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State Policymaking and Stated Reasons: Prenatal Care for Undocumented Immigrants in an Era of Abortion Restriction

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Policy Points:

- States can create policies that provide access to publicly funded prenatal care for undocumented immigrants that garner support from diverse political coalitions.
- Policymakers have used a wide range of moral and practical reasons to support the expansion of care to this population, which can be tailored to frame prenatal policies for different stakeholder groups.

Context: Even though nearly 6% of citizen babies born in the United States have at least one undocumented parent, undocumented immigrants are ineligible for most public health insurance. Prenatal care is a recommended health service that improves birth outcomes, and some states, including both traditionally "blue" and "red" states, have opted to provide publicly funded coverage for prenatal services for people who are otherwise ineligible due to immigration status. This article explores how courts and legislatures in three states have approached the question of publicly funded prenatal care for undocumented immigrants and its relationship to the abortion debate, with a particular focus on the moral and practical justifications that policymakers employ.

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Methods: We employed a review and qualitative analysis of the documents that comprise the legislative histories of prenatal policies in three case states: California, New York, and Nebraska.

Findings: This review and analysis of policy documents identified moral reasons based on appeals to different conceptions of moral status, respect for autonomy, and justice, as well as prudential reasons that appealed to the health and economic benefits of prenatal care for US citizens and legal residents. We found that much of the variation in reasons supporting policies by state can be traced to the state's position on the protection of reproductive rights and whether the policymakers in each state supported or opposed access to abortion. Interestingly, despite these differences, the states arrived at similar prenatal policies for immigrants.

Conclusions: There may be areas where policymakers with different political orientations can converge on health policies affecting access to care for undocumented immigrants. Future research should explore the reception of various message frames for expanding public health insurance coverage to immigrants in other contexts.

Keywords: undocumented immigrants, prenatal care, pregnancy, state policy, abortion, reproductive rights, Medicaid.

Approximately 10.7 million individuals in the United States, or about 3.3% of the population, are undocumented.[1] In addition, 6% of the 4.0 million citizens born in the United States in 2016 had at least one parent who was an undocumented immigrant.[2] Under the Fourteenth Amendment to the US Constitution, all children born within the borders of the United States are legal citizens, regardless of their parents' immigration status. Even so, undocumented pregnant immigrants are less likely to access adequate prenatal care than are pregnant citizens. Among the reasons are "financial difficulties; lack of insurance coverage among poor, un- and underemployed populations; structural barriers that impair efforts to locate providers, and make and keep appointments; and psychosocial obstacles that make women reluctant to trust or rely upon healthcare professionals."[3] Several of these barriers, particularly the financial ones, are a result of US government policy. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, also known as welfare reform) bars most legal immigrants from accessing Medicaid benefits within their

first five years of residence, and it bans the use of federal funds to provide health care to undocumented immigrants except in specific emergency circumstances. In addition, the Affordable Care Act bars undocumented immigrants from purchasing private insurance in the state and federal insurance exchanges.[4]

Despite these federal barriers to care for undocumented immigrants, one federal regulation offers a way for states to insure undocumented immigrants during pregnancy. In 2001, the Bush administration promulgated a new State Children's Health Insurance Program (SCHIP) regulation that allows states to define a "targeted low-income child" as anyone from conception to age 19, rather than anyone from birth to age 19.[5] Known as the "unborn child" option (see Appendix, Note on Language), this regulation allows states to adopt this definition through a state plan amendment (SPA) to their CHIP program and provide prenatal care to undocumented pregnant immigrants using federally matched CHIP money when the unborn child is the beneficiary. This means, in effect, that any care not directly applicable to the health of the fetus (such as dental health care for the mother) may not be covered.[5]

The other option left open to states by the 1996 welfare reform to extend coverage to pregnant undocumented immigrants is to adopt an exclusively state-funded program that covers the full range of Medicaid services for financially eligible pregnant people, regardless of immigration status.[6] Nineteen states have implemented either the unborn child option or a separate state policy to cover some health care services for pregnant undocumented immigrants (hereafter termed "prenatal policies").

The political context in which these policy options developed, in the early 2000s, reflected a unique period in American health policy. When both the unborn child option and the state funding of health care for pregnant immigrants began, the Medicaid program was undergoing a dramatic shift in both public perception and populations served. Throughout the 1980s and 1990s, Medicaid incrementally expanded its coverage of pregnant women, and SCHIP was created to be a freestanding entitlement program, a program within Medicaid, or both.[7] The defeat of attempts to block-grant Medicaid and SCHIP in the 1990s also signaled a shift in the political support of public insurance programs, as did President Bill Clinton's full-throated defense of Medicaid as a "broad social entitlement that incorporated the middle class."[7] Following Clinton's efforts to promote the Medicaid program,

President George W. Bush's administration promoted a "compassionate conservative" agenda that upheld the message that "it is compassionate to actively help our citizens in need. It is conservative to insist on accountability and results."[8] The unborn child option emerged against the backdrop of this agenda and the incremental expansion of government health insurance programs, as did the 1996 welfare reform option that allowed states to use their own funds to expand Medicaid coverage to federally excluded populations.

Background

In this article, we explore the arguments used in state policymaking and judicial processes through a review and comparative analysis of three states with different prenatal policies that emerged in the wake of these policy shifts. These states are (1) Nebraska, which adopted the restrictive CHIP option; (2) California, which also adopted the CHIP option but, unlike Nebraska, covers "all medically necessary services"[9]; and (3) New York, one of the only states to use state-only funds. We chose these states because they employ the range of policy options available to states and because all three states have a long history of questioning whether and how to provide prenatal care to undocumented immigrants.

