in times of need, whether they were burdened with large medical debts, and so on. When the uninsured participants were asked to rate their experiences with local safety-net care providers such as charity clinics, the Minnesotan respondents were more likely to praise the quality of local care, while the Texan respondents were more likely to complain. Minnesotan Latina mothers also praised the availability of sliding-scale fees and long-term payment plans to reduce their financial risk, while many Texan Latina mothers reported having to re-cross the border to Mexico to receive affordable care (ibid.). Based on these
answers, Garcia et al. concluded that the health care experiences of the uninsured depend a great deal on the operating practices of surrounding local health care institutions, as well as spill-over effects of local population characteristics. Variations in these geographically specific factors translated into divergent experiences for the two groups who are uninsured, whether immigrant or native-born.

Garcia et al.’s case study provides two examples of geographically specific contextual factors. First, the presence of sliding-scale fees and organized payment plans in Minnesotan clinics (but not in Texan clinics) represents an example of a beneficial local “institutional” context. It was beneficial both for the clinics receiving payments and the mothers receiving treatment. Second, high levels of health insurance among the general population in Minnesota represented a local “population characteristic” context that translated into a higher quality payment flow to clinics. These clinics, in turn, could afford to offer higher quality care to both insured and uninsured patients. In contrast, a higher rate of uninsured and impoverished patients in the Texas study area translated into lower quality compensation for local health providers, with negative spillover effects on care. In sum, differences in population and institutional contexts between Texas and Minnesota – that is, crucial elements in the geography of those places – led to observable differences in the health care experiences of the uninsured in the two locations. Geography matters.

Returning to the topic of this chapter: Minnesota’s immigrant population grew quickly in the 1990s and 2000s, yet it has maintained a relatively low immigrant uninsurance rate in the 2000s. I argue that three local contextual factors have enabled this low uninsurance rate. First, 

\[58\] In this case, whether the local population as a whole was more or less covered by health insurance.

\[59\] This effect was confirmed by the C.F.O. of a Twin Cities clinic that serves immigrants, in an interview conducted for this project (Clinic Chief Financial Officer A, personal communication, 14 July 2011).
Minnesotan immigrants enjoy a higher rate of ESI coverage than the national average. This can be attributed to high(er)-ESI job opportunities available specifically to immigrants in Minnesota (an institutional context), and lower average local health costs faced by ESI-providing employers. Second, Minnesotan immigrants enjoy a higher rate of GSI coverage than the national average. This, I argue, is the unintended result of Minnesota’s high prevalence of refugee-status immigrants, a group that is designated as “qualified” under PRWORA’s legal classification system. Third, again related to GSI, Minnesotan immigrants benefit from the longstanding state government’s commitment to a government safety-net for health care, and a relative lack of legislative “vulnerability” with respect to GSI cuts (with a few important exceptions in the 2000s era, which I will address). Some of the local contextual factors that enabled Minnesota to have a low immigrant uninsurance rate in the 2000s were also available to other states, but some were unique to Minnesota. Overall, I argue that Minnesota’s immigrant uninsurance experience was likely difficult to emulate by other states. Its geography made the difference.

I begin the chapter with a brief review of Minnesota’s recent immigration history and settlement patterns, and an outline of health insurance status changes for immigrant groups over the course of the 2000s. After presenting this background information, I will examine the primary components of immigrant insurance coverage in Minnesota: ESI and GSI systems, with close attention to the ways in which local contexts shape these systems. Finally, I will briefly examine the local political/public opinion context in Minnesota, to evaluate the claim that PRWORA increased vulnerability among immigrants to targeted state budget cuts.
4.2 Minnesota’s contemporary immigrant population and settlement patterns

Minnesota has a rich history of immigration, albeit an uneven one. Historically, immigrant settlement in Minnesota has centered around its largest cities of Minneapolis and Saint Paul. The Twin Cities area emerged as a significant immigrant destination in the early 20th century by virtue of its high concentration of agricultural and hydro-powered industries (grain milling on the Mississippi river, famously). Immigration to Minnesota waned during the middle of the century, but swiftly accelerated in the 1980s and 1990s with the arrival of Latin American, Asian, and African immigrants, restoring Minnesota’s status as an important immigrant “gateway” to the United States (Singer, 2004). This later era of Minnesotan immigration was driven by a relatively robust state economy, combined with a highly-developed network of social service organizations (governmental, non-governmental, and faith-based) capable of serving needy refugee populations (Minneapolis Foundation, 2010).

Minnesota’s immigrant population grew at a much faster rate during the 1990s than the national average. Between 1990 and 2000, the state’s immigrant population grew 130% while the immigrant population of the nation as a whole grew by 54% (Singer, 2004). New immigrants accounted for a significant percentage of both the state’s and the Twin Cities’ total population growth during the 1990s (ibid.). This trend continued into the 2000s, with a third of population growth between 2000 and 2005 attributable to new foreign-born residents (Office of the Legislative Auditor, 2006a). By 2009 the total foreign-born population in Minnesota was approximately 357,000, of which 199,000 were noncitizens (American Community Survey, 2006).

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60 The most recent year available for detailed immigration-specific census data.
Despite the high growth rate of Minnesota’s immigrant population, however, immigrants make up a small proportion of Minnesota’s total population compared to other states. In 2000, only 5.3% of Minnesotans were foreign born, compared to the national average of 11.1% (Office of the Legislative Auditor, 2006a). Paradoxically, then, while Minnesota was considered a significant and growing immigration destination in the 1990s and 2000s, it was simultaneously a “low immigration” state when compared to more popular entry destinations like California or Florida.

The demographic profile of Minnesota’s immigrant population diverges significantly from the national average, both in terms of national origins and legal status of immigrants. One major reason for this difference is Minnesota’s status as a popular destination for refugee (re)settlement. The history of refugee settlement in Minnesota traces its roots to the 1970s and 1980s. In the aftermath of the Vietnam War, a large influx of refugees from Laos and Vietnam began arriving in America to escape political persecution. Of particular importance to Minnesota were the Hmong, an ethnic group dispersed across several Southeast Asian nations whose members had been contracted to fight on the U.S. side of the Laotian Civil War during the Vietnam War, and who became subject to violent political repression at the hands of Communist forces after the departure of the U.S. The geographic relocation of Vietnamese, Laotian, and Hmong refugees to Minnesota specifically was the result of actions made by Minnesota’s local faith-based and secular social service organizations. The International Institute of Minnesota,

\[\text{61} \text{ Altogether, about one third of Minnesota’s immigrant population in 2008 had entered the state prior to 1990, another third entered between 1990 and 2000, and the final third after 2000 (Minneapolis Foundation, 2010).}\]

\[\text{62} \text{ This percentage increased slightly to 6.8% by 2009 (American Community Survey, 2009a).}\]

\[\text{63} \text{ Popularly known as the “secret war” among the Hmong community in Minnesota.}\]
Lutheran Social Services, Catholic Charities, the Minnesota Council of Churches, and Church World Services each acted as instrumental “transition” agencies that matched incoming refugees with sponsors in Minnesota\(^{64}\) and provided initial basic needs and support (Vang, 2006).

The initial settlement of the Hmong and Southeast Asians in the 1970s and 1980s served as a starting point for larger flows of secondary migration in later years. Many Hmong refugees in particular moved to Minnesota \textit{after} first arriving in different parts of the U.S., given the generosity of the local social service institutions in aiding refugee adjustment (Vang, 2006). A cumulative causation effect was created, with more social service organizations being created to support new refugees, in turn inducing more in-migration. In later decades, the social service agencies listed above were joined by organizations such as World Relief Minnesota and Jewish Family Service (Fennelly, 2005), and Minnesota experienced new waves of refugees and asylum-seekers from countries like Bosnia, Liberia, the Sudan, Somalia, and Myanmar (Minneapolis Foundation, 2010).

In sum, Minnesota’s path-dependent institutional growth of refugee settlement and support service organizations over several decades helped “skew” the balance of immigration to Minnesota by the end of the century. Since the 1990s, Refugees have comprised between 25% and 40% of all new immigrants to Minnesota annually, a much higher rate than the national average (about 10%) (Fennelly, 2006). Because of this skewed distribution of legal status, and given the sending nations of most refugees (concentrated in Asia and Africa), Minnesota has a larger share of Asian and African immigrants than the national average and a (relatively) smaller share of Latino immigrants (Office of the Legislative Auditor, 2006a).\(^{65}\) Not surprisingly,

\(^{64}\) In compliance with the federal regulation standards of refugee settlement.

