Medicaid Eligibility for Immigrants: Demographic Causes for the Adoption of State Policies

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Abstract

This paper merges literatures on threat, contact, and social construction and adds nuance to literature regarding the determinants of state-level policies. Medicaid is used as a case to explore state responses to total immigrant, Latino immigrant, and Asian immigrant concentration and inflows. Logistic regression is used for 2008 and 2011 to control for changes in federal incentives. Other control variables include legislative professionalism, citizen ideology, state government ideology, state policy liberalism, and per capita income. The findings in this paper suggest that Latino and Asian immigrants have different relationships with state-level policies that incorporate and exclude immigrants and Asian contact is driving the positive relationship between total immigrant contact and inclusive state-level policies.

Introduction

Scholars of state-level politics have examined how immigrant concentration and immigration inflows to each state affect state-level policies (Boushey and Luedtke 2011, Graefe et al. 2009, Fox 2005). Theories of contact (Allport 1954) and threat (Key 1949, Blumer 1958) have been explicitly and implicitly used to explore whether demographic determinants, such as total immigration and Latino concentration, affect state-level policies. However, scholars have not examined how concentration and inflows from specific immigrant groups affect state-level policies. This paper will focus on Latino and Asian immigrants because these are two of the largest immigrant groups. Focusing on these two groups will provide nuanced understanding of the demographic conditions that lead states to adopt restrictive or inclusive policies for immigrants. The demographic conditions that this paper will focus specifically on are total immigrant, Latino immigrant, and Asian immigrant concentration as well as total immigrant, Latino immigrant, and Asian immigrant inflows.

State-level Medicaid policies provide an opportunity to explore the relationship between demographic conditions and state-level policies for immigrants. The federal government and states share the cost of Medicaid services. However, from 1996 until 2009, a small number of states voluntarily covered the entire cost of Medicaid services for immigrants without federal assistance. The 1996 Personal Responsibility and Work Opportunity Act (PROWRA) provided states with the option to provide Medicaid services to immigrants who have been in the U.S. for less than five years with state-only funds (Kaiser 2009). Many of the states that used state-only funds to provide Medicaid to immigrants had large immigrant populations (Light 2010). Federal incentives to cover

immigrants under Medicaid changed in 2009 with the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA). Under CHIPRA, states are provided matching federal funds if states choose to provide Medicaid coverage for immigrant children and pregnant women.[1] Due to the universal mandate for emergency care, states with high rates of incoming immigrants are likely to save resources by allowing immigrant access to Medicaid because this access reduces the cost of emergency services for immigrants. Despite these financial incentives to provide Medicaid for immigrant, many states have not exercised the option.

The delegation of authority to states in 1996 along with the passage of CHIPRA in 2009 create an opportunity to examine the demographic conditions that lead states to provide expansive Medicaid coverage for immigrants. The passage of CHIPRA also allows federal incentives to be controlled for. State responses to the 2009 Act will serve as a robustness test for state responses to the 1996 Act. Medicaid delegation allows for the exploration of the specific question: Under what demographic conditions will states provide expansive Medicaid eligibility for immigrants?

Literature Review

Contact and Threat

This paper will test Allport's (1954) contact hypothesis and Key's (1949) threat hypothesis, elaborated by Blumer (1958), for immigrants. Although these are individual level theories that were developed for testing attitudes of whites towards blacks, they offer explanatory power for immigrants.

[1] After CHIPRA, states retained the option to cover adult immigrants who are not pregnant and who have been in the U.S. for less than five years with state-only funds.

Allport's hypothesis assumes that under the right circumstances, contact between racial groups "may decrease the prevalence of negative stereotypes" (Allport 1954, 586). These circumstances include equal group status, common goals, intergroup cooperation, and support of the rule of law. In short, Allport's theory argues that increased, prolonged contact with different groups can reduce prejudice.

The group threat hypothesis (Key 1949) emerges from finding that southern whites viewed African Americans and other minorities as a threat. The hypothesis argues that whites view African Americans as a social, economic, and political threat. Blumer (1958) builds upon Key's (1949) hypothesis and argues that race prejudice exist due to relative group positions. Feelings of prejudice in the dominant group include "(1) a feeling of superiority, (2) a feeling that the subordinate race is intrinsically different and alien, (3) a feeling of proprietary claim to certain areas of privilege and advantage, and (4) a fear and suspicion that the subordinate race harbors designs on the prerogatives of the dominant race" (Blumer 1958, 4). In sum, threat is a measure of the extent to which the majority population perceives their world as changing. This paper will apply these two hypotheses to immigrants, Latino immigrants, and Asian immigrants.

Recent research has explicitly and implicitly tested contact and threat and how this affects state-level policies. In an analysis of state-level immigration policies, Boushey and Luedtke (2011) test the two hypotheses and find that states with relatively high levels of contact between immigrants and native born populations are likely to pass integration policies that provide housing, work, and educational opportunities for immigrants. At the same time, the authors find that states with high levels of threat are likely to pass control policies. In other words, states with relatively low foreign-born populations and rapidly

growing immigrant populations are likely to pass control policies that aim to keep immigrants out of the state.

Portes and Rumbaut (forthcoming) use census data in a purely descriptive manner to highlight the emergence of new places of immigrant settlement. The authors illustrate that 67 percent of the foreign-born population lived in traditional immigrant destinations that include California, New York, Texas, Florida, New Jersey, and Illinois in 2010. The authors also draw attention to the emergence of "new destinations" of immigrant settlement that include a number of southern and mountain west states such as North Carolina, Georgia, Arkansas, Tennessee, Nevada, South Carolina, Kentucky, Nebraska, Alabama, and Utah. Since these "new destinations" had relatively small immigrant populations compared to traditional immigrant destinations prior to the 1990s, these "new destinations" have experienced 280 to 525 percent growth in their immigrant populations.

Similar to Portes and Rumbaut and Boushey and Luedtke, Light (2010) finds that immigrants are heavily clustered in California, New York, Texas, Florida, and Illinois. In 1990 these five states contained 84.8 percent of the nation's immigrant population. This declined to 63.7 percent in 2000 and 61.7 percent in 2007. Light also finds that these five states bear most of the cost for immigrant welfare. In a research report for the Urban Institute, Zimmerman and Tumlin (1999) also find that states with a higher percentage of immigrants have more generous welfare states.

