PUBLICLY FUNDED PRENATAL CARE FOR UNDOCUMENTED IMMIGRANTS: A COMPARATIVE CASE STUDY IN POLICY, PRACTICE, AND ETHICS

by
Rachel E. Fabi

A dissertation submitted to Johns Hopkins University
in conformity with the requirements for the degree of Doctor of Philosophy

Baltimore, Maryland
March, 2018

ABSTRACT

There are over 11 million undocumented immigrants living in the United States and nearly 8% of births each year are to at least one undocumented parent. Under the 14th Amendment to the U.S. Constitution, all children born within the borders of the United States are legal citizens regardless of their parents' immigration status. Many undocumented immigrants are unable to access adequate prenatal care. Nineteen states have implemented one of two policies intended to provide undocumented immigrants with insurance coverage during pregnancy. This dissertation explores the policy, practice, and ethics of these policies through three aims.

Aim 1 examines the relationship between the policy narratives, policy requirements, and the use of moral and prudential reasons by legislatures and courts in state policies that provide publicly-funded prenatal care to undocumented immigrants. The legislative histories of prenatal policies in three case states: Nebraska, California, and New York are reviewed and analyzed. The findings of this analysis include that policymakers and others appeal to moral reasons based on different conceptions of the principles of Respect for Persons and Justice, as well as prudential reasons related to the health and economic benefits of prenatal care for U.S. citizens and legal residents.

Aim 2 describes the professional norms and practices of health care workers who serve undocumented pregnant immigrants in states with different prenatal policies or prenatal policy implementations (Nebraska, California, New York, and Maryland) and the ethical tensions they encounter when providing or facilitating care under policy restrictions that limit the benefits available to undocumented immigrants. In-depth interviews were conducted with purposively sampled health care workers at safety net clinics in each state. Findings include the attitude and professional practice norms held by health care workers who see pregnant patients as well as the ethical tensions they encounter when policy or institutional constraints prevented them from living up to professional norms.

Aim 3 applies three normative accounts of distributive justice regarding a society's obligations to non-citizen residents to the duty of the public to provide care to pregnant undocumented immigrants and locate an overlapping consensus across accounts. This paper explores the moral space that this issue occupies, and the results suggests that real moral progress can be achieved through the consistent application of shared values.

Adviser:	Holly Taylor, PhD, MPH
Readers:	Brendan Saloner, PhD Matthew DeCamp, MD, PhD Katherine Clegg Smith, PhD
Alternates:	Jeffrey Kahn, PhD, MPH Maria Merritt, PhD

To the undocumented immigrants living in communities across America,
who know that "we sink deep roots over [time], and these roots matter
even if we were not authorized to plant ourselves in the first place."[1]

---

[1] Joseph Carens, *The Ethics of Immigration*

ACKNOWLEDGEMENTS

This dissertation would never have been possible without the mentorship, guidance, and support of many individuals whose belief in me and this project was far stronger than my own. Although a note in the acknowledgements section of a 186-page paper hardly seems like sufficient thanks for years of support and friendship, I will endeavor to pay forward the kindness I have been shown by the friends, family, and mentors named here in my own life and academic career.

I am first of all profoundly grateful to my advisor Dr. Holly Taylor, who shepherded this project from its infancy as a set of confused and disjointed "Aims" to the fully-formed manuscript you see here. Holly's steady guidance made this dissertation possible, and her insightful and incisive comments at each step along the way helped shape every aspect of the project, from the background and literature review to the methods and policy discussion. I am thankful for Holly's guidance beyond the dissertation as well; her enthusiastic support for my pursuit of teaching, dissertation funding, and academic jobs never wavered. I am lucky to have had her mentorship throughout the PhD process, and to continue to have it as I move on to the next phase of my academic career.

I also want to thank my thesis committee, and especially Dr. Brendan Saloner, whose mentorship and guidance have been invaluable to my development as a scholar. Brendan has done the most to challenge my thinking on my dissertation, and even (or especially) when we disagreed about what justice requires, he always found ways to help me refine and improve my arguments. Working with Brendan on both this dissertation and other papers has been a highlight of my time at Hopkins, and I look forward to many more years of collaboration. I am grateful as well to Dr. Matt DeCamp and Dr. Kate Smith, both of whom cheerfully

served on both my school-wide oral exam committee and my dissertation committee, and whose contributions to the methods of this project were absolutely indispensable. Matt's deep knowledge of empirical bioethics methodology and the philosophical literature were instrumental to my understanding of the relationship between the empirical and normative aspects of this dissertation. Kate's qualitative methods expertise was equally integral to the success of this project; our discussions about Aim 1 kept me grounded in the face of such a massive document review, and her course on qualitative methods taught me the theoretical approach I employed in analyzing my Aim 2 data.

I am immensely grateful for the support of the Berman Institute of Bioethics, including that of Dr. Jeff Kahn, Dr. Nancy Kass, Dr. Maria Merritt, Dr. Mario Macis, and Dr. Ruth Faden, all of whom I have had the privilege of learning from and working with over the course of my five years at Johns Hopkins. I am also thankful for the support of Dr. Stephanie Morain and Dr. Travis Rieder, both of whom I owe whiskey for their excellent mentorship and friendship. Stephanie taught me how to do qualitative analysis during my first year in the program, and ever since, she has always been available to offer life advice or listen empathetically to my grad student woes. I have known Travis in many roles, first as a post-doc at the Berman, then as my professor in a moral theory class, and now as a valued colleague and friend; his humor and kindness have helped me through the many challenges of writing a dissertation. Thanks as well to the staff of the Berman Institute, whose kindness made it feel like a "home base" I could return to when I needed a break from the School of Public Health; I am lucky to have a been part of such a warm and vibrant community of scholars. Similarly, I want to express my heartfelt appreciation for the staff of HPM, especially Mary Sewell, whose open door and full candy dish were always there for me during

difficult times, and whose enthusiasm for my dream of being on a television quiz show never failed to make me smile.

I owe a great debt of gratitude to Dr. Nancy Berlinger and Dr. Michael Gusmano of the Hastings Center, whose Undocumented Patients Project started me down the path of this dissertation, and who continued to support my research in this area even after I stopped being their intern. Conversations with Nancy about her workarounds framework helped me understand my Aim 2 findings, and proved invaluable to my analysis in that paper.

To all of the physicians, nurses, social workers, and staff of community health centers across the country that agreed to participate in my research, I am so thankful for the work you do, and for your active and enthusiastic engagement with this project. I literally could not have done this project without the support of each and every professional who took time out of their heroically busy schedules seeing underserved patients to speak with me, and I am humbled beyond measure that they felt the research I was doing was worthy of their valuable time. Special thanks to Dr. Lisa DeCamp and Ms. Flor Giusti of the Johns Hopkins Bayview Medical Campus, who helped me pilot my interview guide.

For their financial support of my first two years in this program, I would like to thank the Agency for Healthcare Research and Quality NRSA training grant #T32HS000029, and for years 3-5 I would like to thank HPM for tuition support. For their direct support of this project, I am grateful to the Richard M. Danziger Fund and the Center for Qualitative Studies in Health and Medicine. Additional support during my dissertation completion was provided by the Carefirst/Hal Cohen Memorial Scholarship and the Barbara Starfield Scholarship, both of which made my last two years in this program possible.

I was fortunate to receive the Gordis Teaching Fellowship twice during my time at Johns Hopkins, and it provided me with the most formative experience I had throughout my graduate school experience: teaching the brilliant, inquisitive, passionate, and engaged undergraduate students of the Public Health Studies program. Their enthusiasm for the ethics of immigrant health policy inspired me to delve into aspects of this topic that I had never considered, and they made the challenge of finishing this program without full funding worth every minute.

Finally, words cannot express how thankful I am for the support of my friends and family over the past five years. The Beatles would have you believe that I get by with a little help from my friends, but they're wrong. I get by with a LOT of help from my friends, including those from beyond Baltimore whose friendship got me through middle school, high school, college, and Teach for America. Thank you, and I can't wait to visit all of you now that I have a real job. To Sachini, Shani, Krycia, Molly, Taruja, Hillary, Roza, and Mo, the bad-ass women of my HPM cohort: You ladies rock, and I am so lucky to have been a part of this group of kind, hilarious, and brilliant women. You are all my seatbelt, supporting me throughout this difficult journey and hopefully through whatever journeys are to come. To Christian, Mike, and Ali: Thank you for the Kant jokes and good reasons. To Leila: Your mentorship in everything from academic politics to Belgian beer has taught me so much, and your friendship is one of the best things I found in Baltimore. To Ariella: Thank you for listening to me talk about my topic enough times that you could have given my defense for me; for teaching me how to make sourdough and not making fun of me when I was bad at it; for being an excellent colleague and an even better friend.

To my parents, Nancy and Keith, and my siblings, Zack, Maria, and Matteo: Your love and support made me who I am today, and I am so lucky to be a part of this weird and wonderful family (as the inscription my dad put on the iPod I got in 9th grade inscrutably read, "You live and learn. At any rate, you live"). Finally, to Meaghan: You have been the most incredible, supportive partner I could ever have imagined. Thank you for your warmth; your insight; your brilliance; your patience; your humor. Thank you for everything.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AAP	American Academy of Pediatrics
AB	Assembly Bill
ACOG	American College of Obstetricians and Gynecologists
ACS	American Community Survey
CA	California
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DACA	Deferred Action for Childhood Arrivals
DHHS	Department of Health and Human Services
EMTALA	Emergency Medical Treatment and Active Labor Act
FFP	Federal Financial Participation
IRB	Institutional Review Board
IRCA	Immigration Reform and Control Act
JHSPH	Johns Hopkins Bloomberg School of Public Health
LB	Legislative Bill
LPR	Legal Permanent Resident
MD	Maryland
MRMIB	Managed Risk Medical Insurance Board
NCHS	National Center for Health Statistics
NE	Nebraska
NILC	National Immigration Law Center
NY	New York
OBRA	Omnibus Budget Reconciliation Act
PDF	Portable Document Format
PRUCOL	Permanently Residing Under Color of Law
PRWORA	Personal Responsibility and Work Reconciliation Act
SCHIP	State Children's Health Insurance Program
SPA	State Plan Amendment

A NOTE ON LANGUAGE

This project involves research into issues about which there are considerable disagreements in appropriate terminology. Throughout this manuscript, I have endeavored to use neutral language when possible, but in some cases I deviate from that norm. In this note, I hope to clarify my language choices.

One case in which I use a non-neutral term is in my use of "undocumented immigrants" to refer to immigrants who are residing within the United States without the legally required documentation, either because they crossed the border without the permission of the state or because they overstayed a valid visa and did not subsequently obtain a legal right to remain. The use of term is not morally neutral; other writers may prefer the terms "illegal immigrants" or "irregular migrants" to refer to this population, but I have chosen to use the term "undocumented immigrants" because I feel that it is the most descriptive and aligns with my views on the equal moral worth of all human beings. As advocates for immigrant rights are known to say, "no human is illegal"; rather, it is the act of immigrating or remaining without state permission that is illegal. Thus the term "illegal immigrant" fails to capture that it is the action of immigrating, rather the immigrant herself, that is illegal. Additionally, "irregular migrant" belies the permanency of the immigrant condition. This dissertation is concerned with the condition of individuals who have chosen to reside permanently within the United States. The term "irregular migrants" signifies a more temporary population, based in the distinction between "migration" (movement) and "immigration" (movement to a new country in order to resettle permanently).

A second case in which clarity of language is deeply important is my use of the term "unborn child." Throughout this dissertation, and particularly in Chapter 3 (Manuscript 1), the term "unborn child" is used in descriptions of policy and legislative history documents, and by policymakers themselves, often with an expectation that it conveys a particular view on the moral status of a fetus. When this language is used in the authorial voice, it is not meant to convey my own views on the personhood (or lack thereof) of a fetus, but rather as a reflection of its use by others. Similarly, any use of the terms "pro-life" or "pro-choice" are the emic terms used by speakers or policy documents rather than an endorsement of those terms.

Finally, although I strive to employ the gender-neutral term "pregnant immigrants" to refer to the population whose health care is the focus of this project, there are times when this paper refers to "pregnant women" because it reflects the language of research participants or policy documents. It is important to note that not all pregnant people are women, as transgender men and gender non-binary people can also be pregnant.

CHAPTER I. INTRODUCTION

BACKGROUND

Current estimates place the population of undocumented immigrants living in the United States at approximately 11.3 million individuals, which is approximately 3.5% of the U.S. population (Krogstad & Passel, 2015). According to a recent measure, 295,000 of the 3.9 million babies born in the United States in 2013 had at least one parent who was an undocumented immigrant (Passel & Cohn, 2015). Under the Fourteenth Amendment to the constitution, all children born within the borders of the United States are legal citizens regardless of their parents' immigration status, which arguably generates a strong government interest in ensuring that babies born to undocumented immigrants have the best possible health outcomes.

Many undocumented immigrants are unable to access adequate prenatal care due to a range of challenges, including financial, structural, and psychosocial barriers to care (Korinek & Smith, 2011). Several of these barriers are imposed by the U.S. government, including the 1996 welfare reform[2] provisions that made it illegal to use federal money to provide health care to unqualified immigrants, including undocumented immigrants and most legal residents who have been in the U.S. for fewer than five years, except in specific emergency circumstances covered by the Emergency Medical Treatment and Active Labor Act (EMTALA). In addition, the Affordable Care Act bars undocumented immigrants from purchasing private insurance in the state and federal insurance exchanges (Sommers, 2013).

---

[2] This law is officially called the Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA

Despite these federal barriers to care, nineteen states have acknowledged the importance of ensuring that undocumented mothers receive adequate prenatal care, and have implemented one of two policies intended to provide them with insurance coverage during their pregnancy (hereafter referred to as "prenatal policies"). These policy options are (1) an exclusively state-funded expansion of Medicaid to all pregnant people regardless of immigration status and (2) a State Plan Amendment that extends CHIP benefits to the unborn fetus of pregnant immigrants (Fabi, 2014).

RATIONALE FOR RESEARCH

This project explores the compelling ethical and policy questions that arise at the intersection of migration and public health. These issues have become more pressing as the public health implications of voluntary and involuntary migration around the globe continue to dominate the public discourse. The central moral question of this empirical and normative ethics dissertation is "what is the moral relevance of immigration status to the entitlement to public resources?" or, more simply, *"what do we owe to undocumented immigrants?"*.

Migration and public health are inextricably intertwined; the movement of people across borders inevitably affects demand for health resources, and as a result, questions that focus on what we owe to migrants and non-natives as members of our local, state, national, and international communities have become some of the most pressing in public health. The policies employed to address these issues must be informed by prudential considerations of cost and resource constraints, as well as moral considerations about the demands of distributive justice. In an effort to balance prudential and moral considerations, this dissertation project weighs both types of considerations and employs empirical methods to inform the central normative question of whether and how immigration status is morally relevant to the entitlement to publicly-funded health care, and whether pregnancy affects this claim. To ground this question empirically, this project employs a comparative case-study approach in which the unit of analysis is the state prenatal policy, examined through the lenses of policy, practice, and ethics, described in the following specific study aims.

STUDY AIMS

- **Aim 1**: Examine the relationship between the policy narratives, policy requirements, and the use of moral and prudential reasons by legislatures and courts in state policies that provide publicly-funded prenatal care to undocumented immigrants
- **Aim 2:** Describe the professional norms and practices of health care workers who serve undocumented pregnant immigrants in states with different prenatal policies and the ethical tensions they encounter when providing or facilitating care under policy restrictions
- **Aim 3:** Apply three normative accounts of distributive justice regarding a society's obligations to non-citizen residents to the duty of the public to provide care to pregnant undocumented immigrants and locate an overlapping consensus across accounts.

DISSERTATION ORGANIZATION

This dissertation is organized into six chapters. Chapter I presents a brief introduction to the project, including the rationale for research and the specific aims of the study. Chapter II reviews the public health and moral/political philosophy literature relevant to the project. This includes the literature on the U.S. policy environment regarding the provision of public services to non-citizens; policy and public health literature regarding immigrant access to prenatal care; and the moral and political philosophy literature on obligations towards non-citizens. Chapter III (Manuscript 1) presents results from a content analysis of the relationship between the policy narratives, policy requirements, and the use of moral and prudential reasons by legislatures and courts present in the legislative and judicial histories and of state policies that provide publicly-funded prenatal care to undocumented immigrants. Chapter IV (Manuscript 2) presents results from an empirical study that examines the practice implications of various state policies that provide publicly funded prenatal care to undocumented immigrants for health care workers who see undocumented patients, including the effects of the policy on health care workers' abilities to live up to their professional norms under policy constraints. Chapter V (Manuscript 3) examines three normative accounts of the requirements of distributive justice for non-citizens to determine what they might suggest about the provision of publicly funded prenatal care to undocumented immigrants and compares these accounts to locate an overlapping consensus on the duty of the public to provide care to pregnant undocumented immigrants. Chapter VI presents a discussion of the findings of each manuscript and their implications for policy and practice. Appendix A provides additional information about each of the prenatal policies examined in this dissertation, including a policy distribution map and a timeline of each state's policy history. Appendix B presents additional materials related to data analysis methods. Additional appendices include the IRB exemption letter (Appendix C), study recruitment materials (Appendix D), interview guides and disclosure scripts (Appendix E), and qualitative analysis codebooks (Appendix F). A master list of references and a curriculum vitae are also included.

REFERENCES

Fabi, R. (2014). Undocumented Immigrants in the United States: Access to Prenatal Care. *The Undocumented Patients Project*. Retrieved from http://undocumentedpatients.org/issuebrief/undocumented-immigrants-in-the-united-states-access-to-prenatal-care/

Korinek, K., & Smith, K. R. (2011). Prenatal care among immigrant and racial-ethnic minority women in a new immigrant destination: exploring the impact of immigrant legal status. *Soc Sci Med, 72*(10), 1695-1703. doi:10.1016/j.socscimed.2011.02.046

Krogstad, J. M., & Passel, J. (2015, September 23, 2014). 5 facts about illegal immigration in the U.S. *FactTank*. Retrieved from http://www.pewresearch.org/fact-tank/2015/07/24/5-facts-about-illegal-immigration-in-the-u-s/

Passel, J., & Cohn, D. (2015, September 11, 2015). Number of babies born in U.S. to unauthorized immigrants declines. *FactTank*. Retrieved from http://www.pewresearch.org/fact-tank/2015/09/11/number-of-babies-born-in-u-s-to-unauthorized-immigrants-declines/

Sommers, B. D. (2013). Stuck between health and immigration reform--care for undocumented immigrants. *N Engl J Med, 369*(7), 593-595. doi:10.1056/NEJMp1306636

CHAPTER II. LITERATURE REVIEW

This section will review the policy literature about non-citizen access to public services; the epidemiology literature about the importance of prenatal care and immigrant access to it; the policy options that are the focus of this dissertation; and the ethics literature related to the moral relevance of immigration status in the distribution of public resources.

NON-CITIZEN POPULATIONS AND PUBLIC SERVICES

There are many categories of immigrants and non-citizens living within the borders of the United States, which determine not only how long a non-citizen can legally remain in the U.S. but also what public services a non-citizen may access. This section reviews the current immigrant eligibility categories for public benefits and the ways different non-citizen categories used by the U.S. government are employed to determine eligibility for government assistance in 2018. This survey of immigrant categories serves as context for the concluding discussion of undocumented immigrants, whose access to health care is the subject of this dissertation.