\(^{65}\) This being said, Mexico remains the largest single-nation origin for Minnesotan immigrants (ibid.).
Southeast Asian immigrants, particularly from Laos, Vietnam, and Cambodia, make up the largest regional-origin proportion of the total state immigrant population (Fennelly, 2006). Yet as new “waves” of immigrants enter the U.S., Minnesota’s year-to-year immigrant demographic changes. **Table 4.1** displays the largest immigrant groups entering Minnesota between 2005 and 2009, defined by nation of origin.

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>No. of Immigrants</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somalia</td>
<td>14,413</td>
<td>1st</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>6,603</td>
<td>2nd</td>
</tr>
<tr>
<td>Thailand</td>
<td>4,677</td>
<td>3rd</td>
</tr>
<tr>
<td>Liberia</td>
<td>4,021</td>
<td>4th</td>
</tr>
<tr>
<td>Mexico</td>
<td>3,836</td>
<td>5th</td>
</tr>
<tr>
<td>Kenya</td>
<td>3,458</td>
<td>6th</td>
</tr>
<tr>
<td>China (PRC)</td>
<td>3,024</td>
<td>7th</td>
</tr>
<tr>
<td>India</td>
<td>2,999</td>
<td>8th</td>
</tr>
<tr>
<td>Vietnam</td>
<td>2,888</td>
<td>9th</td>
</tr>
<tr>
<td>Philippines</td>
<td>2,199</td>
<td>10th</td>
</tr>
</tbody>
</table>

**Table 4.1:** Top ten sending nations for new Minnesota (legally present) immigrants, 2005-2009. Total immigration over this period was 81,376 persons. Source: Derived from Minnesota Department of Administration (2010).

There are no definitive data on the number of undocumented immigrants in Minnesota, nor their demographic characteristics (Office of the Legislative Auditor, 2006a). The state demographer’s office has not attempted to produce an official estimate (ibid.), leaving the federal government and non-governmental organizations to make educated estimates at the size of the state’s undocumented population. Estimates range from 55,000 to 85,000 undocumented immigrants living in Minnesota, though the state demographer has insisted upon a lower number (Minneapolis Foundation, 2010).

Minneapolis and St. Paul remain the central destinations for new immigrants to Minnesota. The immigrant population in the Twin Cities metro area grew from 54,918 in 1970 to
210,344 in 2000 (Singer, 2004), and to 268,751 by 2009 (American Community Survey, 2009b). Immigrant population growth in the suburbs rose significantly in the 1990s and 2000s as employment opportunities in the Twin Cities metro area experienced significant decentralization away from the core cities (Fennelly & Orfield, 2008). In the 2000s, the foreign-born population growth rate in suburbs actually surpassed that of the Twin Cities proper (Walker, 2007). Immigrant settlement in the suburbs did not necessarily signal upward mobility. Many immigrant populations in the suburbs still experienced racial and ethnic segregation and held lower socioeconomic positions, similar to urban immigrant populations (Fennelly, 2006). After a detailed GIS analysis of 2000 census data, Walker (2007) found evidence of “clustering” by ethnicity within the Twin Cities and surrounding suburbs: the majority of Mexicans, Hmong, and African immigrants lived in the central cities, while Asian Indians and Vietnamese living in suburbs outnumbered their urban counterparts. A few emerging multi-ethnic suburban “clusters” were identified, including Brooklyn Park and Brooklyn Center for Asian and African immigrants, and the southwest exurbs of Chaska, Jackson Township, and Shakopee for Latino immigrants (ibid.). In spite of these decentralizing tendencies, however, immigrant settlement to Minnesota remains largely confined to the Twin Cities metropolitan region and not other “growth poles” within the state.

4.3 Health insurance profiles of native-born and immigrant Minnesotans, 2001-2010

Minnesota enjoyed nearly universal health insurance coverage at the beginning of the 21st century. 95% of Minnesotans in 2001 were covered by insurance, compared to a national rate of 86% (Chollet & Achman, 2003). A full 83% of the state’s non-elderly adult population was covered by private insurance (mostly employer-group), compared to 72% nationally (ibid.). The
state’s collective insurance status benefited most from a history of low health care costs relative to national averages, which provided employers with a greater incentive (and fiscal ability) to include health coverage in their employees’ compensation plans, and also allowed state government to fund generous GSI programs without dangerously straining state budgets (ibid.).

Minnesota’s health insurance profile deteriorated, however, in the 2000s. Between 2001 and 2009, the percentage of Minnesotans covered by ESI fell by over 10 points, while the uninsured population rose by close to 75% (albeit starting from a low base level). Although the recession of 2008 certainly affected these trends, state statistics offices also reported a more gradual erosion in ESI between the late 1990s and the late 2000s (Minnesota Department of Health, 2010). Over the same time period, GSI coverage of Minnesotans rose from 21% to 28.5%. The proportion of Minnesotans purchasing private insurance outside of their job remained relatively unchanged (Figure 4.1).

Minnesotan immigrants fared better than national averages with respect to health uninsurance, but still faced structural disadvantages in obtaining coverage in the 2000s. In 2001, foreign-born Minnesotans (including naturalized citizens) had a collective uninsurance rate of 17.1% (Minnesota Department of Health, 2011), much lower than the national average of 31.2% around the same period (Borjas, 2003). Similarly, Minnesotan immigrants enjoyed higher than average rates of ESI and GSI coverage at the turn of the century (ibid.). Minnesotan immigrants’ ESI coverage was ten percentage points below that of the state’s native-born population in 2001, however, and this disparity persisted after the 2008 recession. Rates of GSI coverage were similar between U.S.-born and foreign-born Minnesotans in both periods.

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66 Partially attributable at the time to the prevalence of “managed care” organizations in the state, which served to essentially ration care and minimize price increases (Chollet & Achman, 2003).
Figure 4.1: Health insurance status for Minnesotans, native-born Minnesotans, and foreign-born Minnesotans, 2001 and 2009. Data labels are for foreign-born Minnesotans only. Numbers in parentheses equal the percentage point increase or decrease between 2001 and 2009 for a particular insurance status among foreign-born Minnesotans. Overall, all groups experienced a 10% point drop in ESI coverage in the 2000s, and a near 10% point increase in public (GSI) coverage. The structural disadvantage for foreign-born Minnesotans in acquiring ESI remained relatively unchanged, as did the uninsurance rate. Source: Minnesota Health Access Survey (Minnesota Department of Health, 2011).

As with immigrants nationally, the lower rate of ESI for Minnesotan immigrants translated directly to a disproportionately high uninsurance rate. Curiously, the immigrant uninsurance rate did not climb nearly as fast as the U.S.-born uninsurance rate after the 2008 recession, and native/foreign-born rates of GSI usage reached near-parity by the end of the decade, suggesting that immigrants were able to fall back on the state’s GSI system.

Large disparities in insurance coverage exist within the Minnesota immigrant community. Unfortunately, limitations of publicly-available data prevent a broad analysis of insurance coverage by immigration status (e.g. refugee vs. LPR or undocumented) or ethnicity.
Researchers must instead depend on either (over-) aggregated data from government data warehouses or small-scale surveys commissioned by non-profits and research task forces to study Minnesota’s racial and ethnic health insurance disparities. The Minnesota Department of Health’s survey of health insurance provides a glimpse of insurance disparities between white and non-white immigrants and native-born citizens (Figure 4.2). In 2009, white, foreign-born Minnesotans were covered by ESI and GSI at almost the same rate as native-born whites, though their uninsurance rate was double that of native-born whites. Non-white immigrants had a slightly higher uninsurance rate than white immigrants, and a significantly lower ESI rate. Non-white immigrants received GSI at a lower rate than the statewide non-white average, and purchased individual insurance at a significantly higher rate than the state average. These results speak to wider disparities between whites and non-whites in Minnesota, of course, but it provides a “first-cut” measure of intra-immigrant inequalities in local health insurance access.