Graefe and colleagues (2009) find that experience with immigration leads to more generous welfare states for immigrants. The authors also put forth an immigration concentration hypothesis, in which welfare policies toward immigrants will be more stringent in places where immigrants comprise a large share of the welfare caseload. Yet,

the authors acknowledge that states with more immigrants are likely to have relatively generous welfare state policies. The authors use dependent variables that measure AFDC/TANF eligibility requirements for immigrants during their first five years in the U.S. from 1996 to 2003. The authors find mixed results for their immigration concentration hypothesis. Specifically, "having a high Hispanic population increased stringency toward these immigrant groups, but being an immigrant destination state and being a state with higher rates of immigrant in-migration reduced policy stringency" (Graefe et al 2009, 113).

However, states with generous TANF policies for immigrants do not necessarily have generous Medicaid eligibility for immigrants. Filindra (2013) finds that states have different incentives to extend TANF and Medicaid benefits to immigrants. Due to the federal mandate for universal emergency care, which is often more expensive than Medicaid services, excluding immigrants from Medicaid can be more costly than excluding immigrants from TANF. Filindra finds that these incentive structures lead states to adopt relatively inclusive Medicaid policies and relative restrictive TANF policies.

Contact and Threat of Latinos and Asians

Restrictive welfare state policies have been found to be related specifically to minority diversity and not necessarily white ethnic diversity. Hero (2003) explores the effects of minority diversity and white ethnic diversity in state Medicaid spending and finds that the racial and ethnic makeup of each state has an effect on state Medicaid policies, but minority diversity and white ethnic diversity affect Medicaid policies in different ways. Hero includes blacks, Latinos, and Asians in the "minority" category and southern and eastern Europeans in the "ethnic white" category. Hero finds that white ethnic diversity is

positively related with Medicaid payments per recipient and Medicaid spending per capita, while minority diversity has a negative relationship with Medicaid payments and spending.

Research also suggests that certain groups are viewed as more deserving than others and this affects welfare state policy. In a content analysis of opinion pieces, letters, and editorials regarding SSI from 1993 to 1998, Yoo (2000) finds that after the passage of the PRWORA, low-income elderly immigrants began to be seen as legitimately in need of SSI. Yoo also finds that most of the articles from 1993 to 1998 regarding elderly immigrants and SSI appeared in states with high immigrant populations such as California, Florida, and New York.

Similarly, other scholars have found that certain racial and ethnic groups are deemed as more deserving than others for welfare state benefits following the 1996 act. In general, Asians have been depicted as "deserving" and a "model minority," yet "foreign" and relatively inferior to whites. At the same time, Latinos have been portrayed as both "undeserving" and "deserving."

Fujiwara (2005) finds that certain Asian Americans were constructed as "deserving" following the passage of the PRWORA. Fujiwara examines grassroots mobilization and the media's reception of these efforts and finds a change in the description of immigrants who are perceived to be deserving of SSI benefits. Before the PRWORA, anti-immigrant politicians argued that the availability of welfare benefits attracted immigrants to the U.S. Through her participant-observation study in northern California in areas with high Asian populations from 1996 to 1998, Fujiwara finds that immigrant rights organizations originally argued that the PRWORA would hurt all immigrants. Eventually, these organizations began to exploit U.S. memories of the nation's involvement in Southeast Asia

and highlighted "this particular group to whom the United States once declared a moral obligation to assist and provide a place of refuge" (91). In Fujiwara's analysis of national news coverage, she finds that by the time the story reached the media, "we see a more specific depiction of the very elderly, disabled, and chronically ill, as well as refugees from Southeast Asia as the primary 'victims' of welfare reform" (96).

In contrast to this depiction of Southeast Asians as "deserving" poor, Kim (1999) argues that Asian Americans have been valorized relative to blacks, but have been and continue to be perceived as foreign and inferior to whites. Kim illustrates that anti-Asian sentiment has been relatively noticeable when there has been an Asian threat in foreign affairs. Kim also demonstrates that this anti-Asian sentiment is ubiquitous among Asian Americans in positions of authority.

Kawai (2005) extends Kim's framework and argues that both the model minority stereotype and the idea of yellow peril are attached to Asian Americans. The model minority stereotype emphasizes Asian American success through individual effort despite their racial background, while "yellow peril refer[s] to cultural threat as well as economic, political, and military threats to the White race" (Kawai 2005, 113).

Fox (2004) extends Allport's (1954) contact hypothesis, which has been tested for white and blacks, and applies it to whites and Latinos. Fox finds that the contact hypothesis holds for Latinos and welfare services and that whites believe Latinos to be less lazy in states with higher Latino populations. Fox also finds that whites are more wiling to support spending on welfare when they do not think that Latinos are lazy. Despite this finding that whites have different attitudes toward Latinos in different contexts, Fox also

notes that whites' stereotypes of blacks are relatively consistent and do not change in different racial contexts.

In contrast to Fox's findings, Graefe and colleagues (2009) find that states with high Hispanic populations have more stringent welfare policies regarding green card and refugee immigrants. At the same time, the authors find that immigrant destination states and states with higher rates of immigrant in-migration have less restrictive policies.

These conflicting findings on the construction of Asians and Latinos suggest ambiguous relationships between Latino and Asian contact and threat. This paper will test these relationships by using the state option to provide Medicaid to recently arrived immigrants.

Table 1. Hypothesized relationships between demographic conditions and expansive Medicaid policies

Independent Variable	Hypothesized relationship with providing expansive Medicaid eligibility	
Immigrant Contact		
Total	+	
Latino	+	(less than Asian contact)
Asian	+	(more than Latino contact)
Immigrant Threat		
Total	–	
Latino	–	
Asian	–	

Table 1 summarizes the hypothesized relationships between each demographic condition and expansive Medicaid policies and puts forth three hypotheses, which I will label the contact hypothesis, threat hypothesis, and social construction hypothesis. The contact hypothesis follows Allport's contact hypothesis (1954). For this hypothesis, I expect to find that total immigrant contact, Latino immigrant contact, and Asian immigrant contact will increase the likelihood of a state providing expansive Medicaid eligibility. The threat hypothesis follows Key (1949) and Bulmer's (1958) threat hypothesis. Here, I expect to find that total immigrant threat, Latino immigrant threat, and Latino immigrant threat will reduce the likelihood of providing expansive Medicaid eligibility. The social construction hypothesis emerges from the relatively positive social constructions of Asians relative to Latinos. In this hypothesis, I expect that Asian contact will increase the likelihood of a state providing expansive Medicaid eligibility more than Latino contact.