Passed in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) defined two eligibility categories of immigrants (qualified and unqualified) that have implications for which public benefits an immigrant may access. Qualified immigrants include legal permanent residents (LPRs), refugees, asylees, long-term parolees, persons whose deportation has been withheld, battered spouses and children, and victims of human trafficking (Fortuny & Chaudry, 2011). Nonqualified immigrants include immigrants formerly considered "PRUCOL" ("Permanently Residing Under Color of Law"), who are living in the United States with the knowledge of immigration enforcement, as well as asylum applicants, students, tourists, and undocumented immigrants (Fortuny & Chaudry, 2011).

Qualified immigrants are ineligible to receive federal means-tested public benefits during their first five years of residency in the United States. This restriction, known as the "five-year ban," applies to all qualified immigrants who arrived in the U.S. after the 1996 enactment of PRWORA. The ban limits immigrant eligibility for Medicaid, Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), and the Children's Health Insurance Program (CHIP), although the 2009 CHIP Reauthorization Act (CHIPRA) gave states the option of covering legally residing pregnant women and children inside the five-year ban through CHIP. Refugees, asylees, and other humanitarian immigrants, as well as immigrants who join the U.S. military to expedite their naturalization process and their spouses and children, are exempt from the 5-year ban. After the five-year ban, all states provide Medicaid to qualified immigrants, although there are a number of states that only provide Medicaid to the groups of qualified immigrants required by law (humanitarian immigrants, LPRs with 40 qualifying quarters of work, and military members/veterans and their families) (Fortuny & Chaudry, 2011).[3]

States wishing to provide non-exempt qualified immigrants with access to public benefits such as Medicaid or CHIP during the five-year ban, or to unqualified immigrants, may do so with state-only funds. There are a number ways that states may extend publicly funded health insurance coverage to groups otherwise uncovered due to immigration status, and generally do so based on age, disability, or specific disease status (i.e. breast or cervical cancer). Most commonly, states will provide medical coverage during the five-year ban,

---

[3] This is the case in Alabama, Mississippi, North Dakota, Ohio, Texas, Virginia, and Wyoming.

either through Medicaid or CHIP, to legally residing pregnant women and children (Fortuny & Chaudry, 2011).

Unqualified immigrants include undocumented immigrants and people in the country temporarily, such as students and tourists. These groups are ineligible for almost all forms of public medical insurance, although they can access some services on a sliding fee scale at Federally Qualified Health Centers (FQHCs) (Gusmano, 2012). Many undocumented and otherwise unqualified immigrants access health care through emergency rooms under the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals to accept patients in life-threatening condition or active labor without ascertaining immigration or insurance status (Siskin, 2004). In specific circumstances, treatment provided under EMTALA will be covered by Emergency Medicaid, which is an encounter-based payment by Medicaid to the institution providing care to cover the emergency medical costs of some unqualified patients, including low-income pregnant women, children under 19, and disabled persons (GAO, 2004; Siskin, 2004). The literature suggests that undocumented immigrants account for approximately 99% of these expenditures in many states, and that approximately 80% of these costs are childbirth-related (DuBard & Massing, 2007). Although Emergency Medicaid covers active labor and emergent childbirth-related complications, it does not cover pre- or post-natal care.

IMMIGRANT ACCESS TO PRENATAL CARE

Although in general the health literature about undocumented immigrants is sparse, a 2013 literature review, which sought to describe the literature that had been published on undocumented pregnant migrants, identified ten studies that examine undocumented pregnant women in the United States that were published between 1967 and 2010 (Munro, Jarvis, Munoz, D'Souza, & Graves, 2013). Five additional studies have been published since 2010 (Atkins, Barroso, Anderson, Meadows, & Lindley, 2017; Korinek & Smith, 2011; Rhodes et al., 2015; Swartz, Hainmueller, Lawrence, & Rodriguez, 2017; Wherry, Fabi, Schickedanz, & Saloner, 2017). Several of these studies focus specifically on health outcomes experienced by undocumented pregnant immigrants; in particular, a 2005 study of undocumented immigrants living in Colorado found that undocumented immigrants had higher rates of childbirth-related hospitalizations and labor complications such as excessive bleeding, precipitous labor, breech presentation, cord prolapse, and fetal distress" compared to citizen and documented immigrant controls (Reed, Westfall, Bublitz, Battaglia, & Fickenscher, 2005). Another study in New York City found that undocumented immigrants were significantly more likely to experience low birth-weight than documented immigrants (Kelaher & Jessop, 2002). These disparities illustrate the nature of the problem of poor health outcomes for undocumented immigrants and their infants.

One possible cause of these poor outcomes is the low rate of prenatal care utilization among undocumented immigrants, which was the focus of four of the studies identified. A study in California determined that undocumented immigrants who did not receive prenatal care had a relative risk of low birth weight of 3.8, and a relative risk of preterm births of 7.4 relative to those who did (Lu, Lin, Prietto, & Garite, 2000). Utilization of adequate prenatal care by both documented and undocumented immigrants has been the focus of several studies, including one that examined the effect of PRWORA on use of prenatal care by Hispanic immigrants in three states. This study found that documented and undocumented immigrants living in Florida, which did not provide expanded coverage for pregnant immigrants after PRWORA, were 2-4 times more likely to make inadequate use of prenatal care than U.S. born citizens in New York, which did expand coverage (Fuentes-Afflick et al., 2006). A more recent study in Utah found that undocumented immigrants were significantly less likely to access "adequate" prenatal care than their documented and native-born counterparts (Korinek & Smith, 2011).

Three studies specifically examined the impact of the expansion of publicly funded coverage for prenatal care to low-income undocumented immigrants. One study, specific to the state of Nebraska, found that publicly funded insurance increased the adequacy of prenatal care utilization but did not improve birth outcomes (Atkins et al., 2017). These findings are similar to those of a study that looked at prenatal care utilization and birth outcomes using national vital statistics data, which also found that immigrant-friendly prenatal policies increased utilization without affecting birth outcomes (Wherry et al., 2017). The third study, based in Oregon, found that public insurance for low-income undocumented pregnant immigrants both improved utilization and reduced the incidence of low birthweight (Swartz et al., 2017).

In general, inadequate access to prenatal care has immediate negative implications for outcomes at birth, but also indicates that the mother and child will not accrue the additional benefits that come along with receiving prenatal care, including integration into the healthcare system, which helps ensure both later access to primary and preventive care and access to social services (Frisbie, Echevarria, & Hummer, 2001; S. Miller & Wherry, 2016).

PRENATAL POLICY OPTIONS

Because of the short- and long-term health benefits of early and adequate prenatal care utilization, a number of states have introduced policies intended to provide access to prenatal care for undocumented immigrants who are ineligible for Medicaid due to their immigration status. To this end, 19 of the 50 states have adopted one of two policy options. Of these, 16 have adopted the "Unborn Child" option and 3 have adopted the "Medicaid Expansion" option (see Appendix A1) (Fabi, 2014). Each of these policies will be discussed below after a brief discussion of the status quo.

There are 32 states that do not provide any form of government-funded insurance to undocumented immigrants to improve access to prenatal care. Undocumented immigrants in these states, as in all others, can access care at safety net providers (such as Federally Qualified Health Centers, or FQHCs), but must do so without insurance coverage, paying out of pocket on a sliding-scale. This is not an ideal situation, however, as geographic proximity to safety net providers is widely varied, which has been shown to affect access to care (Hadley & Cunningham, 2004). Furthermore, the effect of geography on access to care at safety net providers is compounded by limited English proficiency, which is a common issue for undocumented immigrants (Cordasco, Ponce, Gatchell, Traudt, & Escarce, 2011). These geographic and language barrier concerns also persist in states that have a prenatal policy, but it is reasonable to suppose that providing insurance coverage for prenatal care could mitigate some of these issues. The following two prenatal policy options enable states to provide insurance to pregnant undocumented immigrants, although they do so in very different ways (see also: Appendix A2).

THE "UNBORN CHILD" OPTION

The first option for states wishing to provide prenatal care for low-income undocumented immigrants is to adopt the so-called "Unborn Child" Option for their CHIP programs. Under this option, states can choose to extend CHIP eligibility to any "individual under the age of 19 including the period from conception to birth" who also meets income guidelines (CMS, 2002). This allows the state to treat the unborn fetus of an undocumented immigrant as a citizen of the United States who is therefore eligible for benefits (Dallard, 2002; Ludomirsky, 2010). In these states providers can seek reimbursement for care delivered to the pregnant undocumented immigrant and her fetus, as long as the care directly benefits the future U.S. citizen baby (Baumrucker, 2008). Therefore, CHIP in these states covers the cost of ambulatory prenatal care and delivery, but does not cover treatment provided to the mother that does not directly benefit the child. This restriction means that states using the Unborn Child option can opt not to cover postpartum care or other services applicable only to the mother, such a mental or dental health care; which services are actually covered differ from state to state (Baumrucker, 2008). This option is attractive to states because it allows the use of federal dollars to pay for care administered to the fetus despite the mother's ineligibility for federally-funded care due to her immigration status.

STATE-FUNDED MEDICAID EXPANSION

The second option available to states would be to expand eligibility for full Medicaid benefits by eliminating citizenship as an eligibility requirement.[4] This option is both more comprehensive for pregnant undocumented immigrants and more expensive for the state, because federal dollars cannot be used to provide non-emergency care for undocumented immigrants, meaning all care provided under this mechanism is funded entirely by the state. This sort of eligibility expansion is less restrictive than the Unborn Child option, however, because it allows pregnant undocumented immigrants to receive full Medicaid benefits, which do not limit care to ambulatory prenatal care and delivery but also includes such services as dental care and mental health care. Currently, New York and Massachusetts are the only states that provide reimbursement for this this care through Medicaid, although

---

[4] This option could be considered a "Medicaid Look-Alike" because Medicaid, as a federally funded program, is not available to nonqualified immigrants. This option is referred to as a Medicaid Expansion because the provider and patient experience of the program is identical to that of regular Medicaid.

New Jersey also administers a prenatal care program available to undocumented immigrants which is subject to the availability of grant funds (Fabi, 2014).

MORAL RELEVANCE OF IMMIGRATION STATUS

There are a wide variety of normative positions that can be harnessed to support or oppose the provision of prenatal care to non-citizens. The range of normative positions that support provision of some degree of access to care for "irregular migrants" (including the undocumented and temporary non-immigrants) can be categorized into four groups: minimalist humanitarianism, full equality, instrumental middle grounds, and partial entitlement (Hall & Perrin, 2015). This categorization forms a helpful framework for considering the similarities and differences between the various normative accounts regarding the provision of public services to non-citizens found in the ethics literature. This section gives brief overview of each of these categories and goes into detail about two normative positions that resonate with the empirical findings of Manuscript 1; these are the cosmopolitan position and the communitarian position. This review also lays the groundwork for the normative considerations in Manuscript 3 by presenting some of the major normative positions relating to the distribution of public services to non-citizens.

MINIMALIST HUMANITARIANISM

The category of moral argument that provides justification for a weak state obligation to provide publicly funded prenatal care to undocumented immigrants is minimalist humanitarianism. This category includes a range of normative accounts that support an obligation to provide care in emergency situations, or "a widely shared and deeply felt humanitarian ethic, which compels individuals, institutions, and society to come to the aid of any person in serious distress" (Hall & Perrin, 2015). One such normative account is the “rule of rescue,” which is “the imperative people feel to rescue identifiable individuals facing avoidable death” (McKie & Richardson, 2003). It could be argued that such an ethic does not generate an obligation to provide prenatal care to pregnant non-citizens because prenatal care is not necessary to avoid death. Although it has been argued that the rule of rescue could require relief of immediate suffering, rather than only preventing death, this interpretation of the rule may still fail to support publicly funded prenatal care because it is preventative, not responsive to an immediate crisis or suffering (Hall & Perrin, 2015). Indeed, the rule of rescue could in fact be used to oppose the implementation of a state prenatal policy altogether, since pregnancy is not an emergency condition and does not generate a humanitarian obligation. The political course of action that is recommended by an application of the rescue principle will depend on the way “serious distress” or “urgent need” is defined. Despite its limited utility in justifying the provision of non-emergency care to undocumented immigrants, minimalist humanitarianism merits inclusion in this review because it could support the provision of some public services to non-citizens.

FULL (OR PARTIAL) EQUALITY

On the other end of the spectrum from the minimal humanitarianism in terms of duties to non-citizens are accounts that support provision of health care to undocumented immigrants that is equal to that provided to full citizens. This section considers two of these normative accounts that are prevalent in contemporary justice literature: cosmopolitan global justice and fundamental human rights. Two cosmopolitan arguments are explored in detail to illustrate different applications of cosmopolitan ethics, with a brief overview of the human rights position to follow.

a. Cosmopolitanism

Cosmopolitanism holds the position that "societies should not disadvantage immigration because people are entitled to move from place to place as they wish, without legal and social barriers" (Hall & Perrin, 2015). Few philosophers endorse a fully cosmopolitan position due to the realities of the global geopolitics and national sovereignty (Bosniak, 2008). Despite the challenges of supporting a fully cosmopolitan position, there are a number of moral theorists who adopt, with provisions, a cosmopolitan view of entitlement to social services, including Brock and Wild.[5]

Brock roots her argument in a commitment to the "Moral Equality Imperative," which states that "all human beings' needs and interests deserve equal consideration," regardless of where they are located on the globe, all else being equal (Brock, 2015). Although Brock and many other cosmopolitans base their justice claims in the moral equality of all human beings, she settles for a weak form of cosmopolitan. Brock acknowledges the practical limitations of treating all human beings the same regardless of their immigration status or geographic location and suggests that our obligations may end at meeting urgent health care needs (Brock, 2015). As with the minimalist humanitarian position, it is unclear whether Brock's weak cosmopolitanism would entail a moral obligation to provide prenatal care to undocumented immigrants.

Wild engages with Brock's piece and responds that "this indirect and maybe unintended implication of a lower level of health care for migrants as compared to citizens [is] only a half-hearted embrace of cosmopolitan ethics" (Wild, 2015). She presents her own argument for fully equal access to health care for citizens and resident migrants, regardless of

---

[5] This is not by any means an exhaustive list of theorists who take a cosmopolitan or quasi-cosmopolitan approach to this issue, but rather provides a snapshot of current thought in cosmopolitanism.

their immigration status. Wild argues that health is a good with "existential importance," and as such, there is an obligation to ensure that the health care needs everyone are met. Essentially, Wild rejects Brock's considerations of practical difficulties and suggests that there is a state obligation to provide immigrants with access to care on par with citizens when a state has the capacity to do so. Because the United States has the capacity to provide the same coverage to undocumented immigrants as to citizens, Wild would argue that it has a cosmopolitan obligation to do so.

Despite the divergence between these two theorists on the obligations generated by a cosmopolitan ethic in light of practical considerations, they both agree on the fundamental feature of cosmopolitanism, which is a belief that all humans, by virtue of their humanity, have equal moral worth and therefore should be treated alike. Cosmopolitanism therefore provides a strong justification for providing equal health care access to citizens and non-citizens, and will likely prove relevant to my empirical and normative analysis.

b. Human Rights

The fundamental human rights position provides another moral framework from which to argue for equality of health care access between citizens and non-citizens. There is a vast body of human rights "law" that requires equal access to health care for all humans, regardless of their immigration status. One of the major human rights documents is the United Nations Universal Declaration of Human Rights, which promotes the "right to a standard of living adequate for the health and well-being [all humans], including food, clothing, housing and medical care and necessary social services." It further notes that "[m]otherhood and childhood are entitled to special care and assistance" (UN, 1948). There are many difficulties that follow from basing obligations to provide medical care on a human rights framework; critiques of the approach argue that this position suffers from a lack of theoretical justification and relies too heavily on legalism (Hall & Perrin, 2015; Wolff, 2012).

David Miller, a political philosopher, bases some of his arguments on a human rights framework. Drawing on both the minimalist humanitarian position described above and the idea of basic human rights, Miller argues that the "urgent" rights of non-citizens should be protected. Miller defines human rights as "the rights whose possession allows people to meet" the needs "that must be met if people are to be able to lead minimally decent lives" (D. Miller, 2016, p. 32). This ultimately entails a quite narrow view of human rights; while other theorists might include the rights that Miller describes as "rights of citizenship," such as those rights that "provide the conditions under which a person can participate fully in the social and political life of the society to which they belong," Miller's account is minimalist and limited only to those "urgent" rights that generate obligations due to the risk of serious harm.

In the case of legally residing immigrants, it is clear that Miller believes that the provision of health care is an obligation of the receiving state; he argues that "the receiving state by granting entry takes full responsibility for protecting basic rights to subsistence, shelter, health care, bodily integrity, safety at work, and so forth" (D. Miller, 2016, p. 117). It is important to note that this position applies only to those immigrants who were *granted entry*, and therefore may not include undocumented immigrants who enter without authorization. Nonetheless, Miller concludes that "A state that claims authority to apply its laws to everyone within its territory must also protect the human rights of all those present, whether legally or not" (D. Miller, 2016, p. 117). Thus it is the political legitimacy of the state that is at stake when it determines whose basic rights it will defend, and a state that protects only the basic rights of some residents and not others is illegitimate. This portion of Miller's position is one example of a human rights approach to the question of obligations towards non-citizens.

INSTRUMENTAL MIDDLE GROUNDS

The next category of arguments examined in this review are the "instrumental middle grounds" arguments, which suggest that providing care to undocumented immigrants is instrumentally valuable for the achievement of other morally significant ends (Hall & Perrin, 2015). One argument that promotes immigrant access to health care for its instrumental value is that "granting [undocumented immigrants] access [to health care] might cure or prevent infectious disease," which may not necessarily seem sufficient to justify coverage of prenatal care, since on the surface prenatal care does not obviously encompass infectious disease care (Hall & Perrin, 2015). It has been shown, however, that publicly-funded prenatal care for undocumented immigrants significantly reduces sexually transmitted infections (STIs), adverse effects on pregnancy from STIs, and the associated medical expenses (Kuiper, Richwald, Rotblatt, & Asch, 1999). The positive public health and public resource benefits of providing access to care are widely documented, and also bolster this medical instrumentality argument (Kullgren, 2003; Nandi, Loue, & Galea, 2009).

One example of this instrumental approach is found in the "global public goods" argument of Patricia Illingworth and Wendy Parmet. Illingworth and Parmet define a global public good as one that is both non-rivalrous and non-excludable, meaning that its use by one person does not diminish the ability of others to use it, and it is difficult to prevent others from enjoying it. They argue that people are "socially embedded and interdependent," and suggest that these community relationships are morally meaningful because the health of individuals impacts the health of other community members with whom they are connected

(Illingworth & Parmet, 2017, p. 127). They cite literature on the spread of diseases through social networks and the impact of social determinants on health status to support this argument, and suggest that human interconnectedness makes it necessary to protect the health status of all community members, regardless of their immigration status, for the good of the community as a whole. They also argue that "health makes people better workers, and presumably more productive within the workforce" (Illingworth & Parmet, 2017, p. 130), implying that we should aim to improve health outcomes for resident non-citizens in our own economic self-interest. Essentially, they argue that "if health is impacted by social determinants, social capital, and norms, and we live side by side with newcomers, we cannot easily remain unaffected by their health," and therefore it is in our own self-interest to promote the health of newcomers (Illingworth & Parmet, 2017, p. 131).

Despite the usefulness of these arguments, however, basing a justice claim on its instrumentality to achieving other ends, rather than treating justice as an end in itself, is a tenuous position that may lead to a reversal of position should the empirical facts supporting its instrumentality change. Although instrumental reasons for providing access to care may be convincing to some, others may find them to be neither fully successful nor normatively satisfying.