More detailed measures of insurance coverage for specific ethnicities have emerged from small-scale surveys. Hispanic/Latino Minnesotans, for example, had the highest rate of uninsurance throughout the 2000s, reaching nearly 25% uninsured by 2009 (Minnesota Department of Health, 2011). A report commissioned by the Hispanic community advocacy and research group HACER concluded that this high rate was influenced by low ESI coverage among the working Hispanic/Latino community in Minnesota (Ulrich, 1999). In contrast, Minnesotans

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67 This limitation arises from small sample sizes of surveyed immigrants, and inconsistent classification and sampling practices of the largest surveyors (e.g. the federal census bureau) (ibid.).
Figure 4.2: Health insurance status in 2009 for “white” and “non-white” demographic groups in Minnesota, separated by immigrant status. This disaggregation of 2009 data shows clear racial/ethnic disparities in health insurance status, in addition to nativity disparities. Source: Minnesota Health Access Survey (Minnesota Department of Health, 2011).

classified as “Asian” reported health uninsurance rates closer to the state average in the 2000s (Minnesota Department of Health, 2011).68

A special research report on Somali health care access69 hints at the extent to which health insurance coverage can vary by national origin. Between 20,000 and 60,000 Somalis reside in the Twin Cities metro area, and comprise nearly half of the total Somali population in America. Somalis are usually classified as “Black” or “African” in census data, a statistical shortcut that masks important differences between Somalis—many of whom come to Minnesota as refugees—and the rest of the state’s black population. Within a small scale 2003 sample,

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68 Unfortunately, these data are not useful for tracking insurance rates among the newest Asian immigrants to Minnesota, such as those from Thailand and Myanmar, as Minnesota has a large population of long-term and naturalized Asian immigrants that entered the state in previous decades. By 2010, parts of the Minnesotan Asian immigrant community have reached second and third-generation status, with positive effects on employment, education, and health insurance rates.

93.6% of surveyed Somali women reported having health insurance, compared with only 64% of Somali men. These insurance/uninsurance rates diverge significantly from the reported “Black” uninsured average of 14% in 2004 (Minnesota Department of Health, 2011). Of the insured Somali women, 85% reported receiving coverage from a GSI program, while only half the insured Somali men reported similarly.70

Comparing the health insurance profiles of Minnesota’s Hispanic/Latino and Somali communities, it is clear not only that large intra-immigrant community disparities exist in coverage, but also that these disparities are influenced by different immigrant groups’ relation(s) to the state’s economy and government health insurance programs. Successful integration into the state’s economy greatly improves immigrants’ chances of being insured, and differential access to GSI programs based on (some) individual characteristics can produce varying rates of public coverage. I explore these variations in the following sections.

4.4 Components of Minnesotan immigrant insurance (I): ESI patterns

Minnesota’s immigrant population consists of mostly working-age people. The statewide adult immigrant population is slightly younger than the national average, translating into a slightly higher labor force participation rate than average. In 2000, 75% of Minnesotan immigrants participated in the labor force, and 94.3% of these participants were employed (Office of the Legislative Auditor, 2006a). Labor force participation varied, however, across ethnicities: for example, between 2005 and 2007, 79% of Chinese immigrants were employed, compared to only 58% of Somali immigrants (Figure 4.3).

70 This implies close to 80% of surveyed Somali women and 32% of surveyed Somali men covered by GSI.
Nonetheless, employed immigrants in Minnesota received ESI at a rate higher than the national average at the beginning of the decade (58.5%, compared to a national average of 51.6 in 2001\textsuperscript{71}).

Despite Minnesotan immigrants’ greater chances of receiving ESI than the national immigrant average, they still face a large disparity compared to the native-born. Following the arguments presented in Chapter 1, structural forces may account for this disparity. Perhaps (1) working immigrants in Minnesota are more likely to be hired to do part-time jobs, which are less likely to be covered by ESI; or (2) Minnesotan immigrants’ simply work in lower-ESI occupations than native-born citizens. Figure 4.4 compares the part-time work shares for native-born and noncitizen labor forces in Minnesota between 2002 and 2010.

\textsuperscript{71} Minnesota Department of Health (2011); Borjas (2003).
Figure 4.4: Rates of part-time employment for Minnesotan native and noncitizen populations, 2002 to 2010. The complementary percentage for each bar represents the full-time rate (e.g. as the noncitizen rate in 2006 is ~16%, the full time rate for workers was thus ~84%). Source: U.S. Census Bureau (2010).

Contrary to hypothesis (1), noncitizen part-time employment rates stay close to native-born citizens’ rates over the time period, and even drop below native citizens’ rates (implying more full-time work for noncitizens) during the middle part of the decade. Figure 4.5 provides additional detail for noncitizens’ and natives’ ESI rates for full-time and part-time work between 2002 and 2010. Minnesotan immigrants lagged behind natives in ESI for both categories, but did better than the national average overall, suggesting another factor influenced immigrant ESI coverage. Following the logic of chapter one, I examine immigrants’ work industries and compensation levels as another possible explanation.

Minnesota’s economy in the 2000s was heavily skewed towards services, with a significant manufacturing sector. In 2007, six industries accounted for over 60% of all jobs in the state, and generated slightly less than 60% of the state’s aggregate income (U.S. Census Bureau, 2009).72

72 The top six industries, in order of number of employees, were (1) health care and social assistance, (2) manufacturing, (3) retail trade, (4) accommodation and food services, (5) finance and insurance, and (6) professional, scientific, and technical services (ibid.).
Figure 4.5: ESI rates for part-time and full-time workers in Minnesotan native and noncitizen populations, 2002 to 2010. Black dotted lines represent the noncitizen national average for both work types over the time period. Source: U.S. Census Bureau (2010).

Lower-skill working immigrants entering the Minnesotan economy gravitated towards light manufacturing, the hospitality industries, and health support services, while some highly-skilled immigrants found employment in the professional and scientific fields (Table 4.2). While manufacturing made up the largest single sector of employment for the foreign-born in Minnesota during the 2000s, immigrants were not necessarily working in heavy industry. Food processing plants in rural Minnesota communities (south central Minnesota in particular) acted as strong employment magnets for many low-skilled immigrants during a time when native-born rural populations were aging and declining in size (Fennelly, 2006; Fennelly & Huart, 2009).

Overall, immigrant workers in the 2000s found themselves concentrated at the high and low ends of the job spectrum in terms of income, and largely based on education and skills
<table>
<thead>
<tr>
<th>Industry</th>
<th>Foreign-born</th>
<th>Native-born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturing</td>
<td>22%</td>
<td>14%</td>
</tr>
<tr>
<td>Education, health, and social services</td>
<td>21%</td>
<td>23%</td>
</tr>
<tr>
<td>Arts, entertainment, recreation</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Professional, scientific, management, administrative</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Retail Trade</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>Finance and insurance, and real estate</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>Construction</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Other services</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Transportation and warehousing, and utilities</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Wholesale Trade</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Agriculture, Forestry, Fishing and hunting, and Mining</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Public Administration</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Information</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Table 4.2: Distribution of industries of working foreign-born and native-born Minnesotan adults (age 16 and over), 2007. Source: Fennelly and Huart (2009, p. 17).

(Minneapolis Foundation, 2010). This bifurcation of the immigrant labor force produced an interesting result: in 2000, Minnesotan immigrants had higher median earnings than the immigrant population nationally, but also had a slightly higher rate of poverty (Office of the Legislative Auditor, 2006a). This was likely due to the counteracting effects of higher-than-average wage opportunities for skilled workers and an increase in the number of low-skilled (and low-wage) immigrants around the turn of the century (ibid.). Detailed data on immigrant employment and wages in Minnesota have not yet been publicly released for the year 2010. These data will provide a glimpse into how Minnesotan immigrants are faring after the 2008 recession. There is a strong possibility that the state’s immigrants fared poorly in the last few years of the decade: national-scale data gathered shortly after the recession suggest that foreign-born workers were disproportionately affected by job losses in many industries (Capps et al., 2011).

The combination of the kind of jobs Minnesotan immigrants undertake and the income classes in which they fall provides a clearer explanation of the local ESI context. First,
occupations in manufacturing, education, and health and social services are generally “high-ESI”; this distribution is tied to Minnesota’s pattern of economic growth and may be the reason for Minnesotan immigrants’ higher ESI rate than the national average. Differences in education, skills, and pay, however, between native-born and immigrant workers likely account for much of the disparity gap. As explained in chapter one, differential ESI coverage down the income/education/human capital spectrum is a national trend. It is not tied to Minnesota’s economy or economic institutional structure. In Minnesota, as in other parts of the country, immigrants structural position with respect to “skilled status” affects their incorporation into the local labor/ESI system.73

Certain population characteristics of the immigrant community in Minnesota, such as the lower rate of labor-force participation among Somali and Hmong residents, could also theoretically affect the total ESI rate negatively. As we shall see next, such a negative pressure upon the ESI rate by members of high refugee-status communities may be mirrored by positive pressure upon the local GSI rate.