We found that despite the divergent moral and political discourse in each state, all three have nonetheless implemented policies that provide comparable levels of access to most basic prenatal health services for undocumented immigrants. This convergence on substantively similar policy solutions to a practical problem for different reasons suggests that there has been an underappreciated consensus on policy outcomes despite substantial debates about reproductive rights, immigration, Medicaid, and federalism.

Methods

This study employed a content analysis of key documents. The goal of the content analysis was to examine the broader political and moral context of the policies, including the moral and prudential reasons and justifications given by the policymakers, courts, and citizens who argued publicly for or against policies meant to extend access to prenatal care to undocumented immigrants.

Data Collection

We extensively reviewed the legislative and court documents associated with the passage of each case state's prenatal policy bills, including all versions of relevant bills, committee reports on the bills, transcripts of committee hearings at which the bills were discussed, transcripts of the legislative floor debates on the bills, materials and letters compiled by the state legislature supporting or opposing the bills, judicial decisions affecting the state's prenatal policy, and other associated legislative documents.

Data Analysis

The goals of the data analysis were to identify and classify the reasons used to support or oppose each policy. We also reviewed all materials for their use of normative language (language indicating that certain outcomes were better or worse than others, such as appeals to moral or prudential reasons) to determine which were relevant to the research question of what reasons each state used. Key documents that included normative language were imported into NVivo 11 to facilitate qualitative coding.[10] We then coded the documents using an iterative emergent thematic coding scheme in which codes were hierarchically structured to enable moral and prudential reasons to be coded separately. We evaluated the codes throughout the coding process to more accurately reflect the relationships of emerging themes. During the coding process, we wrote memos detailing the themes prevalent in important documents for each state, as well as narrative memos tracing the development of each state policy. Finally, we examined the coded data to find themes, to tally the frequency of themes, and to compare themes across states.

Results

Nebraska, California, and New York all have long histories of providing prenatal care to undocumented immigrants, but the paths taken by each state to reach that result have differed. In Nebraska, the removal of federal Medicaid funding for prenatal care for undocumented immigrants resulted in the state's adoption of the unborn child option in 2012, which returned federal dollars to the state through CHIP. California's path

included several years of state funding, followed by the adoption of the unborn child option in 2005 once statutory language stating that the acceptance of CHIP funding did not affect the beneficiary's reproductive rights was in place. New York had long received federally matched Medicaid funds for the care of pregnant undocumented immigrants. When a federal court struck down that practice in 2001, the state chose to dedicate its own funds to continue to provide the same level of services.

In this section, we explore the reasons that policymakers, judges, and citizens gave in support of or in opposition to the adoption of their current policy. These reasons emerged through our document review of each state's legislative history, although substantially more data were available from the debates and hearings held in Nebraska than in California and New York. Accordingly, the findings from Nebraska are presented more prominently, and those from California and New York provide counterpoints to or reinforcement of those findings.

Reasons are grouped into moral reasons, which are grounded in a moral principle or claim and may generate obligations, and prudential reasons, which are based on normative but nonmoral self-interest claims that "appeal only to the interests of legal residents of the United States."[11] Moral reasons are not necessarily grounded in a comprehensive or coherent ethical framework (although previous research has examined such reasons for providing prenatal care to undocumented immigrants[12]). Prudential reasons encompass public health as well as legal and political reasons as long as the interests of legal residents motivate the claim. We cite the primary documents in this article using a standardized format of state abbreviation, document title, and date (if applicable).

Moral Reasons

In Nebraska, the vote on the unborn child option was frequently framed as a choice between two politically conservative policy agendas: opposition to abortion and illegal immigration. As one state senator put it during debate on the bill that ultimately became Nebraska's prenatal policy, "This issue represents a tension between two points. It's a balancing test. On one side you have the rule of law, and on the other side you have the pro-life position" (NE, LB599 Floor Debate, 4/3/12). This framing neatly divides the moral reasons for supporting or opposing the

policy between arguments over the moral status of the fetus and the right to terminate a pregnancy on the one hand, and arguments over the demands of justice in the context of immigration on the other.

Respect for Autonomy: Moral Status and Reproductive Choice. The most common reason given in the state of Nebraska to support the unborn child option was that it is a pro-life policy at its core. One state senator even described the policy as "the most significant piece of pro-life legislation that we've [dealt with] in several years" (NE, LB599 Floor Debate, 4/3/12). This understanding of the policy likely can be traced to the language of the unborn child option, which, as noted earlier, changes the definition of a CHIP-eligible child to include the period from conception to birth and finds that "unborn children do not have immigration status," so their "eligibility is independent of the mother's eligibility status" (NE, LB 599, 2012). Many Nebraska state senators supported the unborn child option because of this expanded definition of a child. One proponent of the bill noted that "those of us that have been involved in the pro-life movement, we've been waiting to see this in the statute books for a long time" (NE, LB599 Floor Debate, 4/3/12), implying that the legal recognition of fetal personhood is a step toward banning abortion. Indeed, many of the subsequent moral reasons given for supporting the unborn child option hinged on the rights of the unborn.