Partial Entitlement

The final category of justifications for undocumented access to care includes a range of normative positions that public services should be distributed based on individual entitlement. These positions are based on the premise that "societies should aspire to treat members equally if they are equally entitled to or deserving of social benefits" (Hall & Perrin, 2015). These positions differ from cosmopolitanism in that many hinge on different levels of "deservedness," which a cosmopolitan would reject on the premise that all humans are equally deserving simply by virtue of being human. Different societies may endorse different characteristics that determine entitlement to social benefits, although membership in the society is typically considered relevant. Because entitlement-based normative position is particularly common in American policy debates, reflecting an American ethos of individualism whereby individuals are expected to get ahead on their own merit (Pantoja, 2006), this section considers both the communitarian justification of entitlement and the "deservedness" objection to it.

One communitarian argument in favor of providing at least some level of care to undocumented immigrants is that they "contribute to social welfare in the same ways that other productive members of society do, including paying at least some taxes" (Hall & Perrin, 2015). A recent report by the nonpartisan Institute on Taxation and Economic Policy found that undocumented immigrants paid $11.84 billion in state and local taxes in 2012, at an effective tax rate of 8% (Gardner, Johnson, & Wiehe, 2015), but the claim that undocumented immigrants pay sufficient taxes to merit access to public services is disputed (Camarota, 2009; Edwards, 2010; Martin, 2012). Either way, it could be argued that basing entitlement on who pays taxes may not be the most morally appropriate approach (J. Dwyer, 2004).

A more convincing justification of the communitarian position is the social embeddedness argument that "even when immigrants' social contributions cannot be quantified, they are nevertheless tangible in more diffused or qualitative senses of communitarianism" (Hall & Perrin, 2015). Undocumented immigrants live in neighborhoods and work in businesses, and through the formation of social relationships they become deeply embedded in the society in which they live. Several political theorists argue that this entitles them to some amount of public services, including Joseph Carens and Linda Bosniak (Bosniak, 2007; Carens, 2013). Carens's theory suggests that the amount of time an immigrant has resided in the community is relevant, and that social embeddedness increases with more time, as does the strength of a non-citizen's claim to public resources (Carens, 2013). To a certain extent, this theory is reflected in American policy; PRWORA outlawed the use of federal funds for services to legal permanent residents who had been in the country for fewer than five years, but not for those who have been here longer (although it should be noted that five years may seem like an arbitrary cutoff).

Limiting the time-related benefits to just legal permanent residents does not comport with Carens' theory, but it does reflect "deservedness" objections that "illegality disqualifies [undocumented immigrants] for at least some social services they would otherwise merit" (Hall & Perrin, 2015). There is an aspect of punishment or retributive justice to the line of thinking that suggests that having broken the law to enter the country makes undocumented immigrants undeserving of public benefits, but many citizens violate the law every day without being disqualified from health care coverage (James Dwyer, 2015; Hall & Perrin, 2015). Even if the punishment argument were convincing, however, it could be argued that denying prenatal care to undocumented pregnant immigrants unjustly punishes a fetus for a crime it did not commit; this particular argument seems a likely candidate for the justification of the Unborn Child policy option.

This review of the normative literature related to the provision of health care to undocumented immigrants is far from comprehensive, but provides an overview of the types of arguments that are explored in this dissertation. These moral arguments inform the ethical context surrounding the origin, content, and practice of the prenatal policies examined in this case study.

REFERENCES

Atkins, D. N., Barroso, C. S., Anderson, A. J., Meadows, J. T., & Lindley, L. C. (2017). Maternal Health of Undocumented Women With and Without Medicaid Access in Nebraska, 2007-2011. *Hispanic Health Care International, 15*(1), 13-19.

Baumrucker, E. P. (2008). *SCHIP coverage for pregnant women and unborn children.* Retrieved from

Bosniak, L. (2007). Being here: ethical territoriality and the rights of immigrants. *Theoretical inquiries in law, 8*(2), 389-410.

Bosniak, L. (2008). *The citizen and the alien: dilemmas of contemporary membership*: Princeton University Press.

Brock, G. (2015). Global Justice, Cosmopolitan Duties and Duties to Compatriots: The Case of Healthcare. *Public Health Ethics, 8*(2), 110-120. doi:10.1093/phe/phu039

Camarota, S. A. (2009). Illegal Immigrants and HR 3200. *Center for Immigration Studies.*

Carens, J. (2013). *The Ethics of Immigration*: Oxford University Press, USA.

CMS. (2002). State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children (42 CFR 457). *Federal Register, 67*(191), 61956-61974.

Cordasco, K. M., Ponce, N. A., Gatchell, M. S., Traudt, B., & Escarce, J. J. (2011). English language proficiency and geographical proximity to a safety net clinic as a predictor of health care access. *J Immigr Minor Health, 13*(2), 260-267.

Dallard, C. (2002). New SCHIP Prenatal Care Rule Advances Fetal Rights At Low-Income Women's Expense. *The Guttmacher Report, 5*(5), 3-5.

DuBard, C. A., & Massing, M. W. (2007). Trends in emergency Medicaid expenditures for recent and undocumented immigrants. *Jama, 297*(10), 1085-1092. doi:10.1001/jama.297.10.1085

Dwyer, J. (2004). Illegal immigrants, health care, and social responsibility. *Hastings Cent Rep, 34*(1), 34-41.

Dwyer, J. (2015). On Taking Responsibility for Undocumented Migrants. *Public Health Ethics, 8*(2), 139-147.

Edwards, J. R. (2010). The Medicaid Costs of Legalizing Illegal Aliens. *Center for Immigration Studies. Retrieved December, 18*, 2012.

Fabi, R. (2014). Undocumented Immigrants in the United States: Access to Prenatal Care. *The Undocumented Patients Project.* Retrieved from http://undocumentedpatients.org/issuebrief/undocumented-immigrants-in-the-united-states-access-to-prenatal-care/

Fortuny, K., & Chaudry, A. (2011). A comprehensive review of immigrant access to health and human services. *Washington, DC: Urban Institute.*

Frisbie, W. P., Echevarria, S., & Hummer, R. A. (2001). Prenatal care utilization among non-Hispanic Whites, African Americans, and Mexican Americans. *Matern Child Health J, 5*(1), 21-33.

Fuentes-Afflick, E., Hessol, N. A., Bauer, T., O'Sullivan, M. J., Gomez-Lobo, V., Holman, S., . . . Minkoff, H. (2006). Use of prenatal care by Hispanic women after welfare reform. *Obstet Gynecol, 107*(1), 151-160. doi:10.1097/01.AOG.0000191299.24469.1b

GAO. (2004). *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs.* (GAO-04-472). Washington, DC: U.S. Government Accountability Office.

Gardner, M., Johnson, S., & Wiehe, M. (2015). *Undocumented Immigrants' State & Local Tax Contributions.* Retrieved from

Gusmano, M. K. (2012). *Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care.* Retrieved from Garrison, NY:

Hadley, J., & Cunningham, P. (2004). Availability of safety net providers and access to care of uninsured persons. *Health services research, 39*(5), 1527-1546.

Hall, M. A., & Perrin, J. (2015). Irregular Migrant Access to Care: Mapping Public Policy Rationales. *Public Health Ethics, 8*(2), 130-138. doi:10.1093/phe/phv016

Illingworth, P., & Parmet, W. (2017). *The Health of Newcomers.* New York: New York University Press.

Kelaher, M., & Jessop, D. J. (2002). Differences in low-birthweight among documented and undocumented foreign-born and US-born Latinas. *Soc Sci Med, 55*(12), 2171-2175.

Korinek, K., & Smith, K. R. (2011). Prenatal care among immigrant and racial-ethnic minority women in a new immigrant destination: exploring the impact of immigrant legal status. *Soc Sci Med, 72*(10), 1695-1703. doi:10.1016/j.socscimed.2011.02.046

Kuiper, H., Richwald, G. A., Rotblatt, H., & Asch, S. (1999). The communicable disease impact of eliminating publicly funded prenatal care for undocumented immigrants. *Matern Child Health J, 3*(1), 39-52.

Kullgren, J. T. (2003). Restrictions on undocumented immigrants' access to health services: the public health implications of welfare reform. *Am J Public Health, 93*(10), 1630-1633.

Lu, M. C., Lin, Y. G., Prietto, N. M., & Garite, T. J. (2000). Elimination of public funding of prenatal care for undocumented immigrants in California: a cost/benefit analysis. *Am J Obstet Gynecol, 182*(1 Pt 1), 233-239.

Ludomirsky, A. (2010). *Access to Prenatal Care for Undocumented Immigrants Under Medicaid and CHIP: A Review of State Prenatal Care Programs* Princeton.

Martin, J. (2012). Deterring illegal immigrant settlement: a guide to state and local action: Washington (DC): Federation for American Immigration Reform.

McKie, J., & Richardson, J. (2003). The Rule of Rescue. *Social Science & Medicine, 56*(12), 2407-2419. doi:http://dx.doi.org/10.1016/S0277-9536(02)00244-7

Miller, D. (2016). *Strangers in our midst*: Harvard University Press.

Miller, S., & Wherry, L. R. (2016). The Long-Term Effects of Early Life Medicaid Coverage. *Available at SSRN 2466691.*

Munro, K., Jarvis, C., Munoz, M., D'Souza, V., & Graves, L. (2013). Undocumented pregnant women: what does the literature tell us? *J Immigr Minor Health, 15*(2), 281-291. doi:10.1007/s10903-012-9587-5

Nandi, A., Loue, S., & Galea, S. (2009). Expanding the universe of universal coverage: the population health argument for increasing coverage for immigrants. *J Immigr Minor Health, 11*(6), 433-436. doi:10.1007/s10903-009-9267-2

Pantoja, A. (2006). Against the tide? Core American values and attitudes toward US immigration policy in the mid-1990s. *Journal of Ethnic and Migration Studies, 32*(3), 515-531.

Reed, M. M., Westfall, J. M., Bublitz, C., Battaglia, C., & Fickenscher, A. (2005). Birth outcomes in Colorado's undocumented immigrant population. *BMC Public Health, 5*, 100. doi:10.1186/1471-2458-5-100

Rhodes, S. D., Mann, L., Siman, F. M., Song, E., Alonzo, J., Downs, M., . . . Hall, M. A. (2015). The impact of local immigration enforcement policies on the health of immigrant hispanics/latinos in the United States. *Am J Public Health, 105*(2), 329-337. doi:10.2105/ajph.2014.302218

Siskin, A. (2004). *Federal Funding for Unauthorized Aliens' Emergency Medical Expenses.* Retrieved from

Swartz, J. J., Hainmueller, J., Lawrence, D., & Rodriguez, M. I. (2017). Expanding Prenatal Care to Unauthorized Immigrant Women and the Effects on Infant Health. *Obstetrics & Gynecology, 130*(5), 938-945. doi:10.1097/aog.0000000000002275

UN. (1948). Universal Declaration of Human Rights. *United Nations General Assembly.*

Wherry, L. R., Fabi, R., Schickedanz, A., & Saloner, B. (2017). State And Federal Coverage For Pregnant Immigrants: Prenatal Care Increased, No Change Detected For Infant Health. *Health Affairs, 36*(4), 607-615. doi:10.1377/hlthaff.2016.1198

Wild, V. (2015). Universal Access to Health Care for Migrants: Applying Cosmopolitanism to the Domestic Realm. *Public Health Ethics, 8*(2), 162-172. doi:10.1093/phe/phv014

Wolff, J. (2012). Global Justice and Health. *Global Justice and Bioethics*, 78.

CHAPTER III. MANUSCRIPT 1

Publicly Funded Prenatal Care for Undocumented Immigrants: An Analysis of Moral and Prudential Reasoning in Policy

ABSTRACT

This paper explores the relationship between the policy narratives, policy requirements, and the use of moral and prudential reasons by courts and legislatures in state policies that provide publicly-funded prenatal care to undocumented immigrants (hereafter "prenatal policies"). It does so through 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. Using iterative emergent thematic coding, this review and analysis of policy documents yielded moral reasons based on appeals to different conceptions of the principles of Respect for Persons and Justice, as well as prudential reasons that appealed to the health and economic benefits of prenatal care for U.S. citizens and legal residents. Despite the variety of reasons used across states, however, this paper finds that many of the state differences can be traced to the state's position on the protection of reproductive rights, and that otherwise the differences in the policies themselves are minor relative to states that lack prenatal policies altogether. This conclusion suggests that there may be areas where policymakers with different political orientations can find consensus on prenatal care for undocumented immigrants.

BACKGROUND

Current estimates place the population of undocumented immigrants living in the United States at approximately 11.3 million individuals, which is approximately 3.5% of the

U.S. population (Krogstad & Passel, 2015). According to a recent measure 7.5% of the 3.9 million babies born in the United States in 2013 had at least one parent who was an undocumented immigrant, although data on the number of babies born to undocumented mothers is not available (Passel & Cohn, 2015). Under the Fourteenth Amendment to the U.S. Constitution, all children born within the borders of the United States are legal citizens regardless of their parents' immigration status, but undocumented pregnant immigrants are significantly less likely to access adequate prenatal care than pregnant citizens due to a range of challenges, including financial, structural, and psychosocial barriers to care (Korinek & Smith, 2011). Several of these barriers are imposed by the U.S. government. 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 bans the use of Federal funds in the provision of 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 (Sommers, 2013).

Nineteen states have implemented policy options to cover some amount of health care services for pregnant undocumented immigrants (hereafter "prenatal policies"); these include an exclusively state-funded program that covers the full range of Medicaid services for financially eligible pregnant women regardless of immigration status and a State Plan Amendment that extends Children's Health Insurance Program (CHIP) benefits to the unborn fetus of pregnant immigrants (Fabi, 2014) (See Appendix A1). The legislative histories of these complicated and controversial state policies have not been fully explored in the policy literature, nor have the moral and prudential reasons employed by those who supported or opposed the policies in the legislature and judiciary. This paper explores these questions through a review and comparative analysis of three states with different prenatal policies: Nebraska, which adopted the CHIP option; California, which also adopted the CHIP option, but, unlike Nebraska, allows the use of a bundled payment system for all pregnancy-related care; and New York, one of the only states to use state-only funds.

METHODS

This paper employed a content analysis of key documents. The goals of the content analysis were (1) to capture the policy and political narrative that led to the passage of the prenatal policy; (2) to determine precisely what services each state prenatal policy covers, and (3) to examine the broader political and moral context of the policies, which includes the moral and prudential reasons and justifications given by the policymakers, courts, and citizens who argued for or against the policies.

DATA COLLECTION

An extensive review of the legislative and court documents associated with the passage of each case state's prenatal policy bills was conducted. Documents meeting inclusion criteria were all versions of the 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 prenatal policy, and other associated legislative documents. Many of these documents were located using each state's online legislative archive, although some states had more comprehensive archives than others. Documents for California and New York that could not be accessed online, including videos of hearings and legislative policy analyses, were acquired by contacting the state archive in each state. Judicial decisions were found using the WestlawNext database. For the state of

New York, where the budget-based legislative process led to a dearth of legislative documents due to the circumstances under which the relevant bill was passed, additional information was collected through personal communication with the New York State Assembly Member who sponsored relevant legislation and through news coverage that reported on the policy's passage, much of which included quotations from lawmakers not otherwise available.

DATA ANALYSIS

All materials were reviewed for references to funding mechanisms, services covered, immigration status, policy goals, and moral language to determine which were relevant to the research questions. Key documents, which addressed some or all of these features, were imported into NVivo 11 for Mac software, which is capable of coding PDFs, audio files, video files, and Word documents, for analysis (QSR International, 2017). Documents were then coded using an iterative emergent thematic coding scheme, in which codes were hierarchically structured such that policy requirements, moral reasons, and prudential reasons could be coded separately. The codes were critically evaluated throughout the coding process to more accurately reflect the relationships between emerging themes. During the reviewing and coding process, memos were drafted that detailed the themes that were prevalent in important documents for each state, as were narrative memos that traced the development of each state policy. The coded data was then reviewed and examined for coding of themes across documents and relative code frequency to determine the most prevalent themes from each state. This was done using the "query" function of NVivo, which allows the researcher to explore the relationships between codes and examine coded text in different contexts. The codebook, which provides a visual representation of the relationships between codes, is available in Appendix F1.

RESULTS

POLICY NARRATIVES

Each state followed its own unique path in implementing a prenatal policy for undocumented immigrants. Each path is outlined below in order to provide the context for the disparate policy requirements and the wide range of moral and prudential arguments found in each case state. A table outlining the eligibility criteria and benefits of each state's prenatal policy is available in Appendix A2, and a timeline of the policy narrative in each state is available in Appendix A3.

Nebraska

The state of Nebraska has a long history of covering prenatal care for women who do not qualify for Medicaid in their own right, including undocumented pregnant immigrants, by designating "unborn children"[6] as a class of Nebraska residents eligible for benefits. This has been Nebraska state policy since at least the 1970s, when a Nebraska court determined that "for the purpose of awarding aid to dependent children payments, the term dependent child shall include unborn children." (Elliott v. Ehrlich, 280 N.W.2d 637, Neb. 1979). Nebraska's policy of covering the unborn child continued until 2009, although the Second Circuit of the U.S. Federal Court of Appeals had ruled this illegal in 2001 when deciding the *Lewis v. Thompson* case (discussed below under New York).

---

[6] My use of the term "unborn children" 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 unborn child in every instance it is used, but it should be understood that "unborn child" refers to a specific usage found in the data I present. The same is true of the terms "pro-life" as a stand in for "anti-abortion" and "illegal immigrant" for "undocumented immigrant"

In 2001, the George W. Bush administration promulgated a new State Children's Health Insurance Program (CHIP) regulation that allowed states to define a "targeted low-income child" as anyone from conception to age 19, rather than anyone from birth to age 19 (CMS, 2002). Known as the "Unborn Child" option, states could elect to adopt this new definition through a State Plan Amendment (SPA) to their Medicaid program in order to provide prenatal care to undocumented pregnant immigrants using federally matched CHIP money when the unborn child was the beneficiary. This meant, in effect, that any care not directly applicable to the health of the fetus (such as, for example, dental health care for the mother) would not be covered (CMS, 2002). In most states the SPA can be submitted directly to Centers for Medicare and Medicaid Services (CMS) by the state department responsible for overseeing CHIP and Medicaid, the state legislature does not have to be involved (National Health Law Program & National Association of Community Health Centers, 2006). In Nebraska, the submission of an SPA to adopt the Unborn Child option that was "proposed due to a loss of federal matching funds relating to a particular covered service or eligibility category" was exempt from a requirement of legislative review. (Nebraska Revised Statute 68-91).

Despite the existence of the CHIP Unborn Child option, Nebraska continued to cover undocumented pregnant immigrants through their state Medicaid program, directing the funds to care for the unborn child until 2009, when they received a letter from CMS indicating that they were in violation of federal regulations and needed to switch to the CHIP Unborn Child option if they wished to continue providing publicly funded prenatal care to the "unborn children" of undocumented pregnant immigrants. The Nebraska Department of Health and Human Services (NDHHS) declined to submit an SPA adopting the Unborn Child option and did not inform the State legislature of the CMS letter until the very end of the bill introduction period in 2010. The last-minute bill submitted directing the NDHHS to adopt the CHIP Unborn Child option to cover the care of undocumented pregnant immigrants failed to gather enough support to pass the legislature, resulting in hundreds of immigrants losing coverage for prenatal care (Carter, 2012). This situation was remedied in 2012, when a new bill ordering the implementation of the CHIP Unborn Child option in Nebraska passed the Legislature and was enacted by a vote overruling the governor's veto of the bill (New York Times Editorial Board, 2012). As a result, the current Nebraska policy names the unborn child as the beneficiary, covers only those services that directly affect the health of the fetus, and explicitly excludes access to abortion services.