4.5 Components of Minnesotan immigrant insurance (II): GSI Programs for noncitizens

Low-income noncitizens lacking health insurance could turn to Minnesota’s relatively generous system of public health insurance programs after 2000. Minnesota’s network of GSI programs, one of the most expansive and inclusive in the nation, was built up over several years through the efforts of state legislators committed to improving health care access, and has enjoyed broad public support throughout its existence (Chollet & Achman, 2003). Minnesotan immigrants, like immigrants in the rest of the nation, were eligible for state Medicaid prior to

73 Health system researcher A, personal communication, 16 August 2011.
PRWORA, and in 1997 the Minnesota legislature created the Noncitizen Medical Assistance program (NMED) to provide replacement Medicaid assistance to immigrants excluded from PRWORA using only state funds (Minnesota Department of Human Services, 2008). NMED elected to impose PRWORA’s sponsor-deeming requirements when determining immigrant eligibility for state programs, potentially limiting immigrant eligibility (Zimmerman & Tumlin, 1999). Overall, however, Minnesota’s commitment to providing immigrants with a GSI safety net exceeded that of many other states at the beginning of the decade (ibid.).

Over the past ten years, Minnesota has changed its GSI availability for noncitizens, expanding coverage in some areas while reducing it in others. Table 4.3 provides an overview of the five major GSI programs low-income Minnesotan immigrants could receive during the 2000s, along with enrollment figures for 2005 (the last year for which detailed records are publicly available). Minnesota’s Medicaid program, Medical Assistance (MA), continued to enroll the largest number of noncitizens, thanks in part to the introduction of NMED. MinnesotaCare, a state-founded GSI program for residents with higher incomes, enrolled a smaller number of noncitizens using a combination of state funds and enrollee premiums. Refugee Medical Assistance, a temporary, federally-funded program for new refugee immigrants, covered a relatively small proportion of Minnesota’s immigrants at any one period. Emergency Medical Assistance, Minnesota’s version of federal Emergency Medicaid, offered emergency services only and thus also did not enroll many immigrants at any one period. Finally, General Assistance Medical Care, a state-run temporary program for very low-income Minnesotans ineligible for federally-funded Medicaid, covered a larger fraction of immigrants until its elimination in 2010.
<table>
<thead>
<tr>
<th>GSI Program</th>
<th>Description</th>
<th>Number of noncitizens enrolled in 2005 (% total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Assistance (MA), Noncitizens Medical Assistance (NMED)</td>
<td>Minnesota's Medicaid programs for low income families with children and the elderly, blind, and disabled.</td>
<td>33,771 (7%)</td>
</tr>
<tr>
<td>MinnesotaCare</td>
<td>Subsidized health insurance program for low-income persons who do not have access to affordable health care coverage.</td>
<td>6964 (5%)</td>
</tr>
<tr>
<td>Refugee Medical Assistance</td>
<td>Medical assistance for refugees during the first eight months they are in the country</td>
<td>883 (91%)</td>
</tr>
<tr>
<td>Emergency Medical Assistance (EMA)</td>
<td>Emergency health care program available to people who have a medical emergency and are ineligible for Medicaid due to their immigration status</td>
<td>1049 (99%)</td>
</tr>
<tr>
<td>General Assistance Medical Care (GAMC), discontinued in 2010</td>
<td>Health care program for low-income adults, ages 21 - 64, who have no dependent children under age 18 and who do not qualify for federal health care programs.</td>
<td>3441 (9%)</td>
</tr>
</tbody>
</table>

Table 4.3: GSI programs available to noncitizen immigrants in Minnesota, with enrollment data from 2005 (latest year available with immigrant-specific detail). Numbers in parentheses represent noncitizen enrollees as a percentage of total enrollment per GSI program. Source: Office of the Legislative Auditor (2006b).

Over the course of the 2000s, most of Minnesota’s low-income immigrants fell into one of three categories of GSI eligibility, strongly influenced by PRWORA’s (re)definitions of immigrant classes. First, “qualified” immigrants who either lived in Minnesota more than 5 years, or who had entered the U.S. prior to PRWORA’s passage, qualified for Medical Assistance. Excluded groups from the 5-year-bar—including refugees, significantly—were also eligible for MA. Second, legally-present immigrants who were barred from Medicaid could either enroll in NMED or MinnesotaCare, the two state-run systems.74

An expansion of the Children’s Health Insurance Program (CHIP) in 2009 allowed Minnesota to shift pregnant mothers and children off of NMED and MinnesotaCare and onto

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74 Immigrants themselves did not choose which program(s) to apply to; Minnesota’s GSI enrollment system grants that authority to caseworkers, who are expected to follow specific guidelines (Minnesota Department of Human Services, 2008).
federally-funded Medical Assistance, with clear fiscal benefits for the state. Finally, undocumented immigrants were largely excluded from Medical Assistance and state-funded GSI programs, and could only receive assistance with emergency hospital care, with a small number of exceptions for pregnant women and children. As of 2011, the current eligibility guidelines for Minnesota immigrants are summarized in Table 4.4.

African, Middle Eastern, and Asian immigrants also comprised the majority of Minnesota’s LPRs receiving GSI in 2005, suggesting a ‘cumulative causation’ effect. Minnesota’s Asian and East African communities began to grow in the 1980s and 1990s; by the 2000s, family members and other relatives of earlier Minnesota immigrants followed as LPRs, in addition to new migrants of similar ethnicities attracted to Minnesota’s status as a growing immigrant gateway. Mexican and Central American immigrants made up almost the entirety of the state’s undocumented population receiving public health care benefits, though this population was small compared to legal immigrants. “Other noncitizens,” defined as a statistical group of mostly temporary foreign resident categories, were much more geographically-distributed in terms of nationality than other legal groups receiving GSI, but did not constitute a large proportion of total immigrant GSI enrollees (Table 4.5).

Several conclusions can be drawn from Minnesota’s policies, records, and data regarding the state’s GSI provision system for immigrants in the PRWORA era. First, Minnesota’s sponsor-deeming requirement seems to have largely succeeded in keeping many immigrants out of the GSI system entirely. According to a legislative audit conducted in 2006, only 5 percent of immigrant GSI enrollees had sponsors registered with the state.

75 Minnesota Department of Human Services (2010).
Table 4.4: Simplified table of immigrant eligibility for GSI programs in Minnesota effective July 1, 2010. Eligibility is determined by legal status and “qualified” status as defined by PRWORA, and by membership in categorical groups (e.g. pregnant women and children). Highlighted cells indicate expansions to federal Medicaid eligibility for noncitizen pregnant women and children, effective July 2010. Prior to this expansion, noncitizens under the five-year bar were eligible for MinnesotaCare.
Source: Minnesota Department of Human Services (2010).

Table 4.5: Immigrant GSI enrollment in Minnesota, 2005, sorted by legal status and nationality. Highlighted cells indicate the top two groups receiving GSI for each legal status group. “Other Noncitizens” include visitors and students, parolees, applicants for asylum, and other small legal categories. Source: Office of the Legislative Auditor (2006b).
The implication is that most low-income immigrants with sponsors were likely disqualified from GSI coverage at the time of application (Office of the Legislative Auditor, 2006b). The extent to which Minnesota’s sponsor-deeming requirement contributed to the high noncitizen uninsurance rate is unknown, and would likely require a detailed longitudinal survey of the immigrant population by the Minnesota Department of Health.76

A second, more significant conclusion regarding the cost incidence of Minnesota’s GSI programs for immigrants can be derived from detailed expenditure data compiled by the state in 2005 (Table 4.6). Trends in GSI expenditures, to a greater degree than sheer enrollment counts, make a large difference in determining the feasibility of Minnesota’s immigrant GSI program. If Minnesota shifts responsibility for a larger portion of immigrant GSI expenditures to the federal level, the state can afford to offer coverage to a greater number of immigrants. Conversely, if Minnesota finds itself saddled with large and growing GSI costs, an incentive will appear to cut back on immigrant GSI eligibility or the scope of benefits per enrollee. Internal state government data suggests that when measured in 2005 the Minnesota system of immigrant GSI maintained near parity between federal and state shares of spending for Minnesota’s enrolled immigrants. The state only paid for slightly more than half of total health care expenditures for refugees and asylees (52%) and LPRs (53%). In the same year, the federal government covered 81% of health care expenditures for Minnesota’s undocumented immigrants.77

The only legal category for which Minnesota paid a share significantly higher than 50% was “Other Noncitizens,” and this group only generated about 4% of total immigrant health care

76 The Minnesota Department of Health currently publishes the Minnesota Health Access Survey, which, while highly useful and informative, only produces comparative statics for analysis of health insurance coverage in the state.