For some supporters of the policy, the key moral reason that mattered was the recognition of the dignity of the unborn child. One state senator observed that "the fact that we have another opportunity to understand and recognize that human being and the fact that we are expending money toward his or her better health is a recognition of the inherent dignity of that human being" (NE, LB599 Floor Debate, 4/3/12). The executive director of a religiously affiliated organization echoed these sentiments:

> As a society, we have already determined that caring for human beings who need medical attention is the right thing to do. It is founded upon the principle, the fundamental principle of respect for human dignity. Providing prenatal care and services to unborn children regardless of the mother's immigration status adheres to this fundamental principle. (NE, LB1110 Committee Hearing, 2/25/10)

This explicitly moral argument centers on the unborn child's dignity and moral status rather than on the mother's dignity or moral status. We consider this inconsistency in the Discussion section.

The effort by Nebraska legislators to justify their support based on the rights and well-being of an unborn fetus directly contrasts with the legislative efforts in California. Whereas much of the discussion in Nebraska focused on whether to provide prenatal services to undocumented pregnant immigrants in the interest of a pro-life agenda, the conversation in California tended to view the question of whether to provide services to pregnant undocumented immigrants as settled and instead focused on how best to protect access to abortion while allowing the state to capitalize on the availability of federal funds.

Although both California and Nebraska employ the unborn child option to fund prenatal care for undocumented pregnant immigrants, the stated goals of their programs diverge sharply on the issue of abortion access. The Nebraska bill directed the relevant state agency to adopt the CHIP unborn child option using the Centers for Medicare & Medicaid Services language redefining the term "child" and naming the unborn child as the beneficiary, whereas the California bill did not. Instead, the California bill stated that "through its courts, statutes, and under its Constitution, California protects a woman's right to reproductive privacy" and declared that the state may accept federal Medicaid funds for prenatal care "only when, during the period of coverage, the woman is the beneficiary" (CA, AB 794, 2005). California legislators recognized that the language of the unborn child option raised "a concern that California's privacy protections may be at risk" and cited the decision in Roe v Wade that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn" (CA, AB 794 Enrolled Bill Memo, 2005). Opponents of the California bill noted that the bill was unnecessary and that the governor could enact the unborn child option without a directive from the legislature (i.e., through a state plan amendment enacted by the Medicaid agency). These opponents referred to the bill as an "unneeded political statement," the "real purpose [of which was] to reaffirm California as a 'pro-choice' state" (CA, AB 794 Enrolled Bill Memo, 2005).

In New York, the policy context was shaped by a series of court decisions ending with Lewis v Thompson, a decision by the Second Circuit Court of Appeals in 2001 voiding New York's use of federal funds for the provision of services to undocumented pregnant immigrants. In that decision, the Thompson court determined that a fetus has no legal right to care and that the federal Medicaid statute clearly identifies the mother as the beneficiary of prenatal care (Lewis v Thompson). In reaching that

decision, the Thompson court traced the evolution of the legal status of a fetus's eligibility for federal benefits from the filing of the first Lewis case on the question of prenatal care for the undocumented in 1979 through the string of Lewis cases that culminated in the 2001 decision. Starting in 1981, under the Omnibus Budget Reconciliation Act of 1981 (OBRA '81), a pregnant woman was eligible for Medicaid if the child, if born, would be eligible. This concept is known as "constructive birth." Based on this criterion, Judge Charles P. Sifton, the district court judge who wrote the decisions in most of the early Lewis cases, found that undocumented pregnant immigrants were eligible for prenatal care under the federal Medicaid statute in 1986 (Lewis I). In response to this ruling, Congress passed OBRA '86, which included language restricting "non-PRUCOL aliens" from receiving federal benefits, and the secretary of health and human services (HHS) asked the court to vacate the Lewis injunction. "PRUCOL," which stands for "permanently residing in the U.S. under color of law," was an eligibility category that encompassed noncitizens living in the United States who are not likely to be deported and with the knowledge of the US Citizenship and Immigration Services. This eligibility category was replaced by the term "qualified alien" in PRWORA, and although references to PRUCOL status remain in some states' laws, including New York and California, the category is largely defunct at the federal level.[13] In 1987, Judge Sifton again declined to stop the federal funding of prenatal care for undocumented immigrants, this time relying on the fact that "the Secretary had, at least until that point, continued to consider fetuses as 'individuals under the age of 21'" who were therefore eligible for prenatal care in their own right, regardless of their mother's non-PRUCOL status (Lewis III).

In 1991, the secretary of HHS formally renounced the interpretation of the term "child" that included fetuses (a decision later reversed in 2002 by the introduction of the unborn child option). This action by HHS caused Judge Sifton to reconsider, in the next Lewis case brought by the federal government, the basis of an undocumented pregnant immigrant's entitlement to prenatal care. Because HHS's action cut off the statutory interpretation of the term "child" he had been using up to that point, Judge Sifton's reasoning in Lewis IV shifted from the fetal personhood arguments used in Nebraska to an argument based on justice and equal protection, which we consider in the next section.

It is worth noting that the 2002 New York policy predates the 2002 federal unborn child policy by seven months, so the unborn child option was not yet on the table for the New York legislators, who ultimately passed the budget bill enacting the state-funded prenatal policy. Even though such an option later became available, New York never publicly contemplated a switch from state funding to the unborn child option. The state assembly member who sponsored the bill that was ultimately incorporated into the budget bill in 2001 indicated in a personal communication that even California's version of the unborn child policy would not have been successful in New York:

> Boy, if somebody had suggested doing that in New York, I think we would have been very wary of touching that with a 10-foot pole ... no matter how you tried to pretty it up, anything that refers to a fetus as a child or an unborn child would, I do not think ... would fly in the assembly. (phone call with New York state assembly member, 12/9/16)

He added that this "tells you that there are some things New York will not do to make a buck" (phone call with New York State assembly member, 12/9/16). The assembly member's belief is that even to save money, New York would never switch to a policy that could endanger access to abortion. We discuss cost considerations further in the Prudential Reasons section.