California

Like Nebraska, California has a long and contentious history of providing prenatal care to undocumented immigrants. Starting in 1988, in response to OBRA '86 banning the use of federal funds for health care coverage for any undocumented immigrant, the state of California began providing state funded "Pregnancy-Related Medi-Cal" to all financially eligible immigrants regardless of immigration status. Proposition 187, which banned the use of state funding to provide any public services to undocumented immigrants and required health care providers to report undocumented patients to immigration authorities, passed by referendum in 1994. After a protracted legal battle, federal courts deemed Prop 187 unconstitutional and preempted by the 1996 passage of PRWORA.

Following PRWORA, California opted to continue providing Medi-Cal to legal immigrants within the 5-year bar using state funds. At the same time, Republican Governor Pete Wilson moved to cut off prenatal care for undocumented immigrants in order to bring California into compliance with PRWORA, but this was ultimately blocked by state courts.

While the appeal process was ongoing, the legislature passed a bill to provide coverage for prenatal care services for undocumented immigrants, which Governor Wilson vetoed. After Wilson left office in 1999, newly elected California Governor Gray Davis immediately added state funding for prenatal care for the undocumented immigrants back into the state budget. This remained the status quo until 2005, when the California legislature, in cooperation with Governor Arnold Schwarzenegger, passed a bill authorizing the State Department of Health Services (DHS) and the Managed Risk Medical Insurance Board (MRMIB) to adopt the CHIP Unborn Child option so they could accept federal funds for the services they already provided. As in Nebraska, DHS/MRMIB did not need legislative approval to take this action (National Health Law Program & National Association of Community Health Centers, 2006), but the legislature passed a bill in order to explicitly affirm a woman's right to privacy and call for provision of services under the CHIP Unborn Child option "when, during the period of coverage, the woman is the beneficiary." (AB 794, 2005) The current policy allows undocumented pregnant immigrants to enroll in "Pregnancy-Related Medi-Cal," which covers all "medically necessary" services, including abortion. (Fiory, Landsberg, Sanematsu, & Tawatao, 2016).

New York

New York's policy narrative is unique in that it primarily follows a judicial path, rather than a legislative one. The story begins in 1979, when a group of immigrants who were not legal permanent residents (LPRs) sued the state for denying them access to Medicaid. In order to be compliant with new Department of Health and Human Services (DHHS) regulations, the state had decided to deny benefits to "all aliens except those lawfully admitted for permanent residence or permanently residing in the United States under color of law ('PRUCOL')." The case against the state was built on four arguments:

> (1) the Medicaid statute did not explicitly authorize such regulations;
> (2) the DHHS regulations violated constitutional principles of equal protection and due process;
> (3) the DHHS Secretary's definition of PRUCOL under the regulations was impermissibly narrow; and
> (4) the DHHS regulations did not apply to benefits directed to the unborn children of pregnant alien women. (*Lewis v. Grinker VI*, 2000).[7]

This initial case was decided on the first of these arguments. The court found that the DHHS Secretary did not have the authority to promulgate such a regulation as part of Medicaid, but rather that if Congress intended to deny benefits to some categories of immigrants they would need to do so by enacting a new law. Because the case succeeded on the first argument, the court did not initially consider the other three. The ensuing series of cases, named *Lewis* after the first plaintiff, Lydia Lewis, continued until the seventh and final case *Lewis v. Thompson* in 2001. The fourth argument, related to the "unborn children of pregnant alien women," figured prominently in the final *Lewis* cases.

Lewis was argued several times between 1987 and 2001 in response to changing federal laws, including the passage of the Immigration Reform and Control Act of 1986 (IRCA), the Omnibus Budget Reconciliation Act of 1986 (OBRA '86), and the 1996 PRWORA. The court continued to uphold an injunction preventing the state from denying Medicaid to pregnant undocumented immigrants on varying grounds. In 1987, the plaintiffs argued that their fetuses were "presumptively not aliens," and the court granted their petition for a preliminary injunction on the grounds that they had demonstrated irreparable damage and would likely succeed at trial (*Lewis III* 1987). In 1992, that injunction became permanent in the absence of evidence that Congress intended to deny prenatal care to undocumented immigrants in OBRA '86 despite that statute's explicit denial of using federal

---

[7] I use the labelling practices employed by the District and Circuit courts to number the series of *Lewis* cases.

funds for the provision of non-emergency Medicaid benefits to all other undocumented immigrants (*Lewis V*, 1992). The state of New York brought the issue back to court in 2000 following the passage of Welfare Reform in 1996, arguing that the injunction should be vacated on the grounds that PRWORA provided clear evidence of Congress's intent to deny undocumented immigrants prenatal care (*Lewis VI*, 2001*)*. The court initially upheld the injunction on the grounds that denial of prenatal care to undocumented immigrants violated the Fifth Amendment's Due Process Clause, but this decision was permanently overturned by the 2nd Circuit on appeal in 2001, affirming the right of the state to deny access to federal Medicaid funds to provide care to undocumented pregnant immigrants (*Lewis v. Thompson*, 2001).

Within a year of this decision, the New York State Legislature moved to cover prenatal care for undocumented pregnant immigrants with state funds. The initial effort to accomplish this came in the form of a bill in the state Assembly (A8953, 2001), which was introduced in May 2001, just a week after the *Lewis v. Thompson* case was decided. This bill did not pass the Assembly in time to be debated by the Senate in 2001, but was brought back in January 2002. Ultimately, this bill was held in the state Senate so that prenatal care could be restored through a companion bill to the 2001-2002 "deficiency budget" introduced by Governor Pataki in March 2002 (S6536, 2002). Since 2002, the state of New York has provided full-scope Medicaid services, including abortion, for financially eligible undocumented pregnant immigrants for the duration of pregnancy and two months post-partum using state funds.

MORAL AND PRUDENTIAL REASONS

As the previous sections have indicated, Nebraska, California, and New York all have a long history of providing prenatal care to undocumented immigrants. Despite the similar end result—namely, that undocumented pregnant immigrants are able to receive publicly funded care for services related to pregnancy—the paths taken by each state to reach that result differed significantly. In Nebraska, the removal of federal Medicaid funding resulted in the state's adoption of the Unborn Child option, which returned federal dollars through CHIP. California's path included several years of state funding, but the state ultimately switched to the Unborn Child option once precautionary measures protecting reproductive rights were in place. In New York, the state chose to dedicate its own funds to provide services that had been federally matched until a judicial decision struck that down.

This section will explore the reasons that policymakers, judges, and citizens gave in support of or in opposition to each state's policy. These reasons emerged through the document review of the legislative history for each state, although it should be noted that much more data was available from the debates and hearings held in Nebraska. Because of this, the findings from Nebraska are presented more prominently, and those from California and New York provide counterpoints to or reinforcement of those findings. Additionally, due to the diverse nature of the types of documents that comprised the various legislative histories, it is difficult to meaningfully quantify the themes identified. Therefore, rather than providing exact numbers for the occurrence of each theme, this section will allude to relative frequency to indicate how common each theme was in each state. See Appendices G1 and G2 for coding matrices and hierarchy charts that illustrate the exact and relative frequency of reasons in each state.

Reasons are grouped into *moral reasons*, which are grounded in a moral principle or claim and potentially generate obligations, and *prudential reasons*, which are based on normative but non-moral claims that "appeal only to the interests of legal residents of the United States" (Nickel, 1986). Prudential reasons encompass public health reasons as well as legal and political ones, as long as the interests of legal residents motivate the claim.

Moral Reasons

In Nebraska, the vote on the Unborn Child option was frequently framed as a choice between two politically conservative policy agendas: 1) opposing abortion and 2) opposing illegal immigration. As one state senator put it, "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" (LB599 Floor Debate, 4/3/12). Because of this framing, the moral reasons given to support or oppose the policy can be neatly divided between respect for persons arguments and justice arguments.

Respect for Persons

The most common reason given in the state of Nebraska in support of the Unborn Child option was that it is a pro-life policy at its core.[8] One state senator even described the policy "the most significant piece of pro-life legislation that we've [dealt with] in several years" (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 above, 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" (LB 599). Many Nebraska state senators supported the Unborn Child option because of this new definition of a child; one proponent of the bill noted that

---

[8] As noted earlier, my use of the term "pro-life" is not meant as an endorsement of that term, but rather reflects the emic usage founds in the legislative history documents

“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” (LB599 Floor Debate, 4/3/12). The implication seems to be that legal recognition of fetal personhood is a step towards banning abortion, and 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 moral reason that mattered was that it recognized 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” (LB599 Floor Debate, 4/3/12). The executive director of a Catholic organization echoed these sentiments, saying “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” (LB1110 Committee Hearing, 2/25/10). This explicitly moral argument, which draws on respect for human dignity as the driving principle, centers the dignity of the unborn child with little regard for that of the mother; this inconsistency is considered in the discussion section.

The effort by Nebraska legislators to center 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 or not 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 the reproductive rights of all women while providing services in a way that would promote the state's economic interests.

Although California and Nebraska both 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 reproductive rights. While the bill that directed NDHHS to adopt the CHIP Unborn Child option included the CMS language redefining the term child and naming the unborn child as the beneficiary, the California bill that directed the California DHS/MRMIB to adopt the CHIP Unborn Child option did not. 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" (AB 794). 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" (Enrolled Bill Memo, AB 794). Opponents of the California bill noted that the bill itself was unnecessary, and that California could enact the Unborn Child option without a directive from the legislature; these opponents referred to the bill as "unneeded political statement," the "real purpose [of which was] to reaffirm California as a 'pro-choice' state" (Enrolled Bill Memo, AB 794).

As in California, the 2001 *Lewis v. Thompson* court decision, which ended the use of federal funds for the provision of services to undocumented pregnant immigrants in New York, explicitly stated the fetus had no legal rights to care, and that the Medicaid statute clearly identified the mother as the beneficiary. Before issuing that finding, Judge Newman, writing for the Second Circuit Court of Appeals, traced the evolution of the legal status of a fetus's eligibility for federal benefits from the filing of the first *Lewis* case in 1979 to 2001. 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 herself be eligible. This concept is known as "constructive birth." Based on this criterion, Judge Sifton, the District Court judge who wrote the decision in most of the earlier *Lewis* cases, found that undocumented pregnant immigrants were eligible for prenatal care under the 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. In 1987, Judge Sifton again declined to stop the federal funding of prenatal care to 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*).[9]

In 1991, the Secretary of HHS formally renounced that interpretation of the term child, causing Judge Sifton to reconsider, in the next *Lewis* case brought by the federal government, the basis of an undocumented pregnant immigrants entitlement to prenatal care; his reasoning shifted from the autonomy-based fetal personhood arguments seen in

---

[9] As a point of interest, it should be noted that *Lewis III* was actually decided prior to *Lewis II*, although both were decided in 1987. *Lewis II* is not strictly relevant to the issue at hand; it merely denied the Secretary's request to vacate *Lewis I* and found that members of the plaintiff class (including but not limited to undocumented pregnant immigrants) were still entitled to relief for the period before January 1, 1987.

Nebraska to an argument based on justice and equal protection. The next section will describe this and other justice-based arguments.

It is worth noting that the 2002 New York policy predates the 2002 federal Unborn Child policy by 7 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. Despite the fact that such an option later became available, however, 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, saying:

> 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 that 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 New York would never switch to a policy that could potentially endanger reproductive rights, even to save money. Cost considerations will be discussed further in the prudential reasons section. Although New York never adopted the CHIP Unborn Child option, for reasons likely related to the risks it presented to reproductive autonomy, it continues to provide state funded prenatal care.

As this section has demonstrated, two opposing conceptions of respect for persons 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 persons, predominant in California, which emphasizes the mother's right to reproductive privacy. The next section will review the various conceptions of justice that emerged in each state.

Justice: Entitlement and Societal Obligations

Under most conceptions of justice, we are required to treat similar groups of people similarly, and if we do treat people differently, it must be based on some morally relevant characteristic. The idea that certain individual characteristics or actions could make some people more or less entitled to public resources was very common in the Nebraska public debate, both among proponents and opponents of the Nebraska legislation. The actions lawmakers felt should determine an individual's entitlement to health care varied greatly, and included such considerations as breaking the law, belonging to a community, and paying taxes.

Law-Breaking

The idea that law-breaking 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, will be reaching into the pockets of law-abiding citizens to pay for the responsibilities of those who have broken our laws" (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" (LB599 Veto Letter, 4/13/12). The governor employed explicitly moral language ("wrong" and "unfair") to oppose the provision of public benefits to people he perceived to be law breakers and therefore undeserving of public benefits.

In response to this argument, many Nebraska state senators who favored the legislation relied on the argument that the fetus is a separate person 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" (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 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" (LB599 Floor Debate, 4/3/12).

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

> [L]egislation directing the onus of a parent's misconduct against his children does not comport with fundamental conceptions of justice. '[V]isiting… 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 the line between asserting that 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 were also unconstitutional (*Lewis IV*).

Social Membership

Official or unofficial membership in the Nebraska community was often described as increasing an individual's entitlement to public resources. Some legislators argued that the future citizenship of the fetus makes 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" (LB599 Floor Debate, 4/3/12). For some who believed that citizenship is the feature that determines 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" (LB599 Floor Debate 4/3/12).

The *Lewis* courts also appealed to the future citizenship of the fetus in a number of cases. This goes back to the early argument that the "constructively born" child is a citizen, thereby making the mother eligible for prenatal care (*Lewis I*). The future citizenship of the fetus continued to factor into the courts' decisions after *Lewis I*. In *Lewis III*, Judge Sifton found that there were inconsistencies in the state's practice of providing Medicaid eligibility to the future citizen fetus of a citizen mother but not the future citizen fetus of a non-citizen mother. The state contended that it "cannot be assumed that a child will born in the United States, and, therefore, a child cannot gain U.S. citizenship…until delivery." Sifton disagreed, finding with the plaintiffs that "Nothing in the statute or common sense dictates that subsequent events such as departure from the country *en ventre de sa mere*[10] or the inheritance of great wealth are to be speculated about in determining whether the unborn child is to receive the statute's benefits" (*Lewis III*). The projection of the fetus's citizenship status thus grounded the basis of New York Medicaid's provision of prenatal care to undocumented pregnant immigrants until it was halted in 2001.

Future citizenship, and the rights that accompanied 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 bill that was ultimately folded into the budget bill providing state funded prenatal care to undocumented immigrants listed as its justification that "Lack of [prenatal] care can result in

---

[10] Legal term that translates literally to "in the stomach of his mother"

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" (A8953). While this argument draws on prudential reasons as well (discussed below), 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, another take on the meaning and value of social membership emerged in opposition to the Unborn Child policy, focusing on the non-membership of the mother rather than the future membership of the fetus. The mother's lack of citizenship is a 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" (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 argument, focused on taxpaying as an eligibility criterion for public assistance, also motivated several discussions about the appropriate role of government in the provision of prenatal care for non-citizens. Opponents of the prenatal policy insisted that tax money should not be used for this purpose, and that instead it is a social responsibility that should be shouldered by charities and non-governmental organizations. As one proponent of this position argued:

> This is a responsibility of a fair-minded and just society. To provide this benefit, this prenatal care to these children and to their mothers is the government…the only mechanism by which this care can be provided? Where are the churches in this? Does the church collectively, the churches, have any responsibility to provide this care? I'd say yes. Communities themselves, is there any responsibility? To some extent, I think [yes]… This is a societal responsibility. And I cringe at the thought of equating the word "society" congruently to government. (LB599 Floor Debate, 4/3/12).

This legislator conceded the point that there was, in fact, a moral obligation to provide prenatal care, but did not believe that the government itself had any obligation to non-citizens, but rather that the "societal" responsibility must be met through charity. This sentiment was repeated in the veto override debate, in which a legislator argued that "I think there is an opportunity here for the faith community and the private sector to stand up. Reasonable people can disagree about that. What I can't make myself do is to forcibly take tax dollars from someone to pay for the obligations of one who is breaking the law to be here" (LB599 Veto Override, 4/18/12). This statement draws in the illegality argument to suggest that the obligation of a government to provide care is obviated by the law-breaking of the potential beneficiary, and that the obligation must therefore be met outside of government.

This section has reviewed the reasoning employed by supporters and detractors of the prenatal policies in each state that were derived from a conception of justice that requires a society to treat similar populations similarly. The different justice-based reasons diverge on the individual characteristics or actions that are deemed morally relevant to differential treatment; these included law-breaking and various forms of social membership. The next section will consider a different type of reasoning that emphasized outcomes rather that rights.

Prudential Reasons

While many of the reasons given to support or oppose the various prenatal policies were moral in nature, others were more prudential, in that they appealed to the interests of American citizens and other legal residents (Nickel, 1986). These ranged from the promotion of health for state residents to the protection of state economic interests and the prevention of illegal immigration. When employing one of these reasons, the prenatal policy was presented as instrumentally valuable (or harmful) for achieving an end that the speaker deemed relevant to legal residents.

Promotion of Resident Health

Many who argued in favor of the Unborn Child policy did so on the basis that it would promote the health of current and future residents of the state of Nebraska. Resident 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 the remarks of the sponsor of the Unborn Child policy, who observed that "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" (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" (LB599).

Although many supporters of the Unborn Child policy touted the benefits of prenatal care for the fetus, very few showed an interest in the health benefits that would accrue to the mother. 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" (LB588 Floor Debate, 4/4/12). This policymaker suggests that it is ok not to care about the mother as a person, focusing instead on 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 Medicaid coverage. Indeed, in the *Lewis* cases, the Secretary of HHS conceded that "a significant number of citizen children will suffer birth defects as a direct result of the denial of prenatal care to their non-PRUCOL mothers" (*Lewis V*, 1992). Despite acknowledging the potential harm to future citizens, however, HHS persisted in attempting to deny prenatal care to undocumented immigrants. The positive health effects of prenatal care were central to the justification for state Medicaid coverage that was proposed after the final *Lewis* decision banned the use of federal funds. The New York State Assembly memorandum in support of the legislation to provide Medicaid funds noted that "[a]ppropriate 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" (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 economic interests of the state 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 included language that 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" (LB599). The argument that it is more cost-effective to provide prenatal care than to treat otherwise preventable conditions that result from a lack of prenatal care was very common among supporters of the Unborn Child policy. A representative from the organization March of Dimes testified in favor of the policy, citing numerous statistics about the effectiveness of prenatal care, and concluded "If simple access to prenatal care could reduce or eliminate the 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" (LB599 Hearing, 3/16/11). Both health and economic benefits for the citizens of Nebraska are presented as positive outcomes of the adoption of the Unborn Child option, and the adoption is considered "financially prudent and fiscally responsible" by many legislators who are convinced by these reasons (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 an Institute of Medicine report, noted that "The 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*, 1992). 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*, 1992). 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 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 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*, 2001).

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

The New York State Assembly memorandum in support of 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 $2-10.00 per each dollar expended on medical care. We anticipate cost neutrality, if not actually savings to be the result of this legislation" (A8953, 2001). While this language was not contained in the memo for the budget bill that passed the following year, it is likely that this argument was persuasive in the unrecorded conferencing that led to the bill.

Prevention of Illegal Immigration

One prudential reason against the provision of parental care to undocumented immigrants was raised only in Nebraska; the concern that publicly funded prenatal care might encourage illegal immigration. The governor, in issuing his veto of LB599, 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" (LB599 Veto Letter). The Governor saw the specter of increased presence of undocumented immigrants as harmful to the citizens of Nebraska, and therefore opposed the policy. 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" (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 view that offering prenatal care to undocumented immigrants will create a “social services magnet” (LB1110 Hearing, 2/25/10) was frequently used to oppose the policy on prudential grounds.