77 This is likely the outcome of cuts to state-funded GSI programs for undocumented immigrants (detailed below).
<table>
<thead>
<tr>
<th>Number of enrollees</th>
<th>Refugees and Asylees</th>
<th>Lawful Permanent Residents</th>
<th>Undocumented Persons</th>
<th>Other Noncitizens</th>
<th>Unknown Immigration Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollees</td>
<td>28,406</td>
<td>22,722</td>
<td>8,549</td>
<td>2,758</td>
<td>1,688</td>
</tr>
<tr>
<td>% of total noncitizen enrollees</td>
<td>44.3%</td>
<td>35.4%</td>
<td>13.3%</td>
<td>4.4%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditures (% total per group)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>85%</td>
<td>85%</td>
<td>83%</td>
<td>80%</td>
<td>84%</td>
</tr>
<tr>
<td>MinnesotaCare</td>
<td>1%</td>
<td>1%</td>
<td>&lt;1%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Refugee Medical Assistance</td>
<td>3%</td>
<td>&lt;1%</td>
<td>0%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Emergency Medical Assistance</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>16%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>General Assistance Medical Care</td>
<td>8%</td>
<td>7%</td>
<td>&lt;1%</td>
<td>12%</td>
<td>3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funding source for health care (%)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>52%</td>
<td>53%</td>
<td>18%</td>
<td>64%</td>
<td>51%</td>
</tr>
<tr>
<td>Federal</td>
<td>48%</td>
<td>45%</td>
<td>81%</td>
<td>35%</td>
<td>48%</td>
</tr>
<tr>
<td>County</td>
<td>&lt;1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Enrollee</td>
<td>&lt;1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

| Table 4.6: GSI enrollment and expenditures in Minnesota (2005), disaggregated by legal status, GSI program, and source of funding. Source: Office of the Legislative Auditor (2006b). |

claims in the state (Office of the Legislative Auditor, 2006b). All things considered, the Minnesota GSI system in the 2000s appears to have been successful in placing the majority of its most expensive immigrant enrollee populations onto federally-funded Medicaid. As a result, and in contrast to predictions made by researchers after the passage of PRWORA, Minnesota did not see a large “downward” transfer of immigrant costs onto its GSI program.

Such an outcome could, of course, arise from a systematic exclusion of immigrants from GSI arrangements that would cost the state more money than Medicaid. The sponsor-deeming rule, for example, could be used as a tool for such an end. However, the makeup of Minnesota’s immigrant population also happens to more “favored” under PRWORA’s definitions of “deserving” and “undeserving” immigrants. Minnesota is home to more refugees (a population
waived from PRWORA’s 5-year-bar on Medicaid), and relatively fewer undocumented immigrants (a population harshly targeted by PRWORA), both for reasons specific to the state’s immigration history and geography as mentioned above. The larger the federally “GSI-qualified” population, the more the federal government contributes via Medicaid cost-sharing, and thus the larger the capacity for state-level enrollment. Consider again the survey of Somali immigrants (Herrel & Leinberger, 2004). Low-income Somali women are potentially double-eligible under state-federal Medicaid rules, as they can potentially qualify for federal Medicaid participation via pregnancy protections or via refugee protections (n.b. Table 4.4). Low-income Somali men, on the other hand, cannot qualify for Medicaid via pregnancy protections, but they can still be “qualified” as refugees under certain conditions. When enrolled into Minnesota’s GSI programs, cases like these are diverted towards federally-funded programs whenever possible, in effect reducing the state-funding per GSI enrollee rate.

Favorable demographic trends like high proportions of refugees and low proportions of undocumented residents annually, I argue, are chief enabling factors for the near-parity between native-born and foreign-born GSI rates in Minnesota in the 2000s (Figure 4.1). The general uninsurance rate of immigrants in Minnesota is affected in this manner through the articulation between immigrant population characteristics and the state’s GSI programs, on the one hand, and Minnesota’s state GSI programs and federal PRWORA regulations, on the other. In this situation, Minnesota’s GSI programs can be seen as essentially “middle” organizations linking refugees at the state scale to GSI funding sources at the federal level (close to 50% of total GSI costs, per the Medicaid cost-sharing equation). Without the demographic “advantage” produced by Minnesota’s immigrant population context, Minnesota’s immigrant uninsurance profile would almost undoubtedly be bleaker. Put another way, state uninsurance and GSI rates would be
different if Minnesota had started the decade with a “qualified/unqualified” immigrant demographic closer to the national average in 2000, with only 7% of immigrants with refugee status, 30% LPR, and nearly 30% undocumented (Kaiser Commission on Medicaid and the Uninsured, 2003). The geography of Minnesota’s migration flows provided the state with an advantage over other states providing public benefits to immigrant populations after the passage of PRWORA.

Public policies are not merely driven by demographics, of course. Even if refugees and other immigrants were able to “access” federal GSI funds via exceptions to PRWORA restrictions, this flow of resources is predicated upon the continued existence and support of the “middle” GSI institutions at the state level. Public support for government assistance for immigrants, as well support from lawmakers in St. Paul, work together to enable and constrain Minnesota’s GSI availability for immigrants. The following section describes two important components of civic “support” for immigrant GSI in Minnesota in the 2000s: public opinion regarding welfare for immigrants, and the actions of Tim Pawlenty, Minnesota’s governor for much of the decade. Public opinions on immigrant affairs in Minnesota had the potential to influence state policies by way of the actions of elected officials, while the governor’s budget decisions had a disproportionately large impact on GSI policy in Minnesota in the 2000s. Together, these influences helped to frame the limits of immigrant GSI accessibility in the state.

4.6 “Localized” vulnerability revisited: Public opinion of immigrants and GSI vulnerability at the legislative level in Minnesota

As mentioned in the previous chapter (p. 72-73), PRWORA’s re-arrangement of immigrant affairs rights and responsibilities between federal and state levels made the legal scholars Varsanyi (2008) and Wishnie (2009) wary of the potential for legislative discrimination
at state and local levels, influenced strongly by the local balance of pro- and anti-immigration sentiments among politicians and the public. I now turn to evaluate whether these fears were grounded in the case of Minnesota. Overall, Minnesota maintains a general public policy orientation towards “inclusiveness” with respect to immigrants’ welfare and government health assistance. However, growing sentiments of fear and frustration with new immigrant groups within certain Minnesotan communities, increasing political polarization around the issue of the costs of illegal immigration in the state, and growing and recurrent budget deficits, all present potential growing threats to the state’s immigrant GSI “status quo.” The question at hand is whether these localized “vulnerabilities” were either influenced or exacerbated by the passage of PRWORA.

Minnesotans hold mixed opinions on the recent rise in immigration. A 2004 survey conducted by the University of Minnesota’s public policy school revealed strong partisan divisions in Minnesotans’ attitudes towards the state’s immigrants. Minnesotans who were self-identified as Democrats were more likely to choose positive statements when prompted to give their opinion on immigrants (e.g., that they contribute to cultural diversity or that they are hardworking), while self-identified Republicans were more likely to choose negative statements (e.g., that they do not assimilate or that they are a drain on public resources) (Fennelly, 2006). Given the near-even balance of political support between liberals and conservatives state-wide, this roughly suggests a 50/50 division among Minnesota’s total population (ibid.). Walker (2007), using the same survey’s data, documented a geographic pattern to Minnesotans’ immigrant-specific political views: Twin Cities area native-born populations did not report as many worries about the cost(s) of increasing immigration as native-born populations in outer-ring suburbs and exurbs, where immigrant populations are more sparse. Based on this split,
Walker inferred that Twin Cities communities hold more cosmopolitan conceptions of Minnesotan citizenship and society, while suburban and exurban communities favor stricter immigrant assimilation and are averse to the increasing visibility of cultural diversity.

The growing partisan and geographic split in public support/criticism of immigration is a likely cause for the mixed messages originating from the state government over immigrant access to GSI programs. Minnesota’s legislature displayed some support for an expansion of health insurance care access for immigrants. For example, lawmakers allocated $350,000 in 2002 towards the elimination of health disparities between white and minority populations (including the foreign-born). Although the sum of allocated money was paltry compared to the amount spent on the state’s health and human services and GSI programs, its presence demonstrated a willingness to address the state’s structural problems in health care (Fennelly, 2006). Similarly, after federal legislators passed legislation in 2009 authorizing states to move their eligible LPR pregnant women and children under 21 onto federally-funded Medicaid (in effect undoing PRWORA’s five-year bar for these populations), Minnesota quickly seized the opportunity and opted into the program (see Table 4.4) (Minnesota Department of Human Services, 2010). Although the state had a positive financial incentive to opt into this particular arrangement, the legislation was a clear immigrant-inclusionary gesture.