Medicaid and State Option

State-level Medicaid eligibility for immigrants is used as a case to test theses hypotheses. Medicaid functions as a form of delegated governance because responsibility of this program is delegated from the federal government to the states. Since the creation of Medicaid in 1965, states have had the authority to provide or not provide services to certain groups under the condition that each state meets certain federal mandates (Grogan and Patashnik 2003). Delegated governance is used for a number of practical reasons. In their study of Medicare and delegated governance to non-state actors as well as their argument that the Affordable Care Act serves as a form of delegated governance to the states, Morgan and Campbell (2011a and 2011b) note that the use of delegated governance results from contradictory attitudes surrounding the necessity of social programs and

suspicion of the federal government; mobilization of interest groups in the policy-making process; and institutional barriers to major reform.

The PROWRA of 1996 further devolved authority to the states by offering states more flexibility in deciding whether to cover recently arrived immigrants. Before the law, the federal government had complete responsibility to determine immigrant access to these benefits. The PROWRA allowed states to determine whether recent immigrants would be eligible for services such as Medicaid; Aid to Families with Dependent Children (AFDC), which is now Temporary Assistance to Needy Families (TANF); Social security Income (SSI); and other services (collectively the "welfare state") (Zimmerman and Tumlin 1999).

The law also created legal distinctions between "qualified" and "unqualified" immigrants as well as pre-enactment immigrants who arrived before the PRWORA passed and post-enacted immigrants who arrived after the law passed. For the most part, post-enactment immigrants, or immigrants who entered the U.S. after 1996 are "unqualified," while a few protected groups are "qualified" for federally funded welfare state services.[2]

This distinction created the option for states to provide Medicaid eligibility to recently arrived immigrants who were "unqualified" for federally funded Medicaid. However, states would not receive federal assistance for this (Zimmerman and Tumlin 1999). Overall, the PROWRA delegated a great deal of authority to the states, specifically

[2] "Qualified" immigrants include groups such as asylees; refugees; lawful permanent residents; Cubans; Haitians; aliens paroled into the U.S. for at least one year; aliens whose deportations are being withheld; aliens granted conditional entry; battered alien spouses, battered alien children, the alien parents of battered children, and alien children of battered parents who fit certain criteria; and victims of a severe form of human trafficking (Department of Health and Human Services 2009). These protected groups are eligible for certain welfare state services during their initial years in the U.S., including Medicaid services for their first seven years in the U.S. (Zimmerman and Tumlin 1999).

providing states with the option to set eligibility requirements for recently arrived, "unqualified" immigrants who have been in the U.S. for less than five years (Light 2010; Reese, et al. 2013; Zimmerman and Tumlin 1999).[3]

In response to the passage of the PRWORA, states either expanded or limited Medicaid services for recently arrive immigrants. For example, California continued to provide Medicaid coverage to recently arrive immigrants after 1996 (Ku 1997). Other states, such as Alabama, Georgia, and Idaho, did not exercise the option to provide Medicaid services to recently arrive immigrants (Zimmerman and Tumlin 1999). Since 1996, some states have allowed "unqualified" immigrant eligibility under health care programs that provide limited services. For example, in 1997 Connecticut began offering health care services to recently arrived immigrants through the state's State Medical Assistance for Noncitizens (SMANC) (Cohen 2011). In Massachusetts, recently arrive immigrants are eligible for MassHealth Basic on the same basis as citizens. However, MassHealth Basic offers fewer services than the state's Medicaid program, MassHealth Standard (Bachrach et al. 2001).

Table 2. Timeline of Medicaid Measures

Year	Measure	Implications on unqualified, post-enactment immigrants
1996	Personal Responsibility and Work Opportunity Act (PROWRA)	Created state option to provide Medicaid services to group with state-only funds
1997	State Children's Health Insurance Program (SCHIP)	None. Unqualified immigrant children remained ineligible for SCHIP services
2002	Department of Health and Human Services SCHIP expansion	None. Regulation provides services to pregnant woman, but covers unborn child who does not have immigrant

[3] Undocumented immigrants did not qualify for Medicaid services before or after the passage of the PRWORA.

		status.
2009	Children's Health Insurance Program Reauthorization Act (CHIPRA)	Allows state to receive matching federal funds if state decides to cover unqualified immigrant children and/or pregnant women

Table 2 summarizes measures related to Medicaid and their implications on unqualified, post-enactment immigrants. Since 1996, policies have been enacted to protect certain immigrant groups. The year after the PRWORA was passed, Congress enacted the State Children's Health Insurance Program (SCHIP), which expanded health care eligibility to low-income families that did not qualify for Medicaid. SCHIP gave states the option to expand eligibility for children under Medicaid or create a separate child health program (Dubay et al 2002). However, due to PRWORA restrictions, "unqualified" immigrant children remained ineligible for federally funded SCHIP services (Kaiser 2009). In 2002, the Department of Health and Human Services (HHS) expanded SCHIP services to include prenatal services for immigrant pregnant women during five-year ban. HHS did this through regulation by clarifying that states may choose to cover children from conception to age 19 (U.S. Department of Health and Human Services 2002; Dailard 2002). In 2009, Congress expanded health care services for immigrant children and pregnant women by passing the Children's Health Insurance Program Reauthorization Act (CHIPRA). Under this Act, states can receive matching federal funds if they decide to cover immigrant children and pregnant women under Medicaid or CHIP (Kaiser 2009).

Due to changes in federal policy and data availability, this paper will include state-only coverage for immigrant children and/or pregnant women who have been in the U.S. for less than five years before 2009 as expansive Medicaid coverage without federal incentives. Although states were given a federal incentive in 2002 to cover offer prenatal

services to immigrant pregnant women, these services specifically cover the unborn child who is a U.S. citizen and not the mother who is not a U.S. citizen. This paper will include state coverage for immigrant children and pregnant women after 2009 as expansive Medicaid coverage with federal incentives since states that opt to provide this service receive matching federal funds. Analyses before and after the 2009 Act will allow for the controlling of federal incentives.

Data

To measure how state immigration demographics shape Medicaid policy, I draw upon three distinct sources of data. A 2009 Henry J. Kaiser Family Foundation report, "New Federal Funding Available to Cover Immigrant Children and Pregnant Women," was used for the 2008 dependent variable. This report provides information on states that use state-only funds to cover lawfully residing children and/or pregnant women who have been in the U.S. for less than five years. Although this report was published in 2009, the data used was updated in September 2008.

Information for the 2011 dependent variable was taken from a 2012 issue brief from the Department of Health and Human Services (DHHS) entitled "Overview of Immigrants' Eligibility for SNAP, TANF, Medicaid, and CHIP." This brief provides information, as of 2011, on states that exercise the CHIPRA options for children and pregnant women as well as states that provide state-only funding for immigrants who have been in the U.S. for less than five years. In addition, 2012 and 2013 reports from the Georgetown University Policy Institute entitled "Coverage of Lawfully-Residing Immigrant Children and Pregnant Women without a 5-Year Waiting Period" were used for the dependent variable. The 2012 and 2013 reports were used because some states in 2011

were awaiting approval from the Centers for Medicare and Medicaid Services (CMS) to exercise the CHIPRA option. The two reports confirm CMS approval for states to exercise this option. Data and notes for the dependent variables can be found in the appendix.