DISCUSSION

This study provides an empirical account of the types of reasoning actually used in the policy process, complementing theoretical work in political philosophy that proposes arguments about the proper distributional scheme for public resources to non-citizens.[11] The findings of this study indicate that both moral and prudential reasons were employed by supporters and opponents of the various prenatal policies in each state. The moral reasons included appeals to the principle of Respect for Persons, including the opposing concepts of fetal personhood and reproductive privacy, as well as appeals to different conceptions of Justice based on the morally relevant characteristics that allow differential treatment of individuals and populations, including law-breaking and social membership. As this discussion will show, however, most of the state differences in the use of moral and prudential reasoning relate to the state’s position on abortion rights.

The policy narratives demonstrate that although Nebraska, California, and New York arrived at their prenatal policies through vastly different policy routes, the publicly funded services that undocumented pregnant immigrants can access in each state are more alike than they are different, especially compared to states that lack prenatal policies altogether. This section considers the divergence in moral and prudential reasoning that emerged in each state and the relationship between the reasons given to support or oppose the various policies and the ultimate content of the policies themselves, focusing on the relationship

---

[11] For a more detailed discussion of these theoretical justifications, see Chapters II (Literature Review) and V (Manuscript 3).

between these reasons and the state's position on reproductive rights. It will also propose a set of policy implications for future immigrant health policies.

First, it is worthwhile to consider how the invocation of the threat or promise of codified fetal personhood featured prominently in all three states. Perhaps unsurprisingly, given their political climates, Nebraska and California took opposite stances on the relationship between the Unborn Child option and abortion, while the New York courts rejected arguments based on fetal personhood and the state's legislature dodged the question altogether. In Nebraska, the Unborn Child option was adopted largely as a vehicle for policymakers to signal their opposition to abortion rights, and 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.

One key point of interest in this comparison is that neither state technically required legislative action to implement the Unborn Child option; as mentioned earlier, in most states, including California and Nebraska, some 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 (National Health Law Program & National Association of Community Health Centers, 2006). 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 potential interpretation of the state's decision to use legislative means could be that the bill was useful for signaling moral priorities to constituents. The fact that opponents of the bill argued in floor debate that the bill was simply a "political statement" support this possibility, although of course no supporters of the bill agreed that that was the case. In Nebraska, although there was no formal requirement that the legislature pass a bill authorizing the SPA, the Nebraska DHHS declined to pursue the SPA on its own, which meant that, unlike California, the legislature did need to pass a bill if they 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, despite the fact that the bill itself had no immediate effect on abortion access.

Unlike California and Nebraska, New York's policy makes no reference to abortion rights whatsoever. The *Lewis* cases that preceded the 2002 legislation mentioned fetal personhood often, and the decline of its relevance to the decision presaged its ultimate excise from the state's policy, when New York legislators avoided the question of fetal personhood by employing state funds to provide care to the undocumented pregnant immigrant in her own right. Although abortion was not a motivating factor for the provision of 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 afterwards, as the comments of the New York State Assembly Member indicate.

Another point of interest, from a moral and political perspective, is the juxtaposition of Nebraska legislators supporting the Unborn Child option because it promotes the wellbeing of the fetus with their unwillingness bordering on antipathy towards the protection of the health of the mother. Although the health of the fetus, and the economic benefits of protecting the health of the fetus, were both 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 undocumented pregnant immigrant or the subsequent cost savings that could result from keeping her healthy. Indeed, the health promotion and economic reasons to provide undocumented pregnant immigrants with comprehensive prenatal care go far beyond the wellbeing of the fetus, but Nebraska lawmakers generally spoke only of the "future Nebraskan" fetus. The contrast between the vocalized concern for not-yet-born future citizens and stated disregard for the health of living, working, contributing non-citizen residents of the state illustrates that the morally relevant characteristic that generated an obligation to provide prenatal care, in Nebraska, was *pregnancy with a future citizen* rather than membership or embeddedness in the social community.

It may be tempting to conclude that a different characteristic was the morally relevant factor in the passage of the California and New York policies; after all, both states eschewed reasoning based on fetal personhood and both states continue to fund abortions with Medicaid, even for undocumented pregnant immigrants. Despite a lack of overt prioritization of the fetus over the mother, however, it should be noted that, for the most part, neither state provides non-emergency healthcare coverage to non-pregnant undocumented adults. This indicates that, despite the privileging of reproductive privacy, the morally relevant characteristic in distributing publicly funded health care was still the pregnancy rather than community membership. However, recent legislative initiatives in both New York and California may indicate that this norm is changing; both states now provide coverage to undocumented children, and both provide coverage to recipients of Deferred Action for Childhood Arrivals, also known as DACA. Like the fetuses of undocumented immigrants, these populations can be framed as innocent of intentionally committing the crime of illegal immigration. This could indicate that the justice-based argument about the moral relevance of innocence and law-breaking to the distribution of public resources, prominent in Nebraska, might be successfully extended in order to justify providing health care to undocumented children and DACA in other states as well.

LIMITATIONS

There are a number of limitations to this examination of the various prenatal policies and their diverse justifications. A major limitation is the shortage of publicly available legislative debate from New York and California. Although some hearings and debate are available from California, most are quite brief and lack the vivid debate found in Nebraska, and there is no recording at all of legislative debate from New York because the bills under consideration were never publicly debated. This limitation makes it difficult to illustrate differences across states using similar types of language, and led to the paper's focus primarily on the data from Nebraska rather than an equal consideration of all three states. An additional limitation is that this paper has considered the reasons raised in the legislative histories, but does not address a number of questions that cannot be answered through the legislative histories alone. For instance, California and Nebraska both employed the CHIP Unborn Child option to provide coverage for pregnancy-related services, but the distinction between a pregnancy-related service and a non-pregnancy-related service provided to a pregnant woman remains unclear. This practical question, and others like it that are also not addressed in the legislative histories of the prenatal policies, will be considered in the next dissertation paper, which examines the implementation of these policies on the ground. A final limitation of this paper is its narrow focus on the reasons for providing undocumented immigrants with prenatal care 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. Additionally, this analysis is not designed to assess the actual underlying beliefs or political motivations of the policymakers and others whose public reasons are 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 paper analyzes public reasons rather than private ones, but it does prevent any extrapolation about "true" beliefs as opposed to stated beliefs.

POLICY IMPLICATIONS

Policymakers wishing to pursue a prenatal policy for undocumented immigrants in one of the 32 states currently without a policy could take a lesson from the success of the policies discussed here. Despite hostility towards illegal immigration, Nebraska legislators secured the success of the prenatal policy by tying it to a politically popular pro-life platform. This strategy could be repeated in other conservative states, including those with large numbers of undocumented residents like Arizona and Georgia. Similarly, more liberal states like Nevada and Maryland could look to California for a way to draw down federal CHIP dollars while protecting reproductive rights by implementing a global fee payment structure for pregnancy care.

More broadly, a significant implication of this research for future immigrant-friendly health policy would be the importance of framing the policy to highlight the social membership of the potential beneficiaries. These moral reasons were used successfully in Nebraska despite that state's hesitance to provide benefits to non-citizens, which indicates that such an approach could be leveraged in other conservative states to promote insurance coverage for other populations who could be framed as members of their community, such as undocumented children and DACA recipients. More liberal states, which may already provide some amount of coverage to these populations, could similarly emphasize social membership and prudential reasons and downplay the law-breaking involved in undocumented immigration to fight for broader access to health coverage for other undocumented adult populations.

CONCLUSION

Nebraska, California, and New York all provide undocumented pregnant immigrants with publicly funded coverage for prenatal care, but they all do so in different ways and for a wide range of reasons. This paper has not set out to critically evaluate these reasons, but rather to survey those reasons and explore the relationship between moral and prudential justifications for a particular prenatal policy and the content of the policy itself. The wide range of justifications considered here belies the relatively minor differences in the prenatal policies. 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 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 that underlies 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 that they otherwise might not. Whether the differences in state policies have a significant impact on the lived experience of pregnant undocumented immigrants in each state and the actual services they receive is a question for future research.

As this paper has demonstrated, there are a wide range of reasons that might justify providing undocumented immigrants with access to publicly funded prenatal care, and while not all reasons are convincing to all stakeholders, they can still reach a political consensus that supports immigrant-friendly health policy.

REFERENCES

Carter, J. (2012). Timeline of Prenatal Care Coverage in Nebraska. Retrieved from https://neappleseed.org/blog/5924

CMS. (2002). State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children (42 CFR 457). *Federal Register, 67*(191), 61956-61974.

Fabi, R. (2014). Undocumented Immigrants in the United States: Access to Prenatal Care. *The Undocumented Patients Project*. Retrieved from http://undocumentedpatients.org/issuebrief/undocumented-immigrants-in-the-united-states-access-to-prenatal-care/

Fiory, J., Landsberg, E., Sanematsu, S., & Tawatao, M. (2016). *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates*. Retrieved from

Korinek, K., & Smith, K. R. (2011). Prenatal care among immigrant and racial-ethnic minority women in a new immigrant destination: exploring the impact of immigrant legal status. *Soc Sci Med, 72*(10), 1695-1703. doi:10.1016/j.socscimed.2011.02.046

Krogstad, J. M., & Passel, J. (2015, September 23, 2014). 5 facts about illegal immigration in the U.S. *FactTank*. Retrieved from http://www.pewresearch.org/fact-tank/2015/07/24/5-facts-about-illegal-immigration-in-the-u-s/

National Health Law Program, & National Association of Community Health Centers. (2006). *Role of State Law in Limiting Medicaid Changes*. Retrieved from http://www.healthlaw.org/issues/medicaid/defending-medicaid/role-of-state-in-limiting-medicaid-changes - .WaV61XeGPdQ

New York Times Editorial Board. (2012, April 24, 2012). The Undocumented and the Unborn, Editorial. *The New York Times,* p. A22.

Nickel, J. W. (1986). Should undocumented aliens be entitled to health care? *Hastings Center Report, 16*(6), 19-23.

Passel, J., & Cohn, D. (2015, September 11, 2015). Number of babies born in U.S. to unauthorized immigrants declines. *FactTank*. Retrieved from http://www.pewresearch.org/fact-tank/2015/09/11/number-of-babies-born-in-u-s-to-unauthorized-immigrants-declines/

QSR International. (2017). NVivo 11 for Mac (Version 11.4.2): QSR International. Retrieved from http://www.qsrinternational.com/product/nvivo-mac

Sommers, B. D. (2013). Stuck between health and immigration reform--care for undocumented immigrants. *N Engl J Med, 369*(7), 593-595. doi:10.1056/NEJMp1306636

CHAPTER IV. MANUSCRIPT 2

Prenatal Care for Undocumented Immigrants: Professional Norms, Ethical Tensions, & Practical Workarounds

ABSTRACT

This paper examines the practice implications of various state policies that provide publicly funded prenatal care to undocumented immigrants for health care workers who see undocumented patients. Data were collected through in-depth interviews with purposively sampled health care workers at safety net clinics in California, Maryland, Nebraska, and New York. Health care workers were asked about the process through which undocumented patients receive prenatal care in their health center and the ethical tensions and frustrations they encounter when providing or facilitating this care under policy restrictions. Respondents discussed several attitude and professional practice norms as well as the ethical tensions they encountered when policy or institutional constraints prevented them from living up to professional norms. Using Nancy Berlinger's "workarounds" framework, this paper examines health care workers' responses to the misalignment of their professional norms and the policy restrictions in their state. These findings suggest that the prenatal policies in each state raise ethical and professional challenges for the health care workers who implement them.

BACKGROUND

Undocumented immigrants in the United States are largely ineligible for publicly funded healthcare, with a few notable exceptions. In all states, the federal Emergency

Medical Treatment and Active Labor Act (EMTALA) requires that all health care facilities that receive Medicare funding assess and treat all patients who present to an emergency room in an emergent state or in active labor without ascertaining immigration status or ability to pay (Siskin, 2004). Additionally, certain non-profit safety net health centers in every state are able to offer federally subsidized primary and preventive care on a sliding fee scale to uninsured patients, including the undocumented (Gusmano, 2012). In addition to these nation-wide policies, some states also offer publicly funded prenatal care for undocumented immigrants[12] using a variety of policy mechanisms (see Appendix A2). The first of these is a federal Children's Health Insurance Program (CHIP) policy known as the Unborn Child option, which provides undocumented pregnant patients with insurance coverage for prenatal care and other services relevant to pregnancy in the name of an unborn beneficiary. The Unborn Child option restricts the services covered to just those services that directly affect the fetus, such as ambulatory prenatal care and care for health conditions that could affect the fetus if left untreated, such as gestational diabetes. Sixteen states utilize this policy option to provide this limited care to undocumented pregnant residents (see Appendix A1). The second policy mechanism that states can use is a state-funded Medicaid lookalike program that provides all Medicaid services to financially eligible undocumented pregnant immigrants during pregnancy and for two months post-partum. This policy does not restrict the services for which pregnant undocumented immigrants are eligible, covering the same

---

[12] A note on language: this paper refers to "pregnant women" because it reflects the language of the research participants and policies, but it should be noted that not all pregnant people are women, as transgender men and gender non-binary people can also be pregnant. Additionally, the use of the term "unborn child" is a reflection of the language of a policy rather than commentary on the personhood of a fetus.

range of services that Medicaid would cover for eligible citizens, but is only employed by three states.[13]

The range of benefit restrictions across the various prenatal policies raises questions about the ability of health care workers to carry out their professional obligations towards patients. Physicians and other health care workers may feel that such restrictions limit their ability to live up to their professional norms, which can cause significant distress. Much of the literature on the effects of health care policy on provider distress focuses on the ability of practitioners to conscientiously refuse to provide services to which they object, such as abortion. Some scholars, however, have attempted to reframe the role of conscience in the provision of health care from that of conscientious *refusal* to perform a procedure like abortion to the conscious-driven desire *to provide* health care in the face of policy restrictions (Berlinger, 2016; Buchbinder, Lassiter, Mercier, Bryant, & Lyerly, 2016). Providers experiencing this conscience-based distress may engage in strategic "workarounds," including rule-bending and "working the system" to provide resources to patients for whom they were not intended (Berlinger, 2016; Berlinger & Raghavan, 2013). A small body of research has explored the response of physicians and other health professionals to working within and around institutional or policy restrictions that limit their ability to provide appropriate care. Several studies have examined the willingness of health professionals to work around institutional or policy barriers by bending rules or engaging in other deceptive behaviors, finding that physicians sometimes approve of or engage in these behaviors when attempting to secure insurance coverage for patients (Cain, 1993; Novack et al., 1989; Wynia,

---

[13] New York provides a Medicaid lookalike as an entitlement program to undocumented pregnant immigrants within eligibility thresholds. New Jersey has a similar program that is structured as a block grant, so its services are subject to the availability of funding in the state budget. Massachusetts uses the Unborn Child option to cover eligible services, but uses state funding to cover any other Medicaid services that are not covered by the Unborn Child Option as an entitlement.

Cummins, VanGeest, & Wilson, 2000). Whether these findings are applicable in situations when the policy constraint not only limits a professional's ability to provide care but does so in a way that systematically affects the care of a particularly vulnerable group of patients has not been assessed.

Although a review of the prenatal policies and their legislative histories can provide information on the eligibility for and services covered by each of these policies, it tells us little about how the policies function as implemented or how they affect health care workers' abilities to live up to their professional norms. This study explored the practice-level implications of different prenatal policy environments through interviews with providers in four case states. This paper characterizes the professional attitude and practice norms that providers in each state described holding, the ethical tensions that they encountered in attempting to live up to those norms under each state's prenatal policy, and the "workarounds" they employed to do so.[14]

METHODS

SAMPLE

The sampling frame for the study were safety net health centers located in urban and rural counties across four states with different prenatal policies. The four states were purposively selected to represent the range of prenatal policies in the United States: Nebraska uses the Unborn Child option and restricts benefits to pregnancy-related care; California uses the Unborn Child option but provides all "medically necessary" services; New York uses state funds to enroll undocumented pregnant immigrants in a Medicaid lookalike; and Maryland has no public insurance option, so undocumented immigrants may

---

[14] This paper was determined to be exempt from IRB review by the Johns Hopkins Bloomberg School of Public Health IRB because it involved speaking with health care professionals about their professional role. The IRB exemption letter is available in Appendix C.

seek subsidized care at safety net health centers. National Center for Health Statistics (NCHS) definitions for urban and rural were utilized to identify urban counties (NCHS urban-rural scheme code of 1-2) and rural counties (NCHS urban-rural scheme code 5 or 6) within each state. Among these counties, eligible safety net health centers were those located in the three urban and three rural counties with the highest percent of foreign-born residents in each state (as determined by the American Community Survey), which served as a proxy for undocumented immigrant populations.

RECRUITMENT

To engage eight health centers, clinic directors and CEOs of 35 health centers were contacted. Leaders of the eight health centers that agreed to participate were asked to identify respondents with relevant experience providing or facilitating prenatal care for undocumented immigrants in each of the following roles: primary obstetrical provider (e.g. obstetrician, family doctor, or midwife), nurse or other medical provider (e.g. mental health clinician), patient support worker (e.g. social worker, prenatal educator, or outreach team member), and administrative staff (e.g. billing manager). Within the obstetrical provider and nurse/other medical provider categories, providers who work specifically with pregnant patients (family care doctors, obstetricians, nurse midwives, family nurse practitioners) were targeted for recruitment. Providers and staff were recruited via email to invite their participation in an in-depth semi-structured interview. This sampling method yielded 8-9 informants per state, for a total of 34 informants (see Table 1). All recruitment materials are available in Appendix D.

DATA COLLECTION

Interviews were conducted with clinical staff in each of the roles mentioned above in order to generate a comprehensive picture of the process through which undocumented pregnant immigrants access prenatal care in each clinic as well as the professional norms and ethical tensions that various providers experience. The interview guide (available in Appendix E, along with the disclosure script) covered three major domains:

1. Background information about the clinic and the respondent's role within the clinic;
2. Process through which undocumented patients access and pay for care at the clinic;
3. Ethical tensions that the respondent encounters when serving undocumented pregnant patients in her professional capacity.

At the end of each interview respondents were asked to complete a brief demographic questionnaire. These interviews generally took 30-50 minutes, (mean: 34:40, median: 34:48). Interviews were conducted by phone, recorded, and transcribed. All interviews took place between August 2016 and October 2017.

DATA ANALYSIS

The transcripts of these interviews were imported into NVivo 11 for Mac (QSR International, 2017) to facilitate analysis. The broad goal of analysis was to identify themes that emerged within and across the case states. This was accomplished with an iterative emerging thematic coding scheme that employed a preliminary codebook that evolved in response to the data, in which each code corresponded to a "node" in NVivo. Nodes were organized in a hierarchical coding scheme that tracked categorical respondent-level data (e.g. clinical role), health center-level data (e.g. state, urban/rural), and substantive data related to the prenatal process and ethical tensions, which were the two main focuses of the interview. Nodes were nested within this hierarchical structure to enable visualization of relationships between themes (codebook available in Appendix F2; for a visual representation of this structure, see Appendix G4). Coding was compared across states to identify trends or patterns using the "matrix" function of NVivo (see Appendix G3).

A second coder was employed to validate the final codebook through a comparison of code application on five transcripts, which yielded high consistency of coding. Analysis of codes was conducted by examining coding overlaps and coding matrices using NVivo's query function, which allowed for the examination of patterns across and within states and provider categories, as well as the relative frequency of code application. This paper focuses on the emergent themes related to the professional norms at stake for health care workers who provide or facilitate prenatal care and the ethical/professional tensions they encountered in the course of caring for this population, as well as the ways that the practices they develop to manage these tensions at work.