As this section has demonstrated, two opposing views of the moral status of the fetus emerged in the debate over prenatal care for undocumented immigrants. The idea of fetal personhood and the dignity of the unborn child, which dominated the Nebraska discourse and surfaced in New York as well, directly contrasts with the view of respect for maternal autonomy, predominant in California, which emphasizes the mother's right to reproductive privacy.

Justice: Entitlement and Societal Obligations. The idea that certain individual characteristics or actions could make some people more or less entitled to public resources was common in the Nebraska public debate, among both proponents and opponents of the Nebraska legislation. Lawmakers argued that an individual's entitlement to health care should be based on a variety of reasons, including whether they had broken the law, belonged to a community, and paid taxes.

Lawbreaking. The idea that breaking the law invalidates a claim to health care, or that innocence of a crime strengthens a claim, permeated

much of the debate in Nebraska. Legislators who opposed the passage of the unborn child amendment argued that "by passing LB599, [we] will be reaching into the pockets of law-abiding citizens to pay for the responsibilities of those who have broken our laws" (NE, LB599 Veto Override, 4/18/12). Indeed, the governor vetoed the legislation for this reason, noting in his veto letter that the policy "would utilize … state and federal tax dollars to provide free prenatal care to illegal immigrants who are knowingly and willingly breaking both the immigration and employment laws. This is wrong and fundamentally unfair" (NE, LB599 Veto Letter, 4/13/12). The governor (whose veto was ultimately overridden) also employed explicitly moral language ("wrong" and "unfair") in his veto letter opposing the provision of public benefits to people whom he perceived to be lawbreakers and therefore undeserving of public benefits.

In response, many Nebraska state senators who favored the legislation relied on the argument that the fetus is a person separate from its mother and that its independent personhood makes it innocent of its mother's crime. One state senator argued that

> I think the injustice that comes out of this is that when prenatal care is denied, we know that it's the baby, the unborn child, that bears the full cost of that tragic decision. It's not the person who broke the law to begin with. It's the unborn child, the most innocent of human life. (NE, LB599 Floor Debate, 4/4/12)

This reasoning, which hinged on the separate personhood and therefore the innocence of the fetus, gave lawmakers a way to reconcile their conservative positions with a progressive policy that provides public benefits to "illegal" immigrants. Another senator framed this idea by saying, "To oppose taxpayer funds for illegal activity, I understand. But help me understand what illegal activity has the unborn child in this situation engaged in. They had nothing to do with their parent not entering the country legally" (NE, LB599 Floor Debate, 4/3/12).

This idea also was present in the New York Lewis cases. Judge Sifton, writing in Lewis IV in 1991, cited an earlier Supreme Court case summarizing this view:

> Legislation directing the onus of a parent's misconduct against his children does not comport with fundamental conceptions of justice. "Visiting … condemnation on the head of an infant is illogical and unjust. Moreover, imposing disabilities on the … child is contrary to the basic concept of our system that legal burdens should bear some

> relationship to individual responsibility or wrongdoing." … It is thus difficult to conceive of a rational justification for penalizing these children for their presence within the United States. (Plyler v Doe, cited in Lewis IV)

In the Plyler case, this argument was used to support a right to public education for undocumented immigrant children. In applying the same reasoning to the Lewis case, Judge Sifton needed to walk a fine line between asserting that a fetus should not be punished for the mother's "misconduct" while also not implying that a fetus was a person with rights. He noted that the government defendants argued "that Plyler does not apply because it dealt with already-born children ('persons'), while the present case deals only with the unborn, who are not 'persons' under the Fifth or Fourteenth Amendments," but found that the effect of the denial of prenatal care harmed the mother in ways that also were unconstitutional (Lewis IV).

Social Membership. Official or unofficial membership in the Nebraska community was often described as justifying an individual's entitlement to public resources. Some legislators argued that the future citizenship of the fetus made it deserving of care. One state senator who took this stance argued that

> that baby in the womb, unless you deport that mother as soon as you find out she's pregnant, is a future citizen of this United States and a future Nebraskan. Now, imagine yourself kicking a baby to the curb, and essentially you're denying the service for a future citizen and a future Nebraskan; that's what I believe. (NE, LB599 Floor Debate, 4/3/12)

For some who believed that citizenship is the feature determining one's claim to public benefits, this argument, like the illegality and innocence argument, hinged on the personhood of the fetus:

> "The mother could come here from planet Jupiter, and it doesn't matter … that child is a life, and because of that, that child is an American, and because of that, that child is a Nebraskan, and because of that they are entitled to benefits" (NE, LB599 Floor Debate, 4/3/12).

Future citizenship, and the rights accompanying it, factored heavily in the final two Lewis cases. In Lewis VI, Judge Sifton found that "to deny Medicaid for routine prenatal care to unqualified aliens denies the citizen children of the members of the plaintiff class the equal protection of the laws and, thus, violates the Fifth Amendment's Due Process Clause" (Lewis VI). This decision affirmed a citizen child's right to

prenatal care but was overturned in the final Lewis case, Lewis v Thompson, by a second circuit judge, who found that "the born child's subsequent protection by the Equal Protection Clause cannot retroactively create a claim that was not cognizable before birth" (Lewis v Thompson). The rights of national membership, the court determined, belong only to the born.