Although different sources are used for the 2008 and 2011 variables, all of the sources provide information regarding state-level Medicaid eligibility for "unqualified" immigrant children and pregnant women.

The American Community Survey (ACS) was used for the demographic variables and economic control variable. The methodology section of this paper elaborates on the way in which each demographic and economic variable was constructed.

Data from these sources will allow for a comprehensive examination of Medicaid policy and demographic conditions at the state level. However, the Census data does have limitations. Since the census data is self-reported and respondents can opt of identifying with certain categories, counts of racial groups in each state may not be an accurate measure of total immigrants, Latino immigrants, and Asian immigrants. Nevertheless, data from the census allows for a relatively comprehensive analysis of racial and ethnic demographics.

Political control variables including legislative professionalism, citizen ideology, state government ideology, and state party liberalism were collected from Peverill Squire (2007), William D. Berry and colleagues (2010a), and Jason Sorens and colleagues (2008). The next section elaborates on these political control variables. Medicaid spending per capita is also used to control for Medicaid generosity by state.

Methodology

This paper uses logistic regression to explore the demographic conditions that lead states to adopt expansive Medicaid eligibility for immigrants in 2008 and 2011. These two years capture state policies before and after the availability of the CHIPRA option. This will allow for the controlling of federal incentives with an examination of the demographic conditions that lead states to adopt expansive Medicaid policies without matching federal funds and with federal matching funds. The unit of analysis will be states.[4]

Figure 1 below illustrates the hypothesized relationship between the dependent variable and independent variables. The dependent variable in this analysis will be expansive Medicaid coverage for immigrants. This will be defined as state-level eligibility for lawfully residing pregnant women and/or children who have been in the U.S. for less than five years. The dependent variables will be dichotomous variables with "0" indicating restrictive Medicaid policies for immigrants and "1" indicating expansive Medicaid policies for immigrants.

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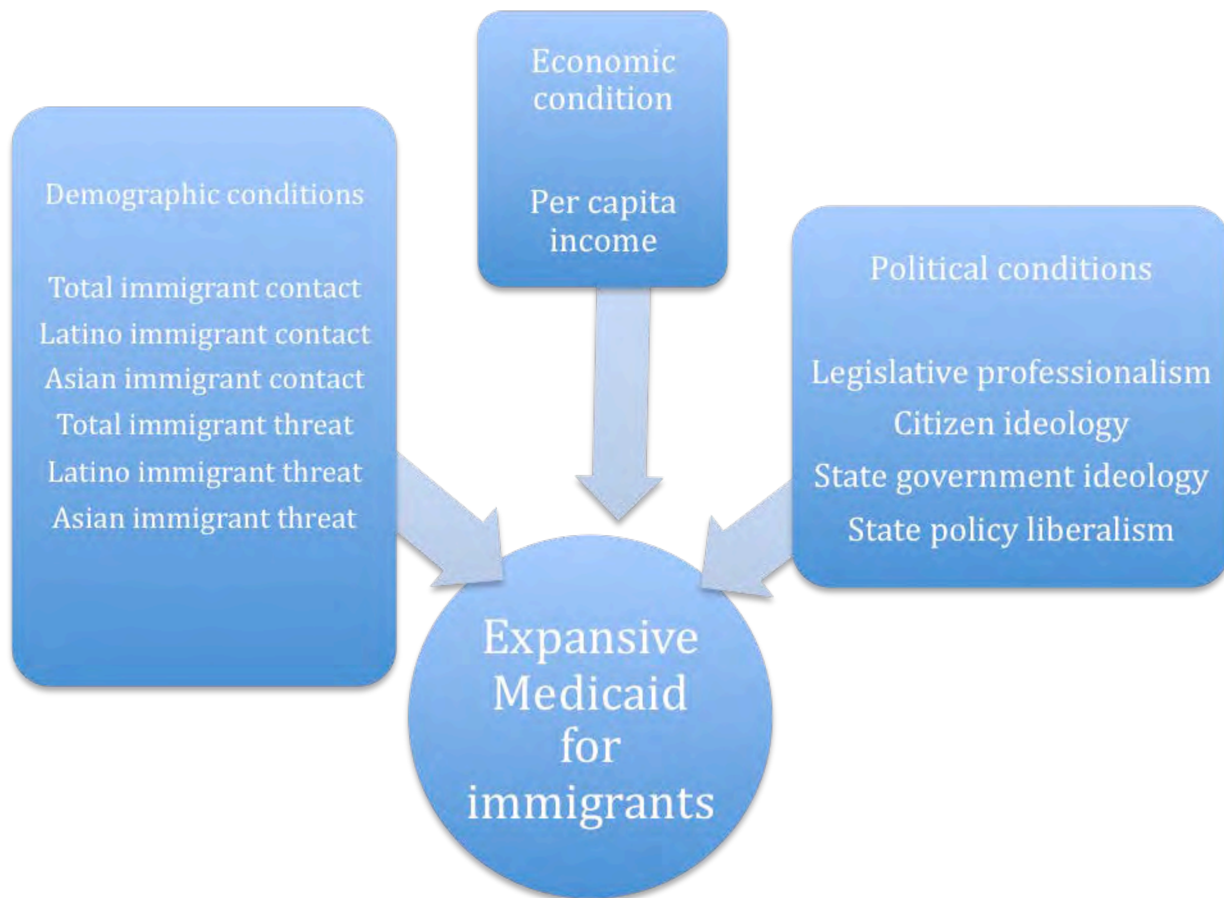
[4] Territories and the District of Columbia are excluded from the analyses due to lack of data for political control variables.

Independent Variables and Hypotheses

Figure 1. Conditions Affecting Expansive Medicaid for Immigrants



Each demographic, economic, condition will be calculated for 2008 and 2011. Total immigrants, Latino immigrants, and Asian immigrants are calculated with total foreign-born, total foreign-born from Latin America, and total foreign-born from Asia.[5] Total immigrant contact, Latino immigrant contact, and Asian immigrant contact are operationalized as the total foreign-born population, Latino foreign-born population, and Asian foreign-born population in each state divided by total population in each state. Total immigrant threat, Latino immigrant threat, and Asian immigrant threat will be measured as

[5] Minus those from Western Asia because it is unclear whether individuals from Western Asia are perceived as Asian

percent change in total foreign-born, Latino foreign-born, and Asian foreign-born from 2000 to 2008 and 2000 to 2011. These measures for immigrant contact and threat are consistent with scholarship that has tested Allport's contact hypothesis and Key's threat hypothesis (Boushey and Luedtke 2011, Fox 2004).[6] In addition, these measures capture the ideas of contact and threat originally put forth by Allport, Key, and Blumer. Operationalizing contact in this manner captures prolonged instead of brief contact between immigrants and the native-born population. Threat is measured in this manner because it captures the extent to which the native-born population views their world as changing.