RESULTS

Respondents were asked to describe the norms they associated with their professional position and to describe how these norms related to their role in providing care for undocumented pregnant patients, as well as the ethical tensions that arise when caring for this population. The norms respondents described could be characterized as belonging to one of two categories: professional attitude norms, and professional practice norms. Attitude norms were the attitudes or mindsets that providers held in relation to their undocumented patients, while practice norms were those actions or practices that providers explicitly endorsed or implicitly performed when providing care to undocumented patients, including the "workaround" norms that emerged in response to ethical tensions caused by policy constraints. In the discussion of findings below, "common" refers to a theme that was identified in the responses of more than 25% of total respondents.

ATTITUDE NORMS

(1) *Respect*; (2) *Empathy*; and (3) *Cultural sensitivity* were the most common attitude norm themes to emerge. One third (n=11) health care workers described *respect*, the most common attitude norm, in a variety of ways. Often, appeals to respect were related to focusing on the patient's interests and treating her as an end in herself. A medical assistant from Nebraska said that a guiding principle for her work is to "treat everyone with respect and provide the best care that we can regardless of their ability to pay. You know, treat others as you would want to be treated," appealing to the "golden rule" of respect (NE-U-Nurse_MA). Similarly, a physician from rural Maryland observed that "[We] make sure that when these women show up for their appointments, that they are treated as respectfully and fairly as anybody else would [be]," linking the importance of respect to fairness (MD-R-PrimaryOB).

A closely related theme to respect was the professional attitude norm of treating patients with *empathy*, which was reported by almost one-third of respondents (n=9). Two of the nine respondents explicitly mentioned having a professional norm of treating patients with empathy, but seven others implied in their descriptions of their feelings towards patients. An administrator from urban New York used the term "trauma informed" to describe her empathy for patients, and noted that "a large percentage of our patient population has faced some form of trauma so I always have to approach every situation with a patient assuming that they've experienced every situation imaginable and always approach it with that open mind and willingness to help" (NY-U-Admin). A midwife in urban Maryland echoed this sentiment, saying "I feel like if they have gone to all the trouble to come here against all the odds and all the hardship they've had to suffer, they deserve to be there… so I kind of just meet them where they're at and I just start from there" (MD-U-

PrimaryOB). This idea of "meeting them where they're at" is related to the third professional attitude norm of cultural sensitivity.

Another common theme was *cultural sensitivity*, also referred to as cultural competence in the public health literature, which involves the recognition of "the importance of social and cultural influences on patients' health beliefs and behaviors" (Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2016). One third (n=11) of respondents described the importance of approaching their patient interactions with a culturally sensitive mindset. A physician from rural California observed that "You have to come from the patient's perspective to understand why they do or don't do certain things that may affect their health ultimately" in the context of a patient's culturally-motivated desire not to take insulin to treat gestational diabetes (CA-R-PrimaryOB). A physician from urban New York described her interactions with patients of a cultural background different from her own, saying "I think a lot of Latin American patients have this sense of, 'Oh, you don't tell the doctor, because you don't want to disappoint the doctor.' So I do tell them, 'Again, it's your body. It's your choice, it's your pregnancy and you don't have to tell me everything because you're right, I will probably not understand, but I'm not going to judge you.'" (NY-U-PrimaryOB-2).This humble approach recognizes, without judgment, that patients come from diverse cultural backgrounds that sometimes manifest in different health behaviors.

While close to two-thirds (n=21) of respondents described at least one of these three attitude norms as paramount to their approach to patient care, they also described professional norms of practice that they believed they ought to uphold in providing or facilitating care for undocumented pregnant patients.

Practice Norms

The most common practice norm themes that emerged through this analysis, from most to least common, were (1) *Treat every patient the same*; (2) *Advocate for patients*; and (3) *Don't ask about patient immigration status.*

Treating every patient the same, mentioned in two thirds of the interviews (n=24), was one of the most common practice norm held by providers and staff across all four states. A physician from rural Maryland explained this norm, saying that she has a "commitment to give everybody as high quality healthcare as possible regardless of their insurance or immigration status" (MD-R-PrimaryOB). Respondents also frequently emphasized that providing all patients with the same level of care was an important part of the ethos of their health center. A patient support worker from rural Nebraska observed that "we treat everybody the same and we believe that our mission is [that] everybody deserves equal health care and everybody deserves to be treated with dignity" (NE-R-PatientSupport). Several respondents indicated that their personal values aligned with the mission of their health center, and that providing care to the underserved was their reason for working at the center; one nurse from rural Nebraska said that "I do everything the same, no matter if they're documented, undocumented, they have insurance, they don't have insurance. You know? *That's why I'm here*" (NE-R-Nurse_MA, emphasis added). By linking the professional norm of treating all patients the same with her vocational calling to serve in a safety net health center, this respondent made it clear that this norm was very important to her personal values as well.

The alignment between personal values and professional practice norms was also apparent in the other most common theme, *advocating for patients*, also mentioned by two thirds of respondents (n=24). An administrator from rural Nebraska described her most important professional norm as "Reducing the barrier to care for patients. You know, we work here for a reason and that is to provide affordable health care for people who can't normally afford it" (NE-R-Admin). This echoes the sentiment of being in a nonprofit community health center "for a reason" and stresses the importance of advocacy to both personal and professional fulfillment. A mental health clinician from New York described advocating for patients as a key part of her job, saying that "Regardless of their status or their background…it is our job to really be with that person and help explore exactly what is going on and making sure that we are doing what we need to do to help really care and connect to multiple services and support patients with their basic needs" (NY-R-Nurse_MA). Despite her primary duty at the health center being the provision of counselling for mental health diagnoses, this respondent described advocacy activities as her "job" and spoke at length about the ways she advocates for patients whose basic needs are not being met.

While almost two thirds of respondents (n=20) explicitly mentioned or described advocating for patients as one of their professional norms, another seven implied it through descriptions of their interactions with patients. One nurse midwife in Maryland, where specialty care is not covered, described an instance of advocating for a pregnant patient who needed an echocardiogram, saying "I actually called my own cardiologist and talked to him personally. [This] is the sort of thing I would do for my daughter. And I said… 'Your office said it was going to be $1,300, she really can't pay that, she could pay up to $600…' And he was great about it. So she actually had it done. So I did intervene on her behalf in that way" (MD-U-PrimaryOB). This respondent went well beyond the requirements of her job as a midwife to help connect her patient to a specialty care service she would otherwise not have been able to receive. This type of advocacy, in which providers leveraged relationships to secure treatment for their patients, was reported by several respondents. A provider from Nebraska also described advocating for patients who were not eligible for certain services, saying "You know if they need something done, we're going to get it done and you know whether I'm calling up various agencies or what not, you know personally or whatever – we're going to get it done" (NE-U-PrimaryOB). Personal investment of time and resourced to secure care for patients could be considered a workaround that enables the health care worker to live up to the practice norm that suggests that all patients, regardless of immigration status, should have access to the same level of care; this idea is explored further in the discussion section.

Another form of patient advocacy that providers described involved using whatever insurance was available during pregnancy to cover medical appointments, treatments, or procedures not explicitly covered by the policy. Most respondents were vague in their descriptions of how this might be accomplished, like one patient support worker from New York, who indicated that although the New York prenatal policy "is supposed to be for pregnancy related things… I think people try to sneak in as much as they can and it totally makes sense because otherwise they're uninsured" (NY-Urban-PatientSupport). Similarly, in California, where the Unborn Child option technically only covers care related to the pregnancy, a provider described how patients "can get everything done while they have it… So if they have underlying health issues that need to be taken care of, that they may not have access to, we try our hardest to get that taken care of when they are pregnant" (CA-R-PrimaryOB). As with leveraging relationships to secure care, pursuit of medical services that the prenatal policy was not necessarily intended to cover could be considered a workaround of a system that health care workers perceive as unjust; this is also explored further in the discussion section.

The third most common theme to emerge relating to professional practice norms, mentioned by a bit more than one third of the respondents (n=13), was to *not ask patients about their immigration status*, which was sometimes described as an unwritten policy of the community health center. A patient support worker described this norm, saying "We don't ask about immigration status. Patients don't usually bring it up as well. We don't like to make patients feel uncomfortable, or questioned. So that is just the subject that we try to avoid" (CA-R-PatientSupport). Providers in other states also mentioned not inquiring about patient immigration status, sometimes in support of norms of treating all patients the same; a patient support worker from New York explained that "I really try not to differentiate [based on immigration status]. I would provide the same level and quality of assistance and support that I would for any patient. I guess I don't even look or pay attention [to status]" (NY-R-PatientSupport). The relative risks and benefits of maintaining this norm throughout the patient-provider relationship will be examined in the discussion section.

ETHICAL TENSIONS AND FRUSTRATIONS

Health care workers described two major ethical tensions and frustrations that they encountered in the course of providing or facilitating care for undocumented pregnant immigrants. These were (1*) inability to provide necessary services due to ineligibility*; (2) *how patient fears related to immigration status affect their access to care*. Although these themes were consistent across states, they manifested differently in different states and health center settings.

The most common frustration that health care workers described was an *inability to provide necessary services*; this frustration was described by more than half of the respondents (n=19). In Maryland, which has no prenatal policy, the unmet patient needs were often necessary medical services that pregnant patients need during pregnancy, while in the other states they were more often non-medical services, such as housing, or necessary medical care before or after pregnancy. One example of a provider being unable to connect a patient with a necessary medical service arose for a midwife in Maryland, who described her inability to send patients to specialty appointments, saying "I feel like my hands have been tied, there's nothing else I can do, that's been hard. It is hard because occasionally when you have to send them to specialists it's very, very hard to get specialists to agree to see them who they can afford to see" (MD-U-PrimaryOB). Another Maryland provider from a different health center recalled a time when she hesitated to recommend that a patient seek care for an abscess behind her tonsil because her immigration status made her ineligible for coverage. This provider reflected on this interaction, saying "it was just kind of one of those moments where I kind of hesitate for a second, like 'I hate to send her to the ER, maybe it's not an abscess.' And then having to catch yourself, wait a second, why am I telling her not to do something when I would tell the next person something differently?" (MD-R-PrimaryOB). Both Maryland providers struggled to reconcile their professional standards of care with the financial realities of their uninsured undocumented patients and the different levels of care that the state's lack of prenatal policy entailed.

Health care workers in other states reported experiencing trouble connecting pregnant patients with care outside of pregnancy. One provider from Nebraska had also worked in California, and so was able to offer a unique insight into the differences between the two implementations of the Unborn Child option. She observed that "I know this is just Nebraska, I also practiced in California for a time and it wasn't that way [there], but [Nebraska has] arbitrary, asinine limitations to care, especially in regards to after the pregnancy," and noted that "if you want to be cost-effective and provide proper care, you need women's health as a whole cared for" (NE-U-PrimaryOB). While this suggests that Nebraska's implementation may not sufficiently provide for post-natal care compared to

California, a provider from California indicated that pre-pregnancy care is also imperfect and difficult to provide in that state. She asserted that "it would be important for women to be able to have access to preventive services like a mammogram, pap smear. Those services are limited now. I feel like if we could have some women's healthcare that would also help women entirely in their health" (CA-R-Nurse_MA). A mental health clinician in New York echoed this sentiment, expressing her belief that "In a perfect world everyone who comes to our office would be able to get the care that they need, not only just for their pregnancy…I feel like the whole system doesn't really allow me and people in my role to help ensure all of that, for everyone we work with" (NY-R-Nurse_MA). This idea that providers were unable to connect undocumented women with necessary health services that were unrelated to pregnancy was common in all four states, including those with more generous prenatal policies.

In a particularly revealing discussion of the limitations on care that undocumented patients experience, one physician from California described the challenges of not being able to provide equal access to care to all of her patients. This provider elaborated on her frustrations and those of other providers, saying:

> I think everyone should [have] access to healthcare and to insurance. So that frustrates me, that we have to kind of maneuver around the system to get people to where they need to be at times. You get to use some creativity, but…some people – they can even break the law at times, and I am not willing to do that. But I think you can sort of figure that out, that if you can't get what you want to do, people become creative and sometimes it may open the door to doing things that they probably shouldn't be doing. We don't do that within our clinic, but I have seen it done locally with other providers (CA-R-PrimaryOB).

While this provider is very clear that she does not break the law in trying to meet what she sees as her professional practice norm, her discussion of "maneuvering" and "creativity" suggests that her frustrations with the healthcare system may lead her to bend the rules for her patients. This response points to a significant ethical tension that reflects the distressing position into which the health care system forces providers when it requires them to treat undocumented patients differently from citizens and legally residing immigrants. This distress, and the workarounds devised to address it, are discussed further in the discussion section.

Although there were not many differences between urban and rural health centers, one interesting difference that emerged in relation to the *inability to provide necessary services* involved difficulties that undocumented patients experienced accessing health centers due to a lack of adequate transportation. Half of the rural health care workers (n=7) reported that their patients sometimes failed to show up for appointments because they were unable to travel to their health centers, some of which were quite remote or isolated, while no urban health care workers shared this frustration. One patient support worker from rural New York described the area around her health center, saying "it's really hard to navigate without a car. There's not a lot of public transportation. There are some buses, but yeah, that's definitely something that a lot of our patients have trouble with, the transportation" (NY-R-PatientSupport). This was also an issue for some providers who sought to connect their patients with specialty care that could not be provided in their health center; providers in rural California and rural Maryland described the challenge of sending patients to urban centers for specialty care. A physician from rural California described this issue, saying:

> The only problem is because we are rural and some of our patients may have high risk problems, they need to go to [university] which is 2 hours away in [city]… They may have some concerns about transport – you know not having a driver's license; not having someone to take them; feeling exposed… when they drive because they can be pulled over for unimportant

> things and then they end up having problems and will get deported or have that hanging over their heads. (CA-R-Physician).

This transportation-related challenge was another reason why providers often felt unable to connect their patients with the medical services they needed. In the case of the rural Californian physician above, this transportation-related challenge also related to the second tension that health care workers experienced when providing care for undocumented patients. More than half of the health care workers (n=18) reported *how patient fears related to immigration status affect access to care*, which they saw as a challenge they encountered when providing care to their undocumented pregnant patients. This challenge emerged in relation to a number of issues, including delaying the point in the pregnancy at which undocumented patients would often seek care, as well as the effect of recent political changes on patients' willingness to come to health centers at all and concerns that their immigration status would be shared with immigration enforcement. As one administrator from rural Nebraska acknowledged, "the majority of that population is scared to seek health care. I think what worries them is what will happen if someone finds out their status" (NE-Rural-Admin-1). These fears manifest in different ways. Some health care providers were concerned that fears related to immigration status were leading pregnant immigrants to seek prenatal care later into their pregnancy. A nurse from New York related this issue to the 2016 election, observing in early 2017 that her patients "are not actually accessing care as early as they may have 6 months or 1 year ago. So they are missing opportunities for me to provide healthcare to them, because they are presenting later for the care and by the time the insurance and everything is in place, it is hard to get scans and things that are [necessary]" (NY-U-Nurse_MA). Other respondents indicated that the election of Donald Trump had caused some patients to stop showing up altogether; a patient support worker from California observed that "we definitely noticed a drop after the inauguration. I would say I think it's going to pick back up again but it seems like a lot of people at the clinic noticed a drop in patients coming for a while after the inauguration due to fear" (CA-U-PatientSupport). Several respondents indicated that they had noticed that their undocumented patients' concerns about enhanced immigration enforcement and deportation by Immigration and Customs Enforcement (ICE) under the new administration were leading to this drop in prenatal care utilization.

DISCUSSION

While most respondents did not indicate that they experienced challenges to upholding their attitude norms of *respect*, *empathy*, and *cultural sensitivity*, these findings illustrate the tensions that arise when health care workers' professional practice norms conflict with institutional or policy constraints that make their norms difficult to fulfill. A majority of respondents indicated that they view *treating every patient the same* as an important practice norm, yet many reported feeling frustrated that they were often *unable to provide necessary services* to their undocumented patients due to policy constraints. In addition to the potential maternal/child health effects of prenatal policies that provide undocumented immigrants with some but not all services that socioeconomically similar citizens would receive (Swartz et al., 2017; Wherry et al., 2017), the results of this study suggest that such policies could also give rise to significant moral distress in health care providers, especially among providers who work in low-income community health settings "for a reason" and believe that they are called to serve under-served populations. This section will review these findings through the lens of Nancy Berlinger's model of workarounds in health care, which she develops in her book *Are Workarounds Ethical? Managing Moral Problems in Health Care Systems.* In her book, Berlinger describes moral distress as "an acute feeling of risk to one's own personal and professional integrity that is associated with the perception of powerlessness to prevent some wrong" (Berlinger, 2016, p. 19). For health care workers who see inequitable access to health care as a moral wrong, their inability to provide all necessary services presents a distressing risk to their integrity.

According to Berlinger, one response to moral distress is to adopt workarounds. Workarounds are "navigational tool[s] devised to get around some barrier to getting the job done," and include strategies that allow the health care worker to avoid responsibility for a problem, as well as strategies to avoid compliance with law, policies, or standards that impede their ability to do their jobs as they believe they should be done (Berlinger, 2016, pp. 75-76). Berlinger conceives of workarounds as ethically fraught; while they may help to alleviate the moral distress of providers, they can also raise unanticipated ethical issues for the provider and the institution in which they occur. She writes that some workarounds may be "ethically problematic because they can sometimes lead to the normalization of deviance and to harm," and additionally that they are "hard to talk about openly" because they are generally secret but also part of normal work (Berlinger, 2016, p. 53). Berlinger suggests that workarounds are the result of complex systems that force a misalignment between "normal work" and "current rules, " and therefore a simple evaluation of their ethical content is elusive (Berlinger, 2016, p. 54). This framing maps onto the various workarounds that respondents to this study reported as norms of practice. These workarounds can be seen in some forms of *advocating for patients*, including both bending the rules relating to the services that are covered under a particular prenatal policy as well leveraging personal connections to secure medical treatment for individual patients. Another type of workaround is the problem-avoidance norm of *not asking about immigration status*. As Berlinger suggests, both types of workaround present ethical challenges.

Among the types of workarounds identified by Berlinger is "bending the rules." Bending the rules is often done "in the interest of the individual patient…who, in the professional's view, would be treated inequitably [or] rendered worse off compared with others with similar needs if otherwise well-intentioned rules were followed" (Berlinger, 2016, p. 79). Respondents who described getting additional services covered for patients during pregnancy may be engaged in this type of workaround by directing resources towards certain patients who would otherwise not be able to secure them. Berlinger distinguishes bending the rules from advocacy, observing that "bending the rules [is] likely to involve concealment or deception because the professional who is doing these things has an interest in avoiding scrutiny," as is indicated by the New York patient advocate's use of the term "sneaking in" (Berlinger, 2016, p. 82). The California provider who described "maneuvering around the system" and "using creativity" likely toed this line; while she is clear that she does not condone breaking the law for patients, she acknowledges that frustration with the healthcare system can lead people to do "things they probably shouldn't be doing" (CA-R-PrimaryOB). One ethical issue that such an approach raises is that rule-bending offers at best an individual or temporary solution, and can often fail to address and can even obscure the underlying justice problem. This is not to suggest that rule-bending is *prima facie* morally wrong, but rather that those who engage in it should be critically aware of the ethical issues that it raises.

Another type of rule-bending workaround employed by health care workers is to expend personal capital to secure treatments for certain patients, as the midwife from urban Maryland did when she called her personal cardiologist to obtain charity care for a patient. While this action avoids the ethical concerns about deception that are related to "sneaking in" services, it can also raise issues of justice because it can involve "subjective judgments about who, in the professional's view, is worth bending the rules for" (Berlinger, 2016, pp.

82-83). As with other forms of rule-bending, this sort of individualized advocacy provides a temporary measure of relief for the moral distress of health care workers who are frustrated by a system that they perceive as unjust, but ultimately will not fix the underlying justice issue. In some cases this type of workaround can actually exacerbate injustice if health care workers make personal efforts for some patients but not all.