Unfortunately, the inclusionary GSI initiatives of the 2000s were overshadowed by anti-immigrant policies initiated by conservative state lawmakers. Influenced by growing concerns at the national level over the costs of undocumented immigration and “national security” issues

78 The Children’s Health Insurance Program Reauthorization Act (CHIPRA).
79 Health system researcher A, personal communication, 16 August 2011.
80 In that it allowed the state to share these populations’ GSI costs with the federal government, instead of paying for them with only state funds in accordance with PRWORA’s original intent.
following September 11th, 2001, Minnesota republicans enacted several budget and public service cuts targeting the state’s undocumented population (Fennelly, 2006). In 2003, the Minnesota legislature, supported by newly-elected Republican governor Tim Pawlenty, stripped undocumented immigrants’ access to GAMC, the state’s self-funded sister program of Medicaid (Minnesota Department of Human Services, 2003). The cuts to GAMC were accompanied by broader cuts to health and human services programs, which Republicans justified as “overdue cost cutting” (Smith, 2003). The same legislation eliminated the EGAMC (Emergency General Assistance Medical Care) program, a state version of federally-funded Emergency Medicaid that served as a secondary safety net for uninsured immigrants in need of emergency care (Fennelly, 2006). Minnesota’s undocumented children were especially affected by this legislative action, as they were left with little or no state or federal GSI support beyond emergency rooms.81

Tim Pawlenty’s administrative strategy led to further cuts to Minnesota’s GSI infrastructure later in the decade. In 2009, facing a massive budget deficit triggered by 2008’s recession, Pawlenty enacted major cuts to state programs in lieu of calling for tax increases. One of Pawlenty’s largest cuts was a unilateral, line-item veto of $381 million for the 2011 GAMC fund, which was followed by a $15 million cut to the 2010 GAMC fund. This veto effectively guaranteed insolvency of the program by March, 2010. Despite outrage from legislators and the state’s Health Services Commissioner, the cuts proceeded and GAMC was shut down in 2010 (Silversmith, 2010). The thousands of noncitizens covered by GAMC (Table 4.3) were either moved to other programs (if eligible), or left without GSI.

Given the actions of the legislative and executive branches of state government, it is reasonable to say that Minnesota’s immigrants have become slightly more vulnerable to

81 Health system researcher A, personal communication, 16 August 2011.
rollbacks of state GSI benefits. The reasons for this vulnerability, however, are perhaps slightly
different than the ones posited by legal and geography scholars following PRWORA. Wishnie
(2009) argues that in recent years, local balances of “exclusionary” and “integrationist”
sentiments towards immigrants hold a greater influence over anti-immigrant state legislation.
Ellis (2006) similarly argues that localized tensions within native-born communities over
providing immigrants with government services may erupt due to the escalating costs of these
services. While Minnesota is certainly subject to divides in public opinion over immigration (as
evidenced by the 2004 U of M survey), the GSI cuts to undocumented immigrants in 2003 were
not merely the manifestation of entirely local frustrations over this population’s presence—
Minnesota hardly had a large enough undocumented immigrant population to justify such
tensions. Rather, it seems that conservative republicans in the state were taking their political
action cues from leading conservatives at the national scale, or lawmakers in other states with
larger undocumented populations. The cuts to GAMC by Tim Pawlenty disproportionately
affected immigrants, but Pawlenty did not appear to have anti-immigrant sentiments in mind
when gouging the program. It is more likely that GAMC was targeted for cuts based on its
fungible program status. GAMC was financed through the state’s general fund, not through a
complicated federal-state arrangement like other Minnesota GSI programs (Chollet & Achman,
2003). From Pawlenty’s perspective, its elimination instantly “freed up” money on the state’s
budget balance. If the affected Minnesotan immigrants were made more vulnerable in this
instance by PRWORA, it was because they had become dependent upon a GSI program that was
more easily cut in the event of a budget crisis, not because they were not singled out for
punishment by a governor with an explicitly anti-immigrant agenda. “Vulnerability,” in these
cases, is more structurally grounded than public-opinion driven.
In sum, then, the recurrence of budget deficits in Minnesota likely posed the greatest state-level threat to GSI for immigrants between 2000 and 2010, as they opened the door for cuts in discretionary health and human services programs. Even after 2010, ongoing budget gridlocks affecting Minnesota’s health services programs\(^{82}\) threaten the ability of the state to maintain government-sponsored insurance to underserved immigrant populations.\(^{83}\) This fact provides a counter-argument to Zimmerman and Tumlin’s (1999) observation on the relation between budget deficits and GSI programs for immigrants. When Zimmerman and Tumlin performed their nation-wide study, they found that the size of budget surpluses and deficits did not seem to affect whether states offered “replacement” insurance programs to federally-barred immigrants—the existence or non-existence of state-funded GSI programs at the time of PRWORA’s passage made a larger difference. The experience of Minnesota, however, suggests that in the decade following PRWORA budget surpluses and deficits affected the chances of sustainability of these programs. In sum, Wishnie, Varsanyi, and Zimmerman and Tumlin were correct to predict that PRWORA’s rearrangement of immigrant affairs costs and powers would increase vulnerability among immigrant populations, though the exact mechanism(s) for constructing such vulnerability varied according to local context, as was the case in Minnesota.

4.7 Conclusions: Geographic context enables, geographic context constrains

As we have seen, immigrant access to health insurance in Minnesota was relatively strong, but not without exceptions. Immigrants settling in Minnesota in the 1990s and 2000s were able to take advantage of a relatively healthy economy to gain employment in industries

\(^{82}\) Benson (2011).

\(^{83}\) Health system researcher A, personal communication, 16 August 2011.
that offered a slightly higher rate of ESI than the national average for immigrants, but faced the same slow erosion in ESI coverage as the rest of the state’s citizens. Minnesotan immigrants’ ESI coverage levels also lagged behind those of native-born citizens, mirroring the national trend of structural disadvantages in obtaining private coverage. The recession beginning in 2008 likely eroded private coverage further for immigrants, though data from state-level surveys do not yet support firm conclusions either way.

Minnesota provided relatively generous levels of GSI coverage for immigrants throughout the 2000s, with the exception of a few politically-motivated cuts to smaller, state-funded GSI programs for undocumented and very low-income residents. The state’s “generosity” in GSI coverage is affected by Minnesota’s migration geography and immigrant demographics (small immigrant population, disproportionately eligible for federal funds after PRWORA, few undocumented immigrants), two structural “advantages” that other states could not duplicate. Texas, for example, entered the 2000s with a nonelderly immigrant population of 2.1 million, of which 56% were uninsured, and only 6% were covered by public insurance (Kaiser Commission on Medicaid and the Uninsured, 2003). Texas also had the second-highest population of undocumented immigrants in the nation in 2000, after California (Hoefer et al., 2011). If a high-immigration, high-undocumented population state like Texas had wished to provide GSI coverage at the same levels as Minnesota after PRWORA, covering around a quarter of the entire immigrant population, it would have had to spend much more state money, both in absolute terms and in terms of the federal-state share of Medicaid financing.

More generally speaking, Minnesota benefits from its low average cost of medical treatment compared to other states and regions. Adjusting for age, sex, race, and the local cost of living, Minnesota still ranks among the lowest-cost regions in the nation, despite having a high
average quality of care (Skinner et al., 2011). Although geographic variation in the cost of care\textsuperscript{84} have been known to exist for some time, the exact reasons for these disparities are hotly debated (Gawande, 2009).\textsuperscript{85} Nonetheless, average costs of care in a state and region affect the ability of employers and private insurers to offer ESI to employees, and the ability of governments to provide GSI coverage to program enrollees, whether immigrant or native-born. The geographically uneven growth of medical costs nationwide over the past few decades (Fisher et al., 2009) implied differential and declining capacities for private and public insurance coverage for immigrants in different states, as it still implies today.

Even as Minnesota is “privileged” in some structural ways, it is constrained in others. Minnesota cannot easily follow some strategies for providing health insurance or cost coverage for immigrants that have been attempted in other parts of the country. San Francisco and Alameda County provide two negative examples. In San Francisco, large amounts of city-budget funds were used to add uninsured immigrants to two of the city’s health programs, San Francisco Healthy Kids and Healthy San Francisco (Marrow, 2010). In Alameda county, a local advocacy consortium established Alameda Family Care, a care program for the county’s uninsured, enrolling residents regardless of their legal immigration status using private foundation grants (Hirota et al., 2006). Unfortunately, the San Francisco strategy depends on (1) the previous existence of a city-scale health programs for the uninsured, and (2) large sources of city tax

\textsuperscript{84} For the same sets of procedures, of similar quality between regions. Most recent studies of health care cost variations must rely on Medicare expenditure data, as it offers a centralized source of data about a single payer (the federal government). The majority of health care costs nation-wide are not publicly available and are hard to aggregate, as they originate from a complicated process of negotiation between multiple, disorganized payers (insurers) and medical providers.