Per capita income for each state will be used as an economic control variable since research has show that states that provide expansive Medicaid services do require the financial capacity to do so. Zimmerman and Tumlin (1999) find that "states with higher per capita income are generally more likely to provide assistance [to immigrants] than states with lower per capita incomes" (4). At the same time, the authors find that states with budget surpluses were not more likely to provide expansive welfare services for immigrants after the 1996 act. Therefore, I expect that states with higher per capita incomes will be slightly more likely to provide expansive Medicaid eligibility.

A measure developed by Squire (2002) will be used to control for legislative professionalism. This measure is "based on legislator pay, number of days in session, and staff per legislator, all compared to those characteristics in Congress during the same year" (Squire 2002, 221). Scores range from 0 to 1 with higher scores indicating higher levels of

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[6] Although the ACS provides annual data on the foreign-born population from 2005 through 2011 and percent change over a one to three year period can be calculated, percent change in foreign-born population from 2000 to 2008 and 2000 to 2011 are used to capture threat at the state-level over a period of time.

legislative professionalism. This paper will use Squire 2003 measure of legislative professionalism because measures are only available for 1979, 1986, 1996 and 2003. Since rankings of legislative professionalism between states do not change greatly between these four years, this paper will use legislative professionalism as a relatively fixed measure. I expect that states with more professionalized legislatures are more likely to have expansive Medicaid policies because Medicaid is a complicated issue and immigrant exclusion from Medicaid can be costly due to the requirement of universal access to emergency care (Filindra 2013).

Measures developed by Berry and colleagues (1998, 2010a, 2013) will be used to control for citizen ideology and state government ideology. State level ideological preferences are related to state policies in a predictable way and those elected to state legislatures are, arguably, reflections of state ideological preferences (Wright Jr. et al. 1987).

Berry et al.'s measure of citizen ideology was constructed using interest groups scores from the Americans for Democratic Action (ADA) and the AFL-CIO Committee on Political Education (COPE). Citizen ideology scores range from 0 to 100 with higher scores indicating a more liberal citizenry. The authors' measure of state government ideology is based on roll call votes and is the central tendency of the following five institutional actors: Democrats in the state house, Democrats in the state senate, Republicans in the state house, Republicans in the state senate, and the Governor. The Governor's ideological position is defined as the central tendency of the Governor's party members. This measure was created in 1998 with ADA/COPE scores and was updated in 2010 using Poole's (2008) NOMINATE coordinates for congressional members. Berry et al. have proposed an updated

state government ideology indicator developed from Boris Shor and Nolan McCarty's (2011) state ideology indicator, which is based on state and federal roll call voting data as well as data from state and federal legislative candidate responses in the Project Votesmart's National Political Awareness Test (NPAT). However, data for Berry et al.'s latest measure is not available online. I hypothesize that liberal citizen and state government ideologies will increase the likelihood of providing expansive Medicaid eligibility.

A measure developed by Sorens and colleagues (2008) will be used to control for state policy liberalism. The authors created this measure with over 170 policy variables, including state-level statutes as well as fiscal and law enforcement data. This measure ranges from conservative to liberal with higher scores given to states with more liberal policies. I expect that higher policy liberalism scores will increase the likelihood of states adopting expansive Medicaid policies.

State Medicaid spending per capita will be used to control for Medicaid spending generosity. This measure has been used by Hero (2003) to measure Medicaid generosity by state. I hypothesize that states with higher Medicaid spending per capita will be more likely to provide Medicaid eligibility for immigrants. Data for Medicaid spending per capita was gathered from the Center for Medicaid and Children's Health Insurance Program (CHIP) Services (CMCS). The measure is calculated as total federal and state Medicaid spending per capita in 2008. Due to lack of data regarding Medicaid spending in 2011, a 2008 measure is used for both 2008 and 2011. I expect that states with relatively generous Medicaid spending will be more likely to provide expansive Medicaid policies.

Findings and Discussion

Table 3. Determinants of Medicaid Eligibility for Immigrants for 2008 (Reported in Odds Ratios)

Independent Variable	Model 1 Total foreign-born	Model 2 Total foreign-born with controls	Model 3 Latino foreign-born	Model 4 Latino foreign-born with controls	Model 5 Asian foreign-born	Model 6 Asian foreign-born with controls
Immigrant Contact						
Total	**1.2685*** **	1.0892	--	--	--	--
	(0.0970)	(0.1459)	--	--	--	--
Latino	--	--	1.1175	1.0245	--	--
	--	--	(0.1056)	(0.1790)	--	--
Asian	--	--	--	--	**4.1963*** **	2.6710
	--	--	--	--	(1.8462)	(2.2970)
Threat						
Total	**0.9506***	1.0219	--	--	--	--
	(0.0272)	(0.0447)	--	--	--	--
Latino	--	--	0.9831	0.9835	--	--
	--	--	(0.0140)	(0.0213)	--	--
Asian	--	--	--	--	**0.9342****	**0.9238***
	--	--	--	--	(0.0306)	(0.0435)
Control Variable						
Per capita income	--	**1.0004***	--	**1.0004***	--	1.0002
	--	(0.0002)	--	(0.0002)	--	(0.0003)
Legislative professionalism	--	0.5661	--	0.1803	--	0.0046
	--	(3.6427)	--	(1.1916)	--	(0.0365)
Citizen ideology	--	1.0308	--	1.0325	--	1.0529
	--	(0.0799)	--	(0.0747)	--	(0.0818)

State government ideology	--	0.9706	--	0.9607	--	0.9459
	--	(0.0289)	--	(0.0303)	--	(0.0365)
State policy liberalism	--	1.4844	--	1.5594	--	1.5438
	--	(0.4721)	--	(0.4695)	--	(0.5816)
Medicaid spending per capita	--	1.0017	--	1.0007	--	1.0013
	--	(0.0028)	--	(0.0025)	--	(0.0029)
Constant	0.2801	**9.71e-07****	0.7634	0.0000	0.2436	0.0008
	(0.2721)	(7.69e-06)	(0.7414)	(0.0001)	(0.2621)	(0.0061)
N	50	50	50	50	50	50
Chi-square	19.34	35.68	5.84	35.81	28.02	39.98
Prob > chi-square	0.0001	0	0.0539	0	0	0
Degrees of freedom	2	8	2	8	2	8
Pseudo-R2	0.3017	0.5567	0.0911	0.5586	0.4372	0.6237