The state's legislative response to Lewis v Thompson repudiated this finding. The original bill (which was ultimately folded into a budget bill providing state-funded prenatal care to undocumented immigrants) listed as its justification that "lack of [prenatal] care can result in expensive neonatal care and lifelong disabilities for the child, who, if born in the United States, is a citizen and eligible for government funded social and medical programs" (NY, A8953, 2001). While this argument draws on prudential reasons as well, the future state membership of the fetus nonetheless clearly factored into New York's decision to fund prenatal care itself, despite the lack of federal participation.

Returning to Nebraska, a different perspective on the meaning and value of social membership emerged in opposition to the unborn child policy, focusing on the nonmembership of the mother rather than the future membership of the fetus. The mother's lack of citizenship was given as a reason against providing public benefits when discussing a policy that provides care to undocumented immigrants, but some legislators made the additional point that the mother was undeserving of prenatal care based on a belief that she had not paid any taxes. One state senator referenced the frustrations of his constituents with a policy that they believed would deplete

> a finite pool of money. And that pool of money comes from Nebraskans, and it comes from the rest of America ... and the frustration is ... when we use dollars for individuals perhaps who are not paying into ... I don't know how an illegal, or someone, pays into a system, you know? But the frustration that I'm hearing from constituents is, there's less left. (NE, LB599 Floor Debate, 4/4/12)

This concern that undocumented pregnant immigrants did not contribute to the tax base that would fund their prenatal care, though not supported by factual evidence, was pervasive among opponents of the policy.

This, then, is the reasoning employed by supporters and detractors of the prenatal policies in each state derived from a conception of justice requiring a society to treat similar populations similarly. The different

justice-based reasons diverge on the individual characteristics or actions deemed morally relevant to differential treatment, such as lawbreaking and various forms of social membership.

Prudential Reasons

While many of the reasons supporting or opposing the various prenatal policies were moral in nature, others were prudential in that they appealed to the interests of American citizens and other legal residents.[11] They ranged from promoting state residents' health to protecting the state's economic interests and preventing illegal immigration.

Promoting Residents' Health. Many who argued in favor of the unborn child policy did so on the basis that it would promote the health of Nebraska's current and future residents. Residents' health was often framed as a worthwhile end in itself, and the ability of the unborn child policy to promote health recommended it to the legislature. One example of this argument can be seen in remarks by the sponsor of the unborn child policy:

> LB599 is extremely important in the sense that we have an opportunity here to say we believe that healthy beginnings and healthy babies are important in the state of Nebraska and they are a priority and that prenatal care isn't just important at the beginning, but it will last a lifetime. (NE, LB599 Floor Debate, 4/4/12)

Supporters of the unborn child policy often cited facts or statistics about the effectiveness of prenatal care at promoting infant and lifelong health as a reason to support the policy. The bill itself contained language stating that

> prenatal care has been clearly shown to reduce the likelihood of premature delivery or low birth weight, both of which are associated with a wide range of congenital disabilities as well as infant mortality, and such care can detect a great number of serious and even life-threatening disabilities, many of which can now be successfully treated in utero. (NE, LB599)

Although many supporters of the unborn child policy touted the benefits of prenatal care for the fetus, very few framed their arguments in terms of the mother's health. One state senator observed that

> what the mother eats and the prenatal care that she has can cause brain damage in the developing baby. And if we don't care about that

> person as such, we should care for the fact that it's going to be much more expensive to educate that American citizen when it's born and all through life. (LB599, Floor Debate, 4/4/12)

This policymaker suggests that even if one does not care about the mother as a person, one still ought to be concerned with the health of the fetus and the cost that might be incurred if that fetus is born with brain damage.

In New York, the promotion of health often played a minor role in arguing for using state Medicaid funds to cover prenatal care for undocumented immigrants. The New York State Assembly memorandum supporting the legislation to provide Medicaid funds noted that

> appropriate prenatal care is medically necessary for the health and future well-being of both mother and child. Lack of such care can result in expensive neonatal care and lifelong disabilities for the child, who, if born in the United States, is a citizen and eligible for government funded social and medical programs. (NY, A8953, 2001)

Although this language was absent from the budget bill that ultimately passed the following year, the mention of the positive effects of prenatal care on the mother's health in the legislative analysis of the original bill is worth noting.

Protection of Economic Interests. While health was often presented as an end valuable in itself, it was more often seen as instrumentally valuable in that it could save money and protect the state's economic interests by reducing the need for expensive medical care or by improving the life prospects of future citizens, whose future economic contributions would be greater with access to timely prenatal care. In Nebraska, the bill to adopt the unborn child option stated that

> it is well established that access to prenatal care can improve health outcomes during infancy as well as over a child's life. Since healthy babies and children require less medical care than babies and children with health problems, provision of prenatal care will result in lower medical expenditures for the affected children in the long run. (NE, LB599)

The argument that it is more cost-effective to provide prenatal care than to treat otherwise preventable conditions resulting from a lack of prenatal care was common among supporters of the unborn child policy. A representative from the March of Dimes organization testified in favor

of the Nebraska policy, citing numerous statistics about the effectiveness of prenatal care, and concluded that

> if simple access to prenatal care could reduce or eliminate prematurity, in some cases, this, in turn, could limit or eliminate the substantial cost burden on Medicaid after that child is born. The physical well-being of Nebraska citizens as well as the financial costs should be a consideration for this body. (NE, LB599 Hearing, 3/16/11)

Both health and economic benefits for the citizens of Nebraska were presented as positive outcomes of adopting the unborn child option, and the adoption was considered "financially prudent and fiscally responsible" by many legislators who were convinced by these reasons (NE, LB1110 Committee Hearing, 2/25/10).