\textsuperscript{85} Atul Gawande’s (2009) conclusion after comparing high-cost and low-cost regions is that much of the geographic disparities have to do with differences in local health care standards of practice that emerge from local medical “cultures,” i.e. localized groups of interacting practices that follow each other’s lead when deciding “best standards” of practice, whether inefficient and expensive or not. This answer is not definitive, however.
revenue available for expenditure on local immigrants. Minneapolis has no such city-scale GSI or health program, and has been recently plagued with large and growing budget cuts, leaving it extremely short on cash that would be needed to start one (Brandt, 2009). Alameda Family Care learned the hard way that private foundation grants are not enough to finance an insurance-replacement scheme for immigrants: only a few years into the program, private foundation grants dried up and were not replaced by state or federal funds, bankrupting the program (Hirota et al., 2006). Given the persistent and recurring budget crises in Minnesota, private foundations, similarly, cannot be expected to fund a sustainable program for the state’s remaining uninsured.86

This final comparison illustrates the most salient point regarding Minnesota’s (and other states’) systems of health insurance for immigrants: the role of institutional path-dependence. Minnesota’s collective capacity to provide health insurance for immigrants has been enabled and constrained by the set of health care and health insurance institutions that were established prior to and during the recent surge of immigration. The prevalence of HMO institutions partially drove Minnesota’s low average cost of health care, which in turn allowed for high levels of private insurance (Chollet & Achman, 2003). The early establishment of multiple, entrenched state-level GSI programs allowed for a sort of “piggybacking” effect after PRWORA as new immigrants arrived in the state later in the 1990s and 2000s. It is even reasonable to say that the state/federal GSI cost advantage attributable to Minnesota’s high proportion of refugees can ultimately be traced back across decades to Minnesota’s large and entrenched network non-governmental social services institutions, the existence of which undoubtedly affected Minnesota’s migration flows (i.e. attracting more refugees) in the 1980s, 1990s, and 2000s.

86 Many of which have, in fact, generously donated to small-scale local health clinics and organizations that provide services to uninsured immigrants in the state in response to PRWORA and federal cuts to GSI aid (Fennelly, 2006).
Geographic-institutional contexts like these mattered following PRWORA and the slow national erosion of private insurance, and states with different contexts find themselves faced with different challenges to providing immigrants with health insurance as they enter the 2010s.
5 “Letting the ethics lead us”

5.1 Conclusions

Since the 1980s, two types of forces have exacerbated the problem of immigrant
uninsurance: *deliberate* restructurings of the institutions surrounding employer-sponsored and
government-sponsored insurance, and *unintentional* consequences of economic or geographic
processes that affect institutional capacities for coverage (e.g. increasing health costs affecting
ESI capacity; shifting demographic patterns affecting GSI capacity). Uninsurance flourishes on
account of both “intentional” and “unintentional” forces working in tandem. For example: with
respect to the eroding system of ESI, it would be almost absurd to say that the entirety of U.S.
business interests preemptively conspired in the 1980s to hold down immigrants’ wages and ESI
throughout the boom years of the 1990s, essentially perpetuating their second-class status as a
captive, peripheral labor force. Yet, to paraphrase Yale political scientist Ted Marmor, nothing
that occurs with regularity is entirely absurd.87 The demotion *en masse* of America’s new,
expanding, and self-sustaining labor force to second-class compensation status was not planned,
but it aligned with the corporate class’s *deliberate* interests in the gradual erosion of the
trappings of the Fordist labor reproduction system. Over time, it solidified into a readily-
available strategy for cheapening the cost of labor, a competitive advantage in the eyes of capital.
The convergence of unplanned “opportunity” and intentional “interests” resulted in the
entrenchment of immigrant ESI disparities in America.

The boundary between “intentional” and “unintentional” forces is similarly blurred in the
case of PRWORA. The largest negative consequences of PRWORA’s immigrant restrictions—

87 Quoted in Evans (2008).
cost devolution effects to states, chilling effects on GSI enrollment, and localized legislative vulnerability—were entirely predictable by the bill’s authors. They were also largely intentional, ostensibly introduced to provoke a behavioral response on the part of immigrants (“self-sufficiency”). Yet, as shown in the case study of Minnesota, PRWORA’s functional goals could not be directly imposed on immigrant populations situated “in place.” Instead, geographic contextual factors played a mediating role. The institutional-demographic context of Minnesota’s voluntary social service agencies, refugee populations, and GSI framework allowed for an effect contrary to PRWORA’s goals: more immigrants were covered by GSI over the years 2000-2010, not less. Immigrants in Minnesota were “winners” of the cruel contest established by PRWORA, thanks in large part to the state’s economic, institutional, political, and demographic contexts.

What of other states? In the introduction to this thesis, I claimed that the health insurance system for immigrants in the 2000s became “increasingly geographically fragmented and contingent.” “Geographic fragmentation” and “contingency,” unfortunately, are difficult phenomena to exemplify. The experience of Minnesota can clearly not be generalized to other immigrant populations, and it is unsatisfying simply to assume that other states’ “geographically-specific contexts” (unexplored in this thesis) produced divergent results. There are ways, however, for testing the presence of increased geographic contingency in immigrant health insurance. One is the Gini index of inequality. It can be constructed to measure the amount of inequality in health uninsurance attributable to interstate differences in noncitizen health insurance rates (e.g. a rate of 50% in one state and a rate of 30% in another state). It is widely known that immigrant uninsurance varies by geography (e.g. Figure 1.1). A comparison of the

88 The methodology and procedure of this test are explained in the Appendix of this thesis.
Gini coefficients for years 2002 and 2009 is revealing, however.\textsuperscript{89} A Gini test comparing measures of geographical inequality in noncitizen health insurance between 2002 and 2009 indicates slightly more inequality in 2009. Put more simply, health insurance and uninsurance was distributed unevenly across the nation’s noncitizen population in 2002, and it grew slightly more so over the 2000s, such that by 2009 the influence an immigrant’s state of residence became a stronger predictor of their (un)insurance status. Immigrants’ chances of obtaining health insurance became more dependent on local state contexts.

Was this increased geographic heterogeneity influenced by government policies like PRWORA? I argue they were. First, as explained in Chapter 2, state noncitizen GSI rates are not correlated with noncitizen poverty rates (p. 80). This suggests a larger influence of institutional differences between state GSI programs (e.g. differing categorical eligibility requirements or income ceilings for coverage). PRWORA essentially codified into law increased heterogeneity between state programs. Also, as explored in Chapter 3, differences in immigrant demographics had the potential to produce a large impact on coverage rates in different states, thanks again to PRWORA’s differential treatment of “qualified” vs. “unqualified” immigrants. In such an institutional environment, an individual immigrant’s chances of receiving stable GSI depended not only on their own characteristics, but also on the (aggregate) characteristics of other immigrants in the state.

Not only did GSI programs and rates vary heterogeneously throughout the 2000s, ESI rates fluctuated as well. \textbf{Figure 5.1} displays a map of ESI gains and losses for noncitizens (i.e. excluding naturalized citizens) in each state between 2002 and 2010.

\textsuperscript{89} The choice of these particular years is driven by limitations of the ASEC data set, which begins in 2002 and only recently released 2010 data at the time of this writing (U.S. Census Bureau, 2010).
Gains and losses are almost randomly distributed across states, with little or no correlation to the geographic pattern of overall uninsurance rates (cf. Figure 1.1). The continued “roll out” of PRWORA’s de facto system of patchwork GSI programs and policies, combined with the heterogeneous progression of immigrant ESI (erosion) patterns, provide substantive mechanisms for the observed increase in geographic contingency in immigrant uninsurance. Changes in these institutions ensured that there could be no such thing as a “common” immigrant uninsurance phenomenon or “equal treatment” with respect to the health care system.

**Figure 5.1**: Percentage point change in noncitizen ESI coverage per state, 2002 – 2010. Source: calculations by author, data from U.S. Census Bureau (2010).
5.2 A chance for change? Obama’s health care reform and the future of immigrant “uninsurance”

A year into his presidency, Barack Obama announced his intention to launch a major health care reform effort to the U.S. congress: “I may not be the first president to tackle [health care reform,]” he declared, “but I am determined to be the last” (White House, 2009). Following a lengthy and fiercely partisan congressional battle, Obama was granted his reform, and the Patient Protection and Affordable Care Act (PPACA) was signed into law in March of 2010.

One of PPACA’s main goals was the reduction of uninsurance in America, and its provisions represent the largest shift in federal health insurance policy for immigrants since PRWORA’s passage nearly fifteen years prior. By 2014, immigrants will be able to participate in state-level health insurance “exchanges,” government-organized (and subsidized) markets for individually-purchased private insurance (National Immigration Law Center, 2010). However, uninsured immigrants will also be mandated to purchase private insurance or face tax penalties (with some exemptions for low-income immigrants) (ibid.). PRWORA’s immigrant exclusion from Medicaid was not repealed or superseded, and remains the law.