Entries are odds ratios. Standard errors in parentheses.
*** p<0.01, ** p<0.05, * p<0.1

Table 4. Determinants of Medicaid Eligibility for Immigrants for 2011 (Reported in Odds Ratios)

Independent Variable	Model 1 Total foreign-born	Model 2 Total foreign-born with controls	Model 3 Latino foreign-born	Model 4 Latino foreign-born with controls	Model 5 Asian foreign-born	Model 6 Asian foreign-born with controls
<u>Immigrant Contact</u>						
Total	**1.1542****	1.2216	--	--	--	--
	(0.0806)	(0.1810)	--	--	--	--
Latino	--	--	1.0449	1.2502	--	--
	--	--	(0.1031)	(0.2007)	--	--
Asian	--	--	--	--	**2.1689****	1.2171
	--	--	--	--	(0.6620)	(0.5718)
<u>Immigrant Threat</u>						
Total	**0.9562****	0.9862	--	--	--	--
	(0.0181)	(0.0291)	--	--	--	--
Latino	--	--	**0.9836***	0.9883	--	--
	--	--	(0.0090)	(0.0142)	--	--
Asian	--	--	--	--	**0.9679***	0.9890
	--	--	--	--	(0.0168)	(0.0226)
Control Variable						
Per capita income	--	1.0002	--	1.0003	--	1.0002
	--	(0.0002)	--	(0.0002)	--	(0.0002)
Legislative professionalism	--	13.6061	--	6.9557	--	3.4853
	--	(76.1032)	--	(38.3836)	--	(19.4342)
Citizen ideology	--	0.9824	--	0.9894	--	1.0321
	--	(0.0697)	--	(0.0598)	--	(0.0600)

State government ideology	--	1.0557	--	**1.0537***	--	1.0271
	--	(0.0357)	--	(0.0317)	--	(0.0253)
State policy liberalism	--	1.0473	--	1.1741	--	1.1573
	--	(0.3085)	--	(0.3000)	--	(0.3180)
Medicaid spending per capita	--	1.0017	--	1.0018	--	1.0000
	--	(0.0024)	--	(0.00222	--	(0.0020)
Constant	2.3069	**0.0000***	2.7547	9.95e-06	1.2364	0.0006
	(2.4902)	(0.0001)	(2.6189)	(0.0001)	(1.3036)	(0.0034)
N	50	50	50	50	50	50
Chi-square	16.40	33.52	6.53	34.74	16.44	31.73
Prob > chi-square	0.0003	0	0.0382	0	0.0003	0.0001
Degrees of freedom	2	8	2	8	2	8
Pseudo-R2	0.2365	0.4836	0.0942	0.5012	0.2371	0.4578

Entries are odds ratios. Standard errors in parentheses.
*** p<0.01, ** p<0.05, * p<0.1

Tables 3 and 4 report the 2008 and 2011 results for the analyses in odds ratios. Models 1, 3, and 5 in both tables test contact and threat for immigrants, Latino immigrants, and Asian immigrants separately. Models 2, 4, and 6 in both tables test contact and threat for each of the groups with economic and political control variables.[7]

Table A.1 in the Appendix shows that a total of 17 states provided expansive Medicaid for immigrants with state-only funds in 2008 and 25 states provided expansive Medicaid for immigrants in 2011 with state and federal funds. All 17 states in 2008 exercised the option to provide expansive Medicaid in 2011 with federal assistance. An additional eight states adopted expansive Medicaid policies in 2011. This increase indicates that states are responsive to federal incentives. On average, these eight states have lower contact and higher threat with total immigrants, Latino immigrants, and Asian immigrants than the national average. This suggests that the 2009 Act incentivized states with relatively low contact and relatively high levels of immigration from these groups to adopt expansive Medicaid eligibility.

The results in Table 3 support the contact and threat hypotheses for total immigrants and Asian immigrants, but not for Latino immigrants. Models 1 and 5 show that higher levels of contact with total immigrants and Asian immigrants significantly increase the odds of a state providing expansive Medicaid eligibility. The size of the odds ratio for Asian immigrant contact is much larger than the size of the odds ratio for total immigrant contact, suggesting that Asian immigrant contact has a more substantively significant relationship with expansive Medicaid policies. These Models also show that increases in total immigrant threat and Asian immigrant threat significantly decrease the

[7] I conducted the analyses in this manner because my N is too small to test threat and contact for all groups in one model.

odds of a state providing expansive Medicaid. When economic and political controls are added, Asian immigrant threat remains statistically significant. However, when economic and political controls are added, total immigrant contact and threat and Asian contact do not have a significant relationship with the dependent variable.

The social construction hypothesis is supported in Table 3 with the lack of significance for Latino immigrant contact in Models 3 and 4 and the large magnitude of the significant relationship between Asian immigrant contact and expansive Medicaid eligibility in Models 5. This suggests that Asian immigrant contact increases the likelihood of a state providing expansive Medicaid services more than Latinos.

Per capita income is also a significant variable in the Latino and Asian models. Although per capita income is a significant variable, it barely increases the odds of a state providing expansive Medicaid eligibility. This conflicts with Zimmerman and Tumlin's (1999) finding that states with higher per capita incomes are more likely to provide welfare state services for immigrants. Instead, Models 2 and 4 in Table 3 indicate that per capita income significantly does not increase or decrease the odds of a state providing expansive Medicaid eligibility for immigrants.

The results in Table 4 provide a robustness check to observe the relationship between contact and threat when federal incentives are provided for states to adopt expansive Medicaid policies for immigrants. Overall, Table 4 confirms the findings in Table 3. The contact hypothesis is supported for total immigrants and Asian immigrants, but not Latino immigrants in Models 1 and 5. Like Table 3, Models 1 and 5 in Table 4 show that higher levels of contact with total immigrants and Asian immigrants significantly increase the odds of a state providing expansive Medicaid eligibility. Again, the relatively large odds

ratio for Asian immigrant contact suggests that variable has a larger substantive relationship with expansive Medicaid than total immigrant contact. The threat hypothesis is supported in Models 1, 3, and 5, which show that increases in total immigrant threat, Latino immigrant threat, and Asian immigrant threat significantly decrease the odds of a state providing expansive Medicaid. Similar to Table 3, the social construction hypothesis is supported in Table 4 with the lack of significance for Latino immigrant contact in Models 3 and 4 and the magnitude of the significant relationship between Asian immigrant contact and expansive Medicaid eligibility in Model 5.