As with the health promotion arguments, the state of New York conceded in the Lewis cases that prenatal care was cost-effective. Judge Sifton, citing a report by the Institute of Medicine, noted that "the [HHS] Secretary does not deny that providing prenatal care is cost-effective. Indeed, that conclusion is intuitive. Studies have shown that every dollar spent on prenatal care saves between two and ten dollars in future medical care costs" (Lewis V). He related this fact to the legislative intent of OBRA '86, pointing out that "in short, there can be little question that denying prenatal care to non-PRUCOL aliens undermines the clearly expressed Congressional purpose of curbing expenditures" (Lewis V). The fact that denying prenatal care to undocumented immigrants would not save money and therefore would fail to meet the goals of OBRA '86 mattered in the Lewis V decision when Sifton could clearly find that the denial of prenatal care contradicted the legislative intent. By Lewis v Thompson in 2001, however, the legislative intent of PRWORA to deny care to unqualified immigrants clearly outweighed the cost-saving measures also contained in that act. Judge Jon O. Newman acknowledged this point, writing:

> The Plaintiffs' argument stresses legislative purpose. It is undisputed, they reason, that prenatal care on balance saves money. And there is no doubt that, as with many of its predecessor statutes, one of the principal purposes of the Welfare Reform Act was to reduce federal spending… . However, even if we were inclined to regard this as the only purpose of the Welfare Reform Act (and it is not), we cannot ignore clear text and clear intent on a specific topic to achieve a more general congressional purpose. (Lewis v Thompson)

The clear text to which Judge Newman is referring is the restriction that bars "an alien who is not a qualified alien" from receiving federal Medicaid funds.

The New York State Assembly's memorandum supporting the unsuccessful bill introduced in the wake of Lewis v Thompson also discussed the cost savings associated with providing prenatal care under the "fiscal implications" heading. The memo noted that "estimates of the cost savings attributable to prenatal care range anywhere from $2[.00 to $]10.00 per each dollar expended on medical care. We anticipate cost neutrality, if not actually savings, to be the result of this legislation" (NY, A8953, 2001). While this language was not contained in the memo for the budget bill that passed the following year, this argument may have been persuasive in the unrecorded conferencing that led to the bill.

Prevention of Illegal Immigration. One prudential reason against the provision of prenatal care to undocumented immigrants was raised only in Nebraska: the concern that publicly funded prenatal care might encourage illegal immigration. In issuing his veto of LB599, the governor argued that

> another concern with this legislation is that it will result in Nebraska becoming a sanctuary for illegal immigrants. Nebraska would become the only state in the Midwest providing these taxpayer-funded benefits to illegal immigrants… . An illegal immigrant from any bordering city or town could establish residency in Nebraska in the morning and apply for benefits provided under LB 599 in the afternoon. (NE, LB599 Veto Letter, 2012)

Another opponent of the prenatal policy shared this view, stating that

> I can't get to the point of saying that we as taxpayers have to reward and invite illegal activity into our state. As I'm aware, no border states have this program. We got rid of this program. The numbers [of undocumented immigrants] have lessened. And … I believe if we enact LB599, it will increase. (NE, LB599 Floor Debate, 4/4/12)

Although other state senators explicitly denied that the available data supported the idea that LB599 would increase unauthorized immigration, the argument that offering prenatal care to undocumented immigrants could create a "social services magnet" (NE, LB1110 Hearing, 2/25/10) was used by multiple Nebraskan legislators to oppose the policy on prudential grounds.

Discussion

The findings of our study indicate that supporters and opponents of the various prenatal policies in each state used both moral and prudential reasons. Among the moral reasons were appeals to respect for autonomy, including the opposing concepts of fetal personhood and reproductive privacy, as well as appeals to conceptions of justice that either supported providing prenatal coverage based on the baby's (and sometimes the mother's) social membership versus those arguing against coverage based on, for example, the fact that the mother had broken the law.

In Nebraska, the unborn child option was adopted largely as a vehicle for policymakers to signal their opposition to abortion rights. In California, legislators adopted the unborn child option as a way to protect a woman's right to choose an abortion. It is striking, then, that both states employ fundamentally the same policy mechanism. Unlike California and Nebraska, New York's policy makes no reference to abortion rights whatsoever. The early Lewis cases often mentioned fetal personhood, but the 2002 legislation enacting New York's current prenatal policy avoided the question of fetal personhood by using state funds to care for undocumented pregnant immigrants. Although protecting a right to abortion was not a motivating factor for providing health insurance to undocumented pregnant immigrants in New York in the same way it was in the other states, it may have played a role in the state's decision not to pursue the federal unborn child option afterward, as the comments of the New York State Assembly member quoted earlier indicate.