PPACA has the potential to re-shape drastically the relationship between immigrants and the U.S. health care system. First, it will almost surely reduce the uninsurance rate. Institutions that are currently calibrated to the needs of uninsured American citizens and noncitizens will have to re-formulae their missions as a result of this change (Clinic Chief Financial Officer A, personal communication, 14 July 2011). It will also change the distribution of uninsurance among different legal groups of U.S. immigrants. In past decades, immigrant uninsurance has followed a gradient pattern, with naturalized citizens “most likely insured” and undocumented citizens “least likely insured” (Carrasquillo et al., 2000). PPACA continues PRWORA’s policy of barring undocumented immigrants from any state-sponsored insurance program, including
state insurance exchanges. Undocumented immigrants, therefore, are expected to become fully one-third of the remaining number of uninsured American residents by the year 2019 (Pear and Herszenhorn, 2010). Consequently, “uninsurance” may become strongly associated with undocumented status in the future, further increasing the stigmatization faced by both undocumented immigrants and uninsured Americans interacting with health care providers (Health system researcher A, personal communication, 16 August 2011).

PPACA’s approach to increased health insurance coverage may, most importantly, erode the ability of “insured/uninsured” status to serve as a strong proxy measure of access to health care (or the lack thereof) and health cost risk. “Immigrant uninsurance” has grown as a significant research and policy issue precisely because this proxy relationship has led to unequal medical outcomes for immigrants in the past. This is not to say, however, that immigrants will cease to be disadvantaged with respect to U.S. health care upon implementation of PPACA and (hopefully) an increase in the immigrant insurance rate. Throughout this thesis I have deliberately side-stepped a significant truth of the U.S. health insurance system: health insurance coverage does not guarantee adequate health care access or health care affordability.

“Underinsurance,” a condition wherein ostensibly “insured” individuals are exposed to significant financial risk for medical treatments that fall beyond variable thresholds (defined by their insurer), is a long-standing and increasingly common phenomenon (Bodenheimer, 1992; Lavarreda et al., 2011). Although PPACA includes provisions intended to combat underinsurance, the nature of private insurance as a financial product guarantees that individuals that can afford more comprehensive policies will find themselves with more treatment “options” in the U.S. health care landscape, and vice versa for less-wealthy insured individuals. It remains to be seen whether: (1) the disproportionately large number of uninsured immigrants will act in
accordance with PPACA and acquire insurance; and (2) how effective “new” coverage will be in practice, once newly-insured immigrants (and other Americans) begin interacting more with the U.S. network of healthcare providers. Geographic context may play as great a role in affecting disparities among future insured immigrants/citizens as they have in affecting uninsurance disparities in the past. In contrast, the only way to avoid underinsurance effects and other intra-coverage disparities among immigrants and others would have been a federally- or state-organized single-payer insurance system, an option that was never seriously considered during the development of PPACA.

Following the logic of this thesis, I argue that the appropriate way to evaluate the effectiveness of Obama’s health care reform on immigrant health care disparities will be a close inspection of its unintended or hidden outcomes. In 2020, for example, will immigrants still be disproportionately uninsured? Disproportionately underinsured? Ethical considerations will be paramount as well. Will immigrants be disproportionately exposed to health cost-risk as average medical costs continue to rise? The health care economist Uwe Reinhardt, in a lecture on health care reform given on the eve of PPACA’s passage in March 2010, wryly and succinctly described the basic process of the U.S. health care system’s evolution:

> Since we [Americans] can’t agree on ethics [of health insurance/care], we just make policy, we set the economic parameters and see where the ethics will lead us. And if it doesn’t stink to heaven we will be happy with it, and we will usually be quite tolerant to the stench that we create.

The “ethics” of the system of health insurance for immigrants over the past three decades have led America to a set of deeply unequal and unjust outcomes for its newest residents. The fate of immigrant health insurance and care will depend on whether we continue to be led by these ethics, or choose to lead with new ones.

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90 Minnesota Legislator A, personal communication, October 2010.
Works Cited


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91 All internet links functional as of September 28, 2011.


SHADAC (State Health Access Data Assistance Center). (2009). Data Availability for Race, Ethnicity, and Immigrant Groups in Federal Surveys. Minneapolis: SHADAC.


Appendix A  Constructing a simple Gini comparison of geographic
dispersion/concentration of uninsurance, 2002-2009

In constructing the Gini index of US noncitizen uninsurance I draw my data from the
U.S. Census Bureau’s Annual Social and Economic (ASEC) Supplement using the two data
series from 2002 and 2009. These data sets provide consistent measurement methods of: (1) total
noncitizen populations for all 50 states plus the District of Columbia; and (2) the total number of
uninsured noncitizens per state over time. The ASEC data are collected from approximately
78,000 households nationwide per year (U.S. Census Bureau, 2010). While this is a large sample
size for the total population, it is not as large for the subset I am interested in: noncitizen
populations in each state. Because of this, I choose to use counts of “noncitizens per state” and
“noncitizens uninsured” rounded to the nearest thousand, as opposed to the whole-number
population counts the ASEC data also provide.

I measure the degree of inequality in health uninsurance among U.S. noncitizens
attributable to interstate differences by creating a simulation data set.92 I first divide the
noncitizen population into blocks of 10,000 people each. Blocks are matched to states according
to the relative sizes of noncitizen populations per state. For example, approximately 451,000
immigrants resided in Massachusetts in 2009 according to ASEC data, so I allocate 45 blocks of
10,000 noncitizens to “Massachusetts” in 2009. After producing this set of population blocks for
each state, I assign “uninsurance share” values for each block according to the following
procedure:

1.) Each state’s total number of uninsured noncitizens are read from ASEC data. This
value is translated into a “state share” of national uninsurance. Example: In 2009

92 This operation and all subsequent steps are performed in Microsoft Excel.
about 52,000 noncitizens in Massachusetts were uninsured, out of a national total of 9,944,000 uninsured noncitizens. Massachusetts noncitizens thus only comprised 0.52% of the “share” of noncitizen uninsurance nationally.

2.) Each population block of 10,000 is assigned an “uninsurance share” (denoted “u” below) proportional to its respective “state share” (denoted “Us” below). For the ith block:

\[ u_i = \frac{U_s}{N_s} \]  

[\( N_s \) is the number of population blocks in the ith block’s state.]

Example: Massachusetts “contributed” 0.52% (0.00529) of the total uninsured noncitizen population in 2009. In this simulation, each block per state is given an equal share of the state share.\(^{93}\) The first 10,000 noncitizens in Massachusetts (block MA1, the first out of the state’s 45) are thus assumed to comprise

\[ \frac{0.00529}{45} = 0.000116 \text{ or } 0.0116\% \text{ of the national total of uninsured noncitizens.}^{94} \]

Once a simulation data set is created for each year, Lorenz curves and Gini coefficients are constructed using normal techniques. Below is the Lorenz curve for 2002 (Figure A.1). Gini coefficients in 2002 and 2009 are 0.1141 and 0.1219, respectively. Since the Gini coefficient scale runs from zero (total equality) to one (maximum inequality), these Gini coefficients indicate that uninsurance was unevenly distributed throughout the noncitizen population on

\(^{93}\) In the real world, of course, uninsurance is also unequally distributed within states; however, since this Gini test only attempts to capture inequality attributable to interstate differences, this unrealistic step is reasonable.

\(^{94}\) The purpose of breaking each state’s uninsurance share into discrete blocks is to adjust for the different noncitizen population sizes of each state, in effect producing an uninsurance share “per capita”. This step comes into play when the Gini coefficient is calculated. Abstractly speaking, the Gini measure compares observed uninsurance patterns to “expected” patterns that would exist if uninsurance were distributed equally. In my simulation, “equality” is defined as every group of 10,000 noncitizens in America having the same uninsurance rate as every other group of 10,000 noncitizens.
a state-to-state basis, though not extremely so. The difference between the two years indicates evidence of a shift towards more inequality, but not a great deal.

This simulation and measurement process is meant to be an investigative exercise only. There are several limitations. First, an issue of accuracy emerges from the granularity of the data sets (both the ASEC data and the rounded simulated population data). Second, I cannot offer any conclusions on the statistical significance of the difference between the two Gini coefficients. Third, this process of measuring inequality is only one of several that could be applied to the ASEC data. Others may produce different results. In sum, this exercise gives plausibility for the hypothesis that geographic inequality increased for noncitizen uninsurance in the 2000s. A more rigorous statistical study would be required to definitively confirm or falsify this hypothesis.