The contact and threat hypotheses regarding total immigrant contact, Asian immigrant contact, total immigrant threat, and Asian immigrant threat are supported in Tables 3 and 4. Model 3 in Table 4 also supports the threat hypothesis for Latino immigrants. The social construction hypothesis also finds support in Tables 3 and 4 with the significant and relatively large odds ratio for Asian immigrant contact and insignificant odds ratio for Latino immigrant contact.

Although most of the demographic variables are not significant after controlling for economic and political condition, the relationships between the demographic variables and expansive Medicaid eligibility are all in the hypothesized directions. In other words, contact from total immigrants, Latino immigrants, and Asian immigrants increases the odds of a state providing expansive Medicaid eligibility, while threat from the total immigrants decreases the odds of a state providing expansive Medicaid eligibility. The lack of significance when controlling for economic and political conditions could be due, in part, to the small number of observations.

The main contribution of this paper is the finding that different groups of immigrants have different relationships state-level policies for immigrants. Scholars have indicated that higher levels of total immigrant contact increases the likelihood of states passing policies that incorporate immigrants, while higher levels of total immigrant threat increases the likelihood of states passing policies that exclude immigrants (Boushey and Luedtke 2011). This paper adds nuance to this scholarship by demonstrating that Latino immigrants and Asian immigrants have different relationships with state-level policies. Table 3 suggests that in 2008, Asian immigrant contact and threat are driving the relationships between total immigrant contact, total immigrant threat, and state policies for immigrants. When controlling for federal incentives, Table 4 indicates that Asian contact is driving the positive relationship between total immigrant contact and expansive state policies.

More broadly, these findings suggest that contact with Asian immigrants mediates threat and creates a relatively positive social construction of the group when compared to Latino immigrants. The finding that Latino immigrants do not fit this pattern suggests that positive social constructions of the group are not crystallizing in areas with high Latino immigrant concentration.

Conclusion

In sum, this paper merges literatures on threat, contact, and social construction and adds nuance to literature regarding the determinants of state-level policies. Specifically, this paper finds that Latino and Asian immigrants have different relationships with state-level policies that incorporate and exclude immigrants and Asian contact is driving the positive relationship between total immigrant contact and inclusive state-level policies.

Although this paper provides nuance to existing literature, this nuance can be explored further.

This paper describes the demographic conditions under which states adopt expansive Medicaid policies for immigrants. Although mechanisms for the adoption of state polices are built into the contact and threat hypotheses, this paper does not further elaborate on *why* states with different demographic conditions respond with different state-level policies. This paper also assumes that Latinos and Asians are constructed similarly across all states and does not address how immigrants, Latino immigrants, and Asian immigrants are perceived and constructed at a state-level. Future research should examine how the construction of different racial and ethnic immigrant groups affects state-level Medicaid eligibility for immigrants since construction of groups as deserving and undeserving has been found to shape policies (Schneider and Ingram 1993).

The findings in this paper also show that states are responsive to federal incentives, but states are not responsive under the expected demographic conditions. On average, the eight states that exercised the 2009 CHIPRA option were states with relatively low levels of contact and relatively high levels of threat from total immigrants, Latino immigrants, and Asian immigrants. Future research could examine these states more in-depth to understand *why* these states are responsive to federal incentives in this policy arena.

Medicaid can also be further explored as a case to examine questions related to immigrant access to health care and the adoption of state-level policies over time. Future research should examine demographic conditions with a more nuanced understanding of health care eligibility for immigrants. I have looked at Medicaid eligibility for immigrant pregnant women and children, but future research could look at these separately in effort

to differentiate between states' treatments of these groups. In addition, future research could also look at state-level health care programs, such as those mentioned in "Medicaid and State Option" section of this paper to explore whether newly arrived immigrants have access to health care through programs other than Medicaid.

Appendix

Table A.1 Medicaid Eligibility for Immigrant Children and/or Pregnant Women

State	2008	2011
Alabama	0	0
Alaska	0	0
Arizona	0	0
Arkansas	0	0
California	1	1
Colorado	0	1
Connecticut	1	1
Delaware	1	1
Florida	0	0
Georgia	0	0
Hawaii	1	1
Idaho	0	0
Illinois	1	1
Indiana	0	0
Iowa	0	1
Kansas	0	0
Kentucky	0	0
Louisiana	0	0
Maine	1	1
Maryland	1	1
Massachusetts	1	1
Michigan	0	0
Minnesota	1	1
Mississippi	0	0
Missouri	0	0
Montana	0	1
Nebraska	1	1
Nevada	0	0
New Hampshire	0	0
New Jersey	1	1
New Mexico	0	1
New York	1	1
North Carolina	0	1
North Dakota	0	0
Ohio	0	0
Oklahoma	0	0
Oregon	0	1
Pennsylvania	1	1
Rhode Island	1	1

South Carolina	0	0
South Dakota	0	0
Tennessee	0	0
Texas	1	1
Utah	0	0
Vermont	0	1
Virginia	1	1
Washington	1	1
West Virginia	0	0
Wisconsin	0	1
Wyoming	0	0
Total	17	25

*Illinois and Vermont received approval from the Centers for Medicare and Medicaid Services (CMS) to exercise the CHIPRA option in 2011. Pennsylvania received approval from the CMS to exercise the CHIPRA option in 2012.

Table A.2 2008 Demographic Conditions

State	% foreign-born	% Latino foreign-born	% Asian foreign-born	% change foreign-born	% change Latino foreign-born	% change Asian foreign-born
United States	12.5	6.6	3.1	22.0	25.3	25.9
Alabama	2.8	1.4	0.7	50.0	87.9	36.6
Alaska	6.5	1.2	3.3	19.2	23.4	22.0
Arizona	14.3	10.2	1.7	42.1	41.2	60.3
Arkansas	3.8	2.5	0.7	48.3	66.4	31.8
California	26.8	14.7	8.7	11.2	9.4	17.6
Colorado	10.1	5.8	1.9	34.9	39.5	36.1
Connecticut	13.0	5.3	2.6	22.7	44.2	41.2
Delaware	7.7	3.3	2.2	48.8	65.3	50.1
Florida	18.5	13.7	1.6	27.0	28.8	48.9
Georgia	9.4	5.0	2.2	57.7	62.5	54.1
Hawaii	17.8	1.2	13.3	8.1	126.9	-2.8
Idaho	5.9	3.4	1.1	39.7	33.8	119.3
Illinois	13.8	6.6	3.1	16.6	16.5	24.5
Indiana	4.0	2.0	1.0	37.3	62.7	41.6
Iowa	3.7	1.5	1.2	23.3	37.4	25.2
Kansas	5.9	3.3	1.5	21.8	24.4	20.6
Kentucky	2.8	1.1	0.8	48.9	82.2	41.0
Louisiana	3.1	1.4	1.0	16.2	33.9	14.3
Maine	3.0	0.2	0.6	7.3	15.4	26.0
Maryland	12.4	4.6	3.8	34.6	46.7	25.3
Massachusetts	14.4	5.0	3.7	21.2	39.8	31.0
Michigan	5.8	1.1	1.8	11.3	28.0	27.4
Minnesota	6.5	1.8	2.3	30.8	50.2	18.9
Mississippi	2.1	1.0	0.5	51.7	110.3	17.6