One key point of interest in this comparison is that neither state technically required legislative action to implement the unborn child option. In most states, including California and Nebraska, some state plan amendments (SPAs) can be submitted by the state's executive agency responsible for the management of CHIP and Medicaid without legislative authorization, although in Nebraska legislative notice is required.[14] Since legislation was not required to enact the unborn child option in California, and the bill had the full support of the governor and the relevant executive agencies, one interpretation of the state's decision to use legislative means could be that the bill was useful for signaling moral priorities to constituents. Indeed, most Medicaid policy tends to fly under the radar, so the fact that the legislature decided to politicize this issue could be interpreted as an attempt to "have it both ways"—to get

the federal matching funds while still signaling their opposition to the Bush administration's perceived assault on abortion rights. The fact that opponents of the bill argued in floor debate that the bill was simply a "political statement" supports this possibility, although of course no supporters of the bill agreed that this was the case. In Nebraska, although there was no formal requirement that the legislature pass a bill authorizing the SPA, the Nebraska Department of Health and Human Services declined to pursue the SPA on its own, which meant that, unlike the situation in California, the legislature did need to pass a bill if it wanted the state to adopt the unborn child option. Nonetheless, the legislators made a great show of pointing out their own opposition to abortion rights, even though the bill itself had no immediate effect on access to abortion.

Another point of interest, from a moral and political perspective, is the juxtaposition of some Nebraska legislators supporting the unborn child option because it promotes the well-being of the fetus with their indifference to the health of the mother. Although both the health of the fetus and the economic benefits of protecting the health of the fetus were frequently cited prudential considerations in favor of the prenatal policy, it was uncommon for a supporter of the policy to raise the health benefits to the mother or the subsequent cost savings that could result from increasing the mother's access to preventive care measures like smoking cessation programs and obesity screening.[15,16] The contrast in Nebraska between the vocalized concern for not-yet-born future citizens and the inattention to the health of noncitizen residents of the state illustrates that the morally relevant characteristics that generated an obligation to provide prenatal care were pregnancy with a future citizen and the innocence of the fetus, rather than membership or embeddedness in the social community.

California and New York eschewed reasoning based on fetal personhood, and both states continue to fund abortions with public money, even for undocumented pregnant immigrants.[17] Despite the lack of overt prioritization of the fetus over the mother, however, neither state provides nonemergency health coverage to nonpregnant undocumented adults, although a California law that passed in 2019 extended state-funded Medicaid coverage to all financially eligible undocumented immigrants under the age of 26, up from the previous coverage through age 19.[18] Although nonpregnant undocumented immigrants can also belong to (and, indeed, be deeply embedded in) their communities, their

exclusion from public health insurance programs is telling. It indicates that although these states do not explicitly link the provision of prenatal care to the moral status of a fetus, community membership alone is not a sufficient reason to distribute publicly funded health care to non-pregnant undocumented adults. This follows the lines of how Medicaid for citizens has traditionally been conceived—specifically, the greatest priority on babies, then older children, pregnant women, parents, and, finally, able-bodied nonparent adults.

The Trump administration radically reconfigured immigration politics on many fronts. An example is the efforts to limit legally residing immigrants' access to public benefits through the restrictive new "public charge" rule rendering ineligible for permanent residency most immigrants who have received benefits from some federally funded programs, including Medicaid.[19] The administration also publicly and aggressively ramped up policing against undocumented immigrants and removed the Obama-era focus on deporting immigrants with criminal convictions, casting a much wider enforcement net.[20] This has had the effect of polarizing Republicans and Democrats on issues related to immigration and, at least for now, reduced the likelihood of bipartisan compromise.[21]

At the same time that the Trump administration reduced access to health care for immigrants, there has been an increase in Democrats' willingness to pursue bolder policy ideas related to health insurance for the undocumented. The recent push by some progressive political groups toward "Medicare for All," which would ostensibly cover "all" Americans, indicates an endorsement of access to health insurance as a human right. Senator Bernie Sanders's "Medicare for All" bill entirely eliminates distinctions based on immigration status, extending coverage to "every individual who is a resident of the United States."[22] Additionally, at a presidential debate in June 2019, all the Democratic candidates indicated that their health plans would cover undocumented immigrants.[23] A complete analysis of the candidates' moral and prudential reasons for this position is beyond the scope of this article, but it seems clear that the political favorability of using public funding of insurance for undocumented immigrants is shifting among progressives.

Despite moves by the Trump administration to limit immigrants' access to public benefits, recent legislative initiatives in New York and California indicate that there may be significant state-level interest to expand eligibility to new categories of undocumented immigrants. Both states now provide coverage to undocumented children, California up

through age 26,[18] and both provide coverage to Deferred Action for Childhood Arrivals (DACA) recipients.[24] Like the fetuses of undocumented immigrants, these populations can be framed as "blameless" in the political debate. This could indicate that the justice-based argument about the moral relevance of innocence and lawbreaking to the distribution of public resources, prominent in Nebraska and court decisions like Plyler v Doe, might be successfully extended in order to justify providing health care to undocumented children and DACA recipients in other progressive states.

Finally, although we have considered only three states, we should ask how these findings might transfer to other states. Given that 19 states have some form of public coverage for prenatal care for undocumented immigrants, we may ask what distinguishes them from the 31 states that do not. In the states examined here, we see three different approaches to the politics of such a policy. In Nebraska, the legislation was framed as a choice between two politically conservative stances, anti-abortion rights and anti-immigration, and was supported by a pro-immigrant and anti-abortion coalition. In California, however, the politics of the question were largely discussed in pro-abortion rights terms, and in New York the policy was politically submerged, undebated and wrapped inside a budget bill. While it is beyond the scope of this article to systematically account for political differences between these states and others, we speculate that those states that have not implemented a prenatal policy may lack the necessary advocacy group organizing around either immigrant rights or abortion rights, or both.