In addition to rule-bending workarounds, another type of workaround that Berlinger identifies is the "avoidance" workaround. The norm of not asking patients about their immigration status may be considered an avoidance workaround because it enables the health care worker to avoid having to confront issues related to immigration status head-on. Not asking about patient immigration status might indicate respect for a patient's privacy before a rapport has been established, especially given the reported effect of fears related to immigration on care-seeking behaviors. This is especially relevant in the current political environment, in which the Trump administration has dramatically increased immigration enforcement (Chishti & Bolter, 2017). Many respondents indicated that their patients' fears related to their immigration status had increased since the 2016 election[15], and that in some cases this had led to undocumented patients presenting later for care. These anecdotal data support the "chilling effect" phenomenon in which increased immigration enforcement reduces health care utilization by undocumented immigrants as well as members of mixed-status families that include people of various immigration statuses (Fuentes-Afflick et al., 2006; Page & Polk, 2017; Watson, 2014). It may be the case, however, that if this practice of not discussing immigration is sustained throughout the course of the patient-provider relationship, it could also present risks to patient health or safety.

---

[15] Note that all Nebraska and some Maryland interviews were completed prior to the 2016 election, while all others were completed in the 11 months after. For this reason, it is difficult to accurately assess whether these concerns were more common in some states than others.

Even for patients who do seek care, their immigration status may have important implications for their health outcomes, given the relationship between immigration status and stress (Arbona et al., 2010). By avoiding conversations about immigration status, health care workers may be overlooking an important determinant of patient health. Confidential knowledge of a patient's status may be important context for patient behaviors and diagnoses, and also enables a health care worker to connect the patient to relevant resources and services. For this reason, advocacy groups like Sanctuary Doctoring recommend that providers create the opportunity for patients to choose to discuss their status by opening a dialogue about immigration, either by asking whether someone in the patient's family or group of friends was experiencing stress related to immigration status or through the use of fliers that indicate that the provider will not disclose their status (Mejias-Beck, Kuczewski, & Blair, 2017). Sanctuary Doctoring also recommends that providers not record immigration status in the patient's chart, which aligns with the recommendations of the National Immigration Law Center (NILC) (National Immigration Law Center, 2017). Similarly, the American Academy of Pediatrics (AAP) recommends that providers ask whether any family member "is potentially going to leave the family for any reason" rather than directly inquiring about the patient's status as a way of assessing deportation risk (American Academy of Pediatrics, 2017). In light of the potential benefits of confidentially discussing immigration status, the norm of not having important conversations about immigration status should be reframed as a norm of creating an opportunity for dialogue about immigration status while maintaining a norm of not recording undocumented status in a patient's chart.

LIMITATIONS

The findings of this study are limited by several key challenges. The most significant of these is the minimal transferability of the case study approach. Findings in a state with a particular prenatal policy may not be true in another state with the same policy, for any number of reasons, including demographic and political differences. There is a tradeoff between the breadth and depth of analysis when conducting case study research. In limiting the number of case states to four, this study opted for increased depth over additional breadth, which also limits transferability. This research may also be limited by researcher perspective or bias; although effort has been made to minimize the effect of bias, there is always a risk that it can shape the collection and analysis of data. This limitation was mitigated through constant researcher reflexivity, in the form of journaling and memos, as well through third-party review of the interview guides, notes, transcripts, and analysis codebook. Member checking was also used to validate findings with respondents from several of the safety net health centers.

There was an additional risk of selection bias, in that participation was completely voluntary, and only health care workers who were interested in the topic of the study opted to participate. This could limit the range of perspectives represented in this data, as health care workers with negative perceptions of undocumented patients may have been less likely to participate. Finally, there is a risk of social desirability bias in these findings. Although participants were informed that their identities and the identity of the safety net health center in which they worked would be kept strictly confidential, it is possible that participants may have answered questions about their professional norms or the challenges they face at work in a way that would reflect positively upon them or their organization. Despite this risk, most discussions about the process through which undocumented immigrants accessed care and the professional norms and tensions they encountered at work were quite frank and generally reflected an honest and open rapport between the interviewer and respondents.

CONCLUSION

The American healthcare system is fragmented and complicated, and for undocumented immigrants and the health care workers who serve them, it is even more so. Between federal policy that limits spending on public insurance for undocumented immigrants to labor and delivery and state prenatal policies that cover some but not all necessary services during pregnancy, health care workers are often left with few choices for how to meet their pregnant undocumented patients' needs. This complex and patchwork system is a manifestation of policymakers "refusing to think through the consequences of excluding undocumented immigrants from reliable access to our health care system," which repeatedly puts health care workers "into distressing and time-consuming binds as they try to respond to medical and social needs rather than being able to rely on a systemic solution for this foreseeable problem" (Berlinger, 2016, pp. 87-88). Even when state policies attempt to provide some amount of care to this vulnerable population, as with Nebraska, New York, and California, there are still a number of limitations to care based on immigration status. This gives rise to the types of moral dilemmas that health care workers described, such as the inability to provide all necessary services to patients, that can lead to the use of workarounds to secure medical treatment.

Given that these dilemmas are policy-driven and therefore largely foreseeable, Berlinger suggests that health centers should have institutional mechanisms in place that enable health care workers to critically examine their own attitude and practice norms and to discuss, in a safe environment, their concerns about the systemic constraints they encounter

(Berlinger & Raghavan, 2013). Such options might help to reduce the moral distress of providers who feel that they have a duty to provide similar levels of care to all patients regardless of immigrations status and provide a way of bringing workarounds into the institutional discourse. Sharing information about advocacy-motivated workarounds that help health care workers connect patients with necessary services could address some of the ethical issues inherent in both the concealment and individualization of rule-bending for some undocumented patients. If a health center can systematize the (legal) workarounds that achieve better patient access to care in this way, the workarounds become part of the complex system that works for patients rather than against them.

Of course, the best solution may be to reconcile the policies with the professional attitude and practice norms of the health care workers who must carry them out; this would be beneficial to both providers and their undocumented patients. The discordance between policies that limit access to health care on the basis of immigration status and the conception of justice held by those who work in low-income healthcare settings indicates that one or the other must be wrong. Future theoretical work will explore this discordance and suggest a normative conclusion regarding the justice implications of these prenatal policies in the practice context.

TABLE 1: RESPONDENT DEMOGRAPHICS

	Nebraska (N=8)	**New York (N=9)**	**Maryland (N=8)**	**California (N=9)**	**Total (N=34)**
Geography					
Rural	4	4	4	5	17
Urban	4	5	4	4	17
Clinical Role					
Primary OB Provider	2	2	2	2	8
Nurse or Other Provider	1	2	2	2	7
Social Worker or Patient Support	2	3	3	4	12
Billing or Clinic Administration	3	2	1	1	7
Gender					
Male	0	1	0	0	1
Female	8	8	8	9	33
Age					
20-29	1	3	2	3	9
30-39	5	3	0	3	11
40-49	1	3	2	0	6
50-59	0	0	2	0	2
60+	1	0	2	3	6

REFERENCES

American Academy of Pediatrics. (2017). *Immigration Child Health Toolkit*. Retrieved from https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Council-on-Community-Pediatrics/Pages/Immigrant-Child-Health-Toolkit.aspx

Arbona, C., Olvera, N., Rodriguez, N., Hagan, J., Linares, A., & Wiesner, M. (2010). Acculturative Stress Among Documented and Undocumented Latino Immigrants in the United States. *Hisp J Behav Sci, 32*(3), 362-384. doi:10.1177/0739986310373210

Berlinger, N. (2016). *Are Workarounds Ethical?: Managing Moral Problems in Health Care Systems*: Oxford University Press.

Berlinger, N., & Raghavan, R. (2013). The Ethics of Advocacy for Undocumented Patients. *Hastings Center Report, 43*(1), 14-17. doi:10.1002/hast.126

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public health reports*.

Buchbinder, M., Lassiter, D., Mercier, R., Bryant, A., & Lyerly, A. D. (2016). Reframing Conscientious Care: Providing Abortion Care When Law and Conscience Collide. *Hastings Cent Rep, 46*(2), 22-30. doi:10.1002/hast.545

Cain, J. M. (1993). Is deception for reimbursement in obstetrics and gynecology justified? *Obstet Gynecol, 82*(3), 475-478.

Chishti, M., & Bolter, J. (2017). *The Trump Administration at Six Months: A Sea Change in Immigration Enforcement*. Retrieved from https://www.migrationpolicy.org/article/trump-administration-six-months-sea-change-immigration-enforcement

Fuentes-Afflick, E., Hessol, N. A., Bauer, T., O'Sullivan, M. J., Gomez-Lobo, V., Holman, S., . . . Minkoff, H. (2006). Use of prenatal care by Hispanic women after welfare reform. *Obstet Gynecol, 107*(1), 151-160. doi:10.1097/01.AOG.0000191299.24469.1b

Gusmano, M. K. (2012). *Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care*. Retrieved from Garrison, NY:

Mejias-Beck, J., Kuczewski, M., & Blair, A. (2017). Sanctuary Doctoring. Retrieved from https://hsd.luc.edu/bioethics/content/sanctuary-doctor/

National Immigration Law Center. (2017). *Health Care Providers and Immigration Enforcement: Know Your Rights, Know Your Patients' Rights*. Retrieved from Los Angeles: https://www.nilc.org/issues/immigration-enforcement/healthcare-provider-and-patients-rights-imm-enf/

Novack, D. H., Detering, B. J., Arnold, R., Forrow, L., Ladinsky, M., & Pezzullo, J. C. (1989). Physicians' attitudes toward using deception to resolve difficult ethical problems. *Jama, 261*(20), 2980-2985. doi:10.1001/jama.1989.03420200070040

Page, K. R., & Polk, S. (2017). Chilling Effect? Post-Election Health Care Use by Undocumented and Mixed-Status Families. *New England Journal of Medicine, 376*(12), e20.

QSR International. (2017). NVivo 11 for Mac (Version 11.4.2): QSR International. Retrieved from http://www.qsrinternational.com/product/nvivo-mac

Siskin, A. (2004). *Federal Funding for Unauthorized Aliens' Emergency Medical Expenses*. Retrieved from

Swartz, J. J., Hainmueller, J., Lawrence, D., & Rodriguez, M. I. (2017). Expanding Prenatal Care to Unauthorized Immigrant Women and the Effects on Infant Health. *Obstetrics & Gynecology, 130*(5), 938-945. doi:10.1097/aog.0000000000002275

Watson, T. (2014). Inside the Refrigerator: Immigration Enforcement and Chilling Effects in Medicaid Participation. *American Economic Journal: Economic Policy, 6*(3), 313-338.

Wherry, L. R., Fabi, R., Schickedanz, A., & Saloner, B. (2017). State And Federal Coverage For Pregnant Immigrants: Prenatal Care Increased, No Change Detected For Infant Health. *Health Affairs, 36*(4), 607-615. doi:10.1377/hlthaff.2016.1198

Wynia, M. K., Cummins, D. S., VanGeest, J. B., & Wilson, I. B. (2000). Physician manipulation of reimbursement rules for patients: Between a rock and a hard place. *Jama, 283*(14), 1858-1865. doi:10.1001/jama.283.14.1858

CHAPTER V. MANUSCRIPT 3

Publicly Funded Prenatal Care for Undocumented Immigrants: Achieving Moral Progress Through Overlapping Consensus

ABSTRACT

What just societies owe to non-citizen immigrants is a controversial question. This paper considers three accounts of the requirements of distributive justice for non-citizens to determine what they might suggest about the provision of publicly funded prenatal care to undocumented immigrants. These accounts are compared to locate an overlapping consensus on the duty of the state to provide care to pregnant undocumented immigrants. The aim of this paper is not to take a substantive position on the "right" prenatal policy, but rather to explore the moral space that this issue occupies and suggest that real moral progress can be achieved through the consistent application of shared values.

I. BACKGROUND

Maria[16] is a 25 year-old survivor of domestic abuse who, upon discovering that she is pregnant, flees her home country of El Salvador for a new life in the United States. She joins her aunt in a city in Maryland, and together they work cleaning houses for low wages. Maria has a childhood history of a heart condition that required surgical repair, but does not know the nature of the surgery she had and does not have access to her medical records. Her provider at a community health center in Maryland is concerned that Maria may be at risk of complications from her heart condition that could endanger her and her fetus and would like

---

[16] Fictional name; Maria's story is a compilation of several anecdotes about patients told to me by providers who see undocumented pregnant patients

her to see a cardiologist and receive an echocardiogram. Because the state of Maryland does not provide health insurance for pregnant undocumented immigrants, however, Maria is unable to afford an appointment with a specialist, and she struggles to find one who will provide her with charity care. After several months of trying to get an appointment, Maria gives up on trying to see a specialist, frustrating her providers and possibly putting her fetus, a potential United States citizen, at risk.

Maria's story, while fictionalized, reflects the reality of many undocumented pregnant immigrants in the 32 states that do not provide insurance coverage of routine or specialty care for undocumented immigrants during pregnancy. It illustrates the challenges inherent in a health care system that treats some patients differently on the basis of their immigration status and raises questions of what we owe to undocumented pregnant patients. There are a multitude of moral and prudential reasons why policymakers may opt for such a system (Fabi, 2017; Hall & Perrin, 2015), and while there is mixed evidence about whether this system has negative health consequences for undocumented immigrants and their American citizen babies (Swartz et al., 2017; Wherry et al., 2017), this issue raises important questions of distributive justice that deserve close scrutiny.

This paper examines the diverse justifications a society might have for providing publicly funded prenatal care to undocumented immigrants to locate areas of compatibility that could enable moral progress. While others exploring this normative territory might conclude that there is no compelling moral justification for providing undocumented pregnant immigrants with publicly funded care, this analysis builds on scholarship in political and moral theory to promote a moral argument in favor of these policies. It does so by examining three accounts on the claims of immigrants in general and then extending these acounts to the question of prenatal care for undocumented immigrants. Additionally, this paper draws on empirical data collected from stakeholders engaged with the issue of prenatal care for undocumented pregnant immigrants (Fabi, 2017).

Part II of this paper lays out the policy landscape in which this question arises, focusing on two state-level policy options that exist in the United States for providing prenatal care to undocumented pregnant immigrants. Having established the policy backdrop against which this debate takes place, Part III introduces the Rawlsian concept of the "overlapping consensus," which might present an avenue to reconciling diverse justifications for the provision of prenatal care to undocumented immigrants.

Parts IV-VI examine three accounts of the obligations of a liberal democratic society to the undocumented immigrants living within its borders and extends these accounts to consider their implications for obligations towards pregnant immigrants in particular. These parts also incorporate relevant empirical data from three case states (California, Nebraska, and New York) that reflects policymakers' perceptions of these obligations in order to provide examples of these arguments in practice. The three theoretical accounts were chosen because they are representative of recent scholarship in political theory focused specifically on duties to immigrants. The first of these accounts is Joseph Carens's social embeddedness argument that he develops in his book *The Ethics of Immigration*, in which he argues that non-citizens have claims to public resources that are proportional to the amount of time they have spent in a society and their embeddedness within that society. The second account is that of Patricia Illingworth and Wendy Parmet, who develop a two-fold account of the claims of "newcomers" to public resources based on both the "global public good" nature of health and an appeal to solidarity in their book *The Health of Newcomers*. The third account is David Miller's theory of immigrant rights that he presents in his book *Strangers in Our Midst*, which appeals both to human rights considerations and reciprocity for participation in an economic system.

Part VII examines a potential critique of these instrumental accounts for determining a pregnant undocumented immigrant's claim to publicly funded prenatal care based on a Kantian objection to instrumentalism that instead stresses the inherent value and personhood of the undocumented mother. Part VIII presents conclusions from this exploration of the moral relevance of immigration status and pregnancy in the distribution of public resources as well the policy implications of these findings.

II. POLICY BACKGROUND

Nearly 8% of babies born in the United States have at least one undocumented parent, and, under the Fourteenth Amendment to the U.S. Constitution, those babies receive citizenship at birth regardless of the immigration status of their parents (Passel & Cohn, 2015). Although undocumented immigrants are ineligible for most publicly funded health insurance except in emergencies or for labor and delivery, 19 states have opted to provide insurance coverage for undocumented immigrants during pregnancy (Fabi, 2014). These policies include a Children's Health Insurance Program (CHIP) State Plan Amendment that allows the state to receive federal matching funds for care provided to the unborn fetus of pregnant immigrants and a state-funded program that provides coverage for Medicaid services for financially eligible pregnant women regardless of immigration status (Fabi, 2014).[17] In the 32 states that do not implement either policy option, pregnant

---

[17] For a more thorough examination of the content and history of these policies, see Manuscript 1 or Appendix A.

undocumented immigrants can access care through safety net providers (such as Federally Qualified Health Centers, or FQHCs), but must do so without insurance coverage, paying on a sliding fee scale. A brief review of how the prenatal policies function is necessary in order to ground the theoretical analysis that follows.

The first option for states wishing to provide prenatal care for low-income undocumented immigrants is to adopt the so-called "Unborn Child" Option for their CHIP programs. Under this option, states can choose to extend CHIP eligibility to any "individual under the age of 19 including the period from conception to birth" who also meets income guidelines (CMS, 2002). This allows the state to treat the unborn fetus of an undocumented immigrant woman as a citizen of the United States who is therefore eligible for benefits (Dallard, 2002; Ludomirsky, 2010). In these states providers can seek reimbursement for care delivered to the pregnant undocumented immigrant woman and her fetus, as long as the care directly benefits the future U.S. citizen baby (Baumrucker, 2008) . Therefore, CHIP in these states covers the cost of ambulatory prenatal care and delivery, but does not cover treatment provided to the mother that does not directly benefit the child. This option is attractive to states because it allows the use of federal matching dollars to help pay for care administered to the fetus despite the mother's ineligibility for federally-funded care due to her immigration status.

The second option available to states is to expand Medicaid eligibility to undocumented pregnant immigrants by eliminating citizenship as an eligibility requirement.[18] Under this option pregnant undocumented immigrants can receive full Medicaid benefits,

---

[18] This option could be considered a "Medicaid Look-Alike" because Medicaid, as a federally funded program, is not available to nonqualified immigrants. For the purposes of this analysis, this option will be referred to as a state Medicaid expansion because the provider and patient experience of the program is identical to that of regular Medicaid.

which do not limit care to ambulatory prenatal care and delivery but also includes such services as dental care and mental health care. The expense of expanding coverage must be covered by the state, because federal dollars cannot be used to provide non-emergency care for undocumented immigrants. Currently, New York and Massachusetts are the only states that provide reimbursement for this this care through Medicaid, although New Jersey also administers a prenatal care program available to undocumented immigrants which is subject to the availability of grant funds (Fabi, 2014).

III. THE OVERLAPPING CONSENSUS

As this paper will demonstrate, there are a variety of conceptions of justice that offer conflicting accounts of what justice demands in regard to health care for undocumented immigrants. Despite these differences, however, it is possible to identify concrete policies upon which they all agree. This idea, known as the "overlapping consensus," derives from John Rawls's *A Theory of Justice*. Although he develops his own theory of justice throughout his book, Rawls acknowledges that "there can, in fact, be considerable differences in citizens' conceptions of justice provided that these conceptions lead to similar political judgments" (Rawls, 1999, p. 340). The utility of the overlapping consensus is to allow political progress to occur even when stakeholders maintain different conceptions of the appropriate distributive scheme or justification thereof. Rawls posits that "both sides must believe that however much their conceptions of justice differ, their views support the same judgment in the situation at hand, and would do so even should their respective positions be interchanged" (Rawls, 1999, p. 340). Essentially, this means that parties holding significantly different views on the reasons or method for distributing public resources may still arrive at the same policy solution to a given problem. What follows is an attempt to identify an overlapping consensus between various theoretical and empirical viewpoints to suggest a space for policymakers to make moral progress.