Missouri	3.6	1.1	1.1	42.3	72.8	38.5
Montana	2.2	0.3	0.6	29.8	79.9	92.5
Nebraska	5.5	3.1	1.1	31.1	39.3	11.0
Nevada	18.9	11.5	4.3	55.0	53.7	64.7
New Hampshire	5.0	1.1	1.4	21.1	81.9	55.4
New Jersey	19.8	8.9	5.7	16.4	22.1	32.9
New Mexico	9.6	7.6	0.9	27.7	30.9	34.1
New York	21.7	10.7	5.0	9.5	10.4	18.1
North Carolina	7.0	4.1	1.4	49.1	58.7	44.5
North Dakota	2.3	0.3	0.6	23.9	21.4	47.7
Ohio	3.7	0.7	1.2	25.9	76.6	27.5
Oklahoma	5.0	2.9	1.2	39.1	56.3	20.1
Oregon	9.7	4.5	2.5	26.5	33.1	23.6
Pennsylvania	5.3	1.4	1.8	29.9	71.3	31.0
Rhode Island	12.2	5.4	1.7	7.7	29.7	4.0
South Carolina	4.4	2.2	0.9	68.2	103.2	40.0
South Dakota	1.9	0.5	0.6	10.4	71.6	16.4
Tennessee	4.0	1.9	1.0	56.3	81.6	40.8
Texas	16.0	11.8	2.5	34.1	32.6	41.3
Utah	8.3	5.0	1.3	42.7	56.0	35.5
Vermont	3.9	0.4	1.0	5.5	82.9	52.0
Virginia	10.2	3.7	3.9	39.5	51.5	38.6
Washington	12.3	3.8	4.7	30.9	41.8	31.9
West Virginia	1.3	0.4	0.5	20.0	166.8	15.9
Wisconsin	4.4	1.8	1.3	27.8	53.0	19.5
Wyoming	2.3	1.1	0.5	10.4	30.9	36.4

Table A.3 2011 Demographic Conditions

State	% foreign-born	% Latino foreign-born	% Asian foreign-born	% change foreign-born	% change Latino foreign-born	% change Asian foreign-born
United States	13.0	6.8	3.4	29.8	32.1	40.5
Alabama	3.4	1.9	0.9	85.3	150.8	71.5
Alaska	7.1	1.2	3.6	38.8	24.9	41.5
Arizona	13.4	8.8	2.1	32.8	21.3	94.6
Arkansas	4.4	2.8	0.9	74.8	91.4	68.0
California	27.0	14.4	9.2	15.0	10.4	27.6
Colorado	9.7	5.4	1.9	33.8	34.6	45.2
Connecticut	13.4	5.5	2.9	29.3	52.7	62.1
Delaware	8.4	3.5	2.4	70.1	79.2	71.7
Florida	19.4	14.6	1.7	38.6	42.8	59.2
Georgia	9.6	5.2	2.4	63.3	69.5	71.9
Hawaii	17.9	0.8	14.0	16.0	58.5	9.6
Idaho	6.0	3.5	1.1	48.9	45.9	138.0
Illinois	14.0	6.7	3.4	17.6	17.1	36.6

Indiana	4.7	2.3	1.3	64.7	90.9	80.4
Iowa	4.4	1.7	1.4	46.6	62.3	49.8
Kansas	6.9	3.8	1.9	47.5	47.9	48.9
Kentucky	3.2	1.2	1.0	74.9	110.5	70.1
Louisiana	3.8	2.0	1.1	50.0	95.8	27.2
Maine	3.2	0.3	0.8	16.5	81.2	51.4
Maryland	13.9	5.6	4.3	56.6	85.3	46.8
Massachusetts	14.9	5.3	3.9	27.2	51.4	42.0
Michigan	6.1	1.1	1.8	15.3	26.3	30.8
Minnesota	7.3	2.0	2.5	49.3	74.8	33.9
Mississippi	2.2	1.2	0.6	63.0	138.0	37.4
Missouri	4.0	1.2	1.3	60.9	91.9	63.1
Montana	2.0	0.2	0.5	22.3	34.1	53.3
Nebraska	6.3	3.6	1.6	55.6	65.4	62.0
Nevada	19.2	11.3	5.0	65.0	58.5	100.6
New Hampshire	5.6	1.1	1.8	36.4	93.0	92.3
New Jersey	21.5	9.9	6.2	28.2	37.6	47.2
New Mexico	10.1	8.1	1.0	41.1	46.1	51.4
New York	22.2	10.9	5.5	11.6	12.4	29.4
North Carolina	7.3	4.3	1.6	64.7	71.5	73.3
North Dakota	2.4	0.2	0.9	37.2	1.0	127.7
Ohio	4.0	0.8	1.3	34.5	99.3	45.1
Oklahoma	5.5	3.3	1.3	58.5	85.8	31.2
Oregon	9.8	4.6	2.7	30.3	36.7	37.5
Pennsylvania	5.9	1.8	2.1	48.8	124.2	57.8
Rhode Island	13.5	6.2	2.1	18.7	48.3	29.3
South Carolina	4.7	2.5	1.0	91.4	140.3	67.7
South Dakota	2.7	0.9	0.7	63.1	197.0	56.8
Tennessee	4.8	2.3	1.1	92.9	130.0	62.5
Texas	16.4	11.8	2.8	44.9	39.7	66.5
Utah	8.4	5.2	1.3	50.0	66.6	43.4
Vermont	3.9	0.5	0.9	4.3	146.5	48.1
Virginia	11.1	4.0	4.2	57.9	72.7	57.8
Washington	13.3	4.1	5.1	48.0	60.6	49.2
West Virginia	1.3	0.3	0.5	22.9	123.8	13.4
Wisconsin	4.7	1.9	1.4	39.2	61.9	36.3
Wyoming	3.2	2.0	0.6	64.1	153.1	50.8

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