To delve into this question of sufficient advocacy in states with and without prenatal policies, we can draw insights from the experience of Nebraska, which failed to pass the unborn child option in 2010 before passing it in 2012. The policy initially failed because, although it had the support of a majority of pro-life and pro-immigrant policymakers, it did not have a significant enough majority to override "a certain veto" from the governor (NE, LB1110 Floor Debate, 3/17/2010). In the following year, when Nebraska lost the federal funding it had improperly received until that point, advocacy groups were able to gather anecdotes and data demonstrating the human, health, and economic impact of denying prenatal care to pregnant immigrants. These stories factored significantly into the debate when the bill was reconsidered in 2012. Transferring this phenomenon beyond Nebraska, we might speculate that the activation of policymakers by advocacy groups through

storytelling and data could account for some of the difference between states with and without prenatal policies. A deeper exploration of this connection should be a topic for future research.

Limitations

Our examination of the various prenatal policies and their diverse justifications has several limitations. A major limitation is the shortage of publicly available legislative debate from New York and California. Although some hearings and debate transcripts are available from California, most are quite brief and lack the vivid debate found in Nebraska, and there is no recording at all of the legislative debate in New York because the bills under consideration were never publicly debated. This limitation makes it difficult to illustrate differences among these states and led to our focus on the data from Nebraska rather than an equal consideration of all three states.

Another limitation is that we examined the reasons raised in the legislative histories but did not address a number of questions that cannot be answered through the legislative histories alone. For instance, both California and Nebraska used the CHIP unborn child option to provide coverage for pregnancy-related services, but the policies did not clarify the distinction between a pregnancy-related service and a non-pregnancy-related service provided to a pregnant woman. The final limitation of our article is its focus on the reasons for providing undocumented immigrants that were preserved in the legislative histories. The range of voices reflected by those histories is narrow, often restricted just to the perspectives of policymakers and politically active citizens. We also could not assess the actual underlying beliefs or political motivations of the policymakers and others whose public reasons we analyzed. It is entirely possible that a policymaker might express one view while secretly harboring another for purely political reasons. This limitation does not affect the interpretation of the data collected here, since this article analyzes public reasons rather than private ones, but it does prevent any theorizing about "true" beliefs, as opposed to stated beliefs.

Conclusions

Nebraska, California, and New York all provide undocumented pregnant immigrants with publicly funded coverage for prenatal care, but

they do so in different ways and for a wide range of reasons. We surveyed the moral and prudential justifications for a particular prenatal policy and the content of the policies enacted in states to achieve this goal. The wide range of justifications considered here belies the relatively minor differences in the prenatal policies adopted. While the benefits covered in each state differ in important ways, some of which can be traced to the disparate moral and prudential values espoused and the state's position on the protection of reproductive rights, the existence of a prenatal policy in each state may ultimately prove more meaningful than the differences in their implementation. In other words, regardless of the logic underlying the passage of a prenatal policy, the practical outcome is essentially the same across states, in that undocumented immigrants are able to access some amount of publicly funded services during pregnancy. Whether the differences in state policies have a significant impact on the lived experience of pregnant undocumented immigrants in each state, the actual services they receive, and their birth outcomes has been the focus of some scholarship in this space.[25–28] Additionally, while not all reasons are convincing to all stakeholders, we have seen that diverse stakeholders who hold different sets of beliefs can still reach a political consensus that supports an immigrant-friendly health policy.

The future prospects for the continued support and expansion of the unborn child option and other policies with blended pro-life/pro-immigrant constituencies are unclear. Whereas the policy emerged during an era of relatively low political attention to undocumented immigration and an era of modest incremental expansion of public insurance, the current conditions at both the federal and state levels are different. Given the increasing political polarization of the American public, there is reason for pessimism regarding the expansion of prenatal policies into more states in the near future. As the parties move farther apart on abortion rights and immigration, compromise will likely be harder to achieve. Especially in light of anticipated fiscal austerity in the wake of the COVID-19 pandemic, as states across the country cut spending on programs (in many states, their Medicaid programs), it seems unlikely that more states will add prenatal policies.[29] Thus, in the current political climate, it would be difficult for states, and particularly Republican-controlled states, to visibly expand their public programs for immigrants, and so further efforts will likely remain submerged. Whether the fragile political consensus that made the unborn child option possible can continue will depend in part on the willingness of the

diverse pro-life and pro-immigrant coalition to find common ground on policy objectives.

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Appendix

Note on Language

Our use of the term "unborn child" is not an endorsement of this language but rather a representation of the emic language found in the policy and the legislative history to describe a fetus. It would be unwieldy and distracting to put quotation marks around this term in every instance it is used, but it should be understood that "unborn child" refers to a specific usage found in the data we present. The same is true of our use of the terms "pro-life" and "pro-choice" as stand-ins for "opposed to abortion access" and "in favor of abortion access," and quotations that use the term "illegal immigrant" to mean "undocumented immigrant." Finally, our use of the term "woman" is limited to instances in which it is part of the language of the policy or speaker. We recognize and affirm that not all pregnant people are women, as transgender men and nonbinary people can also become pregnant and require prenatal care.

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