The Unborn Child option and that state Medicaid expansion provide two different policy avenues for covering prenatal care for undocumented immigrants. Previous descriptive work has examined the moral and prudential arguments that were used to support or oppose the passage of these policies in three case states. This paper presents a synthesis of both the normative literature and the descriptive data on justifications for the provision of care to pregnant undocumented immigrants to develop an overlapping consensus policy position. This is achieved through a description of each of three distinct normative approaches within the cosmopolitan tradition that takes seriously the equal moral value of all humans (those of Joseph Carens, Patricia Illingworth and Wendy Parmet, and David Miller) and a critical application of each approach to the question of publicly funded prenatal care for undocumented immigrants. The examination of each normative approach is supplemented by examples of the arguments as found in the legislative histories of actual prenatal policies to illustrate their practical application in political rhetoric. This analysis generates an overlapping consensus account of the obligations of a society to provide prenatal care to undocumented immigrants.

IV. JOSEPH CARENS: *THE ETHICS OF IMMIGRATION*

While many theorists have explored the distributive justice obligations of a society to its members, fewer have deeply considered the obligations of a society to non-citizens who reside within its boundaries. One predominant theorist who has worked extensively in this area is Joseph Carens, whose book *The Ethics of Immigration* develops an argument about the rights of different types of immigrants living in democratic societies. His argument, called the theory of social membership, is that "living in a society over time makes one a member and being a member generates moral claims to legal rights and to legal status" (Carens, 2013, p. 293). He applies this theory to a variety of policy questions, including the rights of temporary workers, legal permanent residents, and undocumented immigrants (or, as he calls them, "irregular migrants"). In all cases, he argues that immigrants develop a claim to public resources over time. He views time as the "crucial variable" because living in a society leads to the development of social connections (Carens, 2013, p. 145). Carens describes this process in a passage about the moral significance of living in a community for ten years, saying:

> Ten years is a long time in a human life. In ten years, connections grow: to spouses and partners, sons and daughters, friends and neighbors and fellow-workers, people we love and people we hate. Experiences accumulate: birthdays and braces, tones of voice and senses of humor, public parks and corner stores, the shape of the streets and the way the sun shines through the leaves, the smell of flowers and the sounds of local accents, the look of the stars and the taste of the air—all that gives life its purpose and texture. We sink deep roots over ten years, and these roots matter even if we were not authorized to plant ourselves in the first place. On a moral scale, the significance of…social membership outweighs the importance of enforcing immigration restrictions. (Carens, 2013, p. 150)

In constructing this argument, Carens is not implying that ten years is a hard and fast benchmark before which an immigrant has no moral claims and after which they deserve full access to the rights of citizens, but rather he is arguing that the accumulation of time within a society matters morally and he implies that the strength of claims is scalar.

Applying Carens's theory to the rights of pregnant undocumented immigrants would suggest that those undocumented immigrants who have spent a meaningful amount of time in the United States have a moral claim to the rights due to social members, which would include some range of health care rights.[19] If a state provides prenatal care to citizens below a certain income threshold, it follows that they should also provide prenatal care to long-time non-citizen members below that same income threshold, because what matters morally is the mother's social membership rather than the political recognition of citizenship or legal immigration status. Of course, this cannot justify providing prenatal care to undocumented immigrants who have not lived in the United States long enough to form sufficiently deep social ties.

If this were the entirety of his argument, it would have negative implications for the claims of newborns and young children who have amassed no significant amount of time in or social connection to the society in which they live. Carens anticipates this concern, building a case for the moral claims of the children of immigrants from analogies to those of the children of citizens. He begins with the moral intuition that the children of citizens should receive birthright citizenship because they are expected to receive their social formation in the country of their birth; while he acknowledges that "newborns have no past (outside the womb) so one cannot appeal to their experience as a justification for granting them citizenship," he argues that "even infants are moral persons. They cannot (yet) exercise political agency but they can be and are bearers of legal rights. So, the state has a duty to recognize them as moral persons and to protect their rights" (Carens, 2013, pp. 21-22). Additionally, Carens argues that newborn babies have morally significant social ties, even if they do not have the same "deep roots" that adults do. He observes that "Babies do not appear upon the earth unconnected to other human beings. A baby emerges physically from

---

[19] Although Carens is hesitant to identify an exact amount of time that counts as "meaningful," such as the ten year benchmark he considered above, he suggests that it would likely be more than a few years but significantly fewer than 20. (Carens, 2013, p. 151)

her mother, of course, but she enters a social world. From the outset, she has various sorts of relationships and belongs to various sorts of human communities" (Carens, 2013, p. 23). For these reasons, Carens maintains that the children of immigrants should receive full membership privileges in the society in which they expect to obtain their social formation, just as the children of citizens do.

It is important to note, however, that Carens makes no claims about the moral personhood or rights of a fetus *in utero*. He likely avoids this issue in order not to engage in the ethically fraught debate over fetal personhood and reproductive rights, but he does leave open a path to argue for even pregnant undocumented immigrants who have not yet spent much time in the country to receive the same access to health care as citizens. This turn would rest upon the empirical likelihood that a child born to a settled undocumented immigrant will, in the future, be raised in society and obtain her social formation there. Carens writes that "by itself, birthplace creates no compelling claim to membership. It is only when birthplace is linked to future expectations of living in the society that it gives rise to such a claim" (Carens, 2013, p. 36). Although this line of argument was likely intended to avoid committing to the provision of public resources to tourists and temporary visitors, it also serves to distinguish the rights of a fetus that is a future community member from those of a fetus that will never receive membership because the mother does not intend to give birth. This dodges the anti-abortion implications of arguing that a fetus has moral personhood by instead arguing that the expectation of future membership is what matters morally. There would only be an expectation of future membership if the mother had already decided she wanted to carry her child to term and give birth, meaning that any membership claims to prenatal care made by a fetus become relevant once it has been determined that the fetus will, in fact, be born into society. While some might express concern that there is no guarantee that the fetus will actually be born in the United States because the mother could, in theory, receive prenatal care for nine months and then return to her country of origin, Carens tends to urge that we "err on the side of inclusion" (Carens, 2013, p. 25).

This future membership argument can also be found in the legislative histories of both the Unborn Child policy in Nebraska and the state Medicaid expansion in New York. In Nebraska, the debate about the enactment of the Unborn Child policy often relied on the fetus's future membership in Nebraskan society. One Nebraskan state senator argued on the floor of the legislature 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 [services] for a future citizen and a future Nebraskan" (LB599 Floor Debate, 4/3/12). This legislator anticipated the objection that the mother might leave the country, but framed that scenario as an absurd hypothetical that hinged on the unlikely deportation of the pregnant mother. A similar argument was made in a New York court case that examined the legality of the state Medicaid expansion. A judge, writing in favor of the policy, noted that "Nothing in the statute or common sense dictates that subsequent events such as departure from the country *en ventre de sa mere*[20] or the inheritance of great wealth are to be speculated about in determining whether the unborn child is to receive the statute's benefits" (*Lewis III*). In both states, the future social membership of the fetus was assumed and used to ground an obligation to provide that fetus with health services, as Carens's theory would require.

---

[20] Legal term that translates literally to "in the stomach of his mother"

Joseph Carens's theory of social membership would support the provision of prenatal care to pregnant undocumented immigrants, regardless of how long they have lived in their community, based on the future membership claims of the fetus. Although Carens's theoretical approach avoids taking a position on the moral status of the fetus, it may fail to satisfy other moral considerations, including beneficence obligations to maximize good health outcomes, solidarity-based obligations to community members, and the moral status of undocumented mothers. These alternative theoretical approaches are considered below.

V. PATRICIA ILLINGWORTH AND WENDY PARMET: *THE HEALTH OF NEWCOMERS*

In their book *The Health of Newcomers*, Patricia Illingworth and Wendy Parmet aim to demonstrate that "it is both rational and moral for nations to treat the health interests of natives and newcomers [resident non-citizens] alike" (Illingworth & Parmet, 2017, p. 2). They do this by first examining immigrant health policies to evaluate their effects on the health of natives and newcomers, and demonstrate that many such policies effectively undermine the health of all residents. Illingworth and Parmet then develop a multiply-determined argument that newcomers should receive access to the same range of health-related goods and the social determinants of health as citizens. This argument is based on both the "global public good" nature of health and the commitments of solidarity that exist between members of the same community to "carry costs" for one another.[21]

Illingworth and Parmet define a global public good as one that is both non-rivalrous and non-excludable, meaning that its use by one person does not diminish the ability of

---

[21] Illingworth and Parmet also draw on the work of Thomas Pogge to discuss reparative duties owed to newcomers from countries that have been harmed by an unjust global order. I set these arguments aside because they are somewhat outside the scope of the present discussion, but it should be noted that this approach to determining the obligations of wealthy states towards immigrants from economically depressed states holds considerable value in the discourse about global justice obligations.

others to use it, and it is difficult to prevent others from enjoying it. Like Carens, they argue that people are "socially embedded and interdependent," but unlike Carens, they suggest that these community relationships are morally meaningful because the health of individuals impacts the health of other community members with whom they are connected (Illingworth & Parmet, 2017, p. 127). They cite literature on the spread of diseases through social networks and the impact of social determinants on health status to support this argument, and suggest that human interconnectedness makes it necessary to protect the health status of all community members, regardless of their immigration status, for the good of the community as a whole. They also make a prudential argument, suggesting that "health makes people better workers, and presumably more productive within the workforce" (Illingworth & Parmet, 2017, p. 130), implying that we should aim to improve health outcomes for newcomers in our own economic self-interest. Essentially, they argue that "if health is impacted by social determinants, social capital, and norms, and we live side by side with newcomers, we cannot easily remain unaffected by their health," and therefore it is in our own self-interest to promote the health of newcomers (Illingworth & Parmet, 2017, p. 131).

Applying this global public goods argument to the case at hand, it would seem that Illingworth and Parmet's theory might support an argument that pregnant undocumented immigrants should receive publicly funded prenatal care because their health, and the health of their babies, will affect the health of the rest of the population. Even people embedded in deeply isolated immigrant communities have contact with natives, and a healthier newcomer population means better health outcomes for natives, and prenatal care is vital in detecting and preventing conditions like low birthweight that could require expensive treatment if not treated *in utero*, as well as sexually transmitted diseases and other communicable health conditions (Henderson, 1994; Kuiper et al., 1999; Moore, Origel, Key, & Resnik, 1986).

Indeed, Illingworth and Parmet discuss this very phenomenon, observing that the governor of Nebraska, in attempting to veto the Unborn Child option, "neglected to consider…that by denying prenatal care to undocumented mothers, the state was harming children who would be citizens [and therefore] eligible for Medicaid. Hence taxpayers end up paying for health care costs that could have been avoided by appropriate prenatal care" (Illingworth & Parmet, 2017, p. 80). Additionally, given the effects of maternal access to prenatal care on long-term health outcomes (S. Miller & Wherry, 2016), it is reasonable to conclude that prenatal care for pregnant immigrants could also have effects on the economic output of their children. These arguments, though perhaps compelling to those motivated by prudential, self-interested reasons, may not convince those who wish to argue that undocumented immigrants have a claim to publicly funded prenatal care in their own right.

Perhaps in recognition of this shortcoming, Illingworth and Parmet articulate a second solidarity-based argument in favor of the provision of health care to newcomers, drawing on the work of philosopher Shawn Harmon. They outline three characteristics of solidarity:

> (1) Solidarity emphasizes community, recognizing that individuals are embedded in social contexts and that they share connections with other people, society, and groups; (2) it is grounded in an interest in the well-being of others and an active commitment to promote their well-being; and (3) "[s]olidarity demands common action to uphold the complex of social relationships and values that is needed to realize useful standards of decency and justice" (Illingworth & Parmet, 2017, pp. 174-175)

Illingworth and Parmet argue that "solidarity is triggered by participation in a community," seemingly echoing Carens's argument that community embeddedness is morally significant because human connections are independently valuable. However, Illingworth and Parmet ultimately veer in a more instrumental direction when making their community-based solidarity argument, suggesting that solidarity-generating relationships arise from the empirical fact that newcomers often serve as caretakers for elderly and sick natives, as well as from the global public goods relationship they outlined earlier.

Elaborating on this solidarity argument, Illingworth and Parmet rely on Iris Marion Young's theory that structural injustice can generate duties of solidarity; they contend that "complicity in a structural injustice can give rise to a duty to help" (Illingworth & Parmet, 2017, p. 183). Young identifies four conditions under which one might be said to have a duty of solidarity: (1) power, (2) privilege, (3) interest, and (4) collective ability. These criteria are sufficient but not necessary to trigger duties of solidarity. For instance, when actors have the power to successfully effect change, this might generate a duty to do so. Similarly, if an actor enjoys benefits as a result of a structural injustice, their privilege with regard to the injustice might also generate a duty of solidarity to correct the unjust system that has benefited them. Actors with vested interests in a structural injustice also have duties to address them. Finally, actors who are able to organize and act collectively to address a structural injustice (such as, for instance, a university) may have a duty to do so (Illingworth & Parmet, 2017, pp. 184-185).

In the case of prenatal care for undocumented "newcomers," Young's theory (and, by extension, the theory of Illingworth and Parmet) might argue that all of these conditions are met. First, states have the *power* to change laws that reinforce structural injustice; indeed, as we have seen, a number of states have already done so by adopting policies that facilitate access to prenatal care for pregnant undocumented immigrants. Second, natives are disproportionately *privileged* by the migration of undocumented newcomers in terms of their labor, as undocumented immigrants frequently perform jobs that Americans do not want, and also are unable to claim many of the benefits that their taxes pay for, including Social Security. The way Americans benefit from this structural injustice generates a duty to correct it. Third, Americans have a vested *interest* in the health of newcomers due to the global public good nature of health, as Illingworth and Parmet previously argued. Finally, the American health system has the capacity to *act collectively* through coordination between health providers and their health centers in which they work (Illingworth & Parmet, 2017, p. 186). If Young, and therefore Illingworth and Parmet, are correct in theorizing that these four conditions generate obligations of solidarity, then the satisfaction of these conditions entails that Americans have a duty of solidarity to "carry costs" for the undocumented immigrants who live among them (pregnant and non-pregnant alike).

This argument was reflected in some of the rhetoric used by policymakers in Nebraska who favored the passage of the Unborn Child option. One policymaker argued that the state has a duty to provide prenatal care to people whose labor benefited the residents of the state, saying "as long as they're hired by somebody…they have jobs. So that's why they're here. And an industry in this state here told me we couldn't do without immigrants…. They just said we couldn't function. So is that their fault or our fault?" (LB599 Floor Debate, 4/4/12). This reflects Young's position that rights to care derives, in part, from participation in an unjust economic scheme that benefits from the willingness of undocumented immigrants to work in industries that Nebraskans will not.[22] Although the term solidarity is not explicitly employed, this policymaker clearly subscribes to the

---

[22] This is a controversial area of publicpolicy debate, and good faith analyses give different answers as to how undocumented immigrants affect the labor market options for citizens. In this analysis, Illingworth and Parmet's empirical assertion, echoed by the Nebraska policymaker, that the presence of undocumented immigrants in the labor market yields net benefits for citizens is accepted at face value.

solidarity-based reasoning based on the privileges Americans experience from participating in an unjust system. However, some theorists may find that this, too, is an inadequate moral justification for the provision of prenatal care to undocumented immigrants because it relies in part on empirical facts about the benefits undocumented immigrants provide to natives. This challenge to the solidarity argument is considered in part VII.

VI. DAVID MILLER: *STRANGERS IN OUR MIDST*

David Miller's *Strangers in Our Midst* takes a different approach to the question of how a society should think about immigration and obligations towards immigrants, including a state's right to exclude immigrants and what a state owes to immigrants who are already territorially present. Although his writing on open and closed borders and the admission of immigrants is insightful, this section will focus on his consideration of immigrant rights within a liberal democratic society.

Unlike Carens, Illingworth, and Parmet, Miller defends a theory of societal obligations to immigrants that generally requires much greater consideration to compatriots. Miller calls this position "weak cosmopolitanism," meaning that "we are required to treat [all] people with equal concern, understood first to mean that we cannot simply ignore their interests when we are deciding how to act," but "it does not in general mean that we have *obligations* toward them… [unless] their claims against us become urgent—when failing to meet them is likely to cause significant harm" (D. Miller, 2016, p. 33). It could be argued that this weak cosmopolitanism resembles a form of the rescue principle, in that obligations only arise when failing to act could result in "significant harm." In building out this theory, Miller argues that receiving states must protect a narrow array of "urgent" human rights for undocumented immigrants, but beyond that, all other social or civic obligations owed to undocumented immigrants derive from their participation in a reciprocal social system on an individual basis. In order to explore what this means for the provision of publicly funded prenatal care to undocumented immigrants, we will need to determine whether Miller would consider prenatal care an urgent human right, and, if not, how participation in a reciprocal social system is measured.

Miller defines human rights as "the rights whose possession allows people to meet" the needs "that must be met if people are to be able to lead minimally decent lives" (D. Miller, 2016, p. 32). This ultimately entails a quite narrow view of human rights; while other theorists might include the rights that Miller describes as "rights of citizenship," such as those rights that "provide the conditions under which a person can participate fully in the social and political life of the society to which they belong," Miller's account is minimalist and limited only to those "urgent" rights that generate obligations due to the risk of serious harm. In the case of legally residing immigrants, it is clear that Miller believes that the provision of health care is an obligation of the receiving state; he argues that "the receiving state by granting entry takes full responsibility for protecting basic rights to subsistence, shelter, health care, bodily integrity, safety at work, and so forth" (D. Miller, 2016, p. 117). It is important to note that this position applies only to those immigrants who were *granted entry*, and therefore may not include undocumented immigrants who enter without authorization. Nonetheless, Miller concludes that "A state that claims authority to apply its laws to everyone within its territory must also protect the human rights of all those present, whether legally or not" (D. Miller, 2016, p. 117). Thus it is the political legitimacy of the state that is at stake when it determines whose basic rights it will defend, and a state that protects only the basic rights of some residents and not others is illegitimate.

Miller's theory, as applied to the case at hand, must first address whether publicly funded prenatal care is a basic or "urgent" right. As mentioned above, Miller includes health care in the list of basic rights that a government owes to legally residing immigrants. It would be incoherent for him to argue that what is a human right for one population is not also a human right for another; by their very nature, human rights are universal and common to all humans, regardless of their immigration status. Indeed, Miller does not deny that health care is a human right that is owed to undocumented residents of a state, but he does diverge from other theorists, most notably Carens, in suggesting that the state has no obligation to guarantee that undocumented immigrants are able to exercise that right (D. Miller, 2016, p. 119). While Carens supports a "firewall" between immigration enforcement and services like health care and local police in order to protect immigrants' abilities to access their rights of membership (Carens, 2013, p. 133), Miller suggests that undocumented immigrants may be forced to choose between exercising "administrative and social rights" and the right not to be deported for doing so. He recognizes that this is a morally untenable claim when it comes to the basic human rights he has identified, and clarifies that "the relevant normative line falls between access to basic rights and access to other benefits," such as "access to libraries or swimming pools, or to social housing" (D. Miller, 2016, p. 120). It should be intuitively and unambiguously clear that health care during pregnancy does not fall into the same category of right as access to a public swimming pool, so Miller's theory would likely hold that undocumented immigrants should be able to access publicly funded prenatal care.

Although Miller considers health care an urgent human right, this view is not necessarily shared by all political stakeholders. As the public hearings for Nebraska's prenatal policy revealed, some people believe that only emergency health care is a right. During a hearing, one citizen testified to that belief in a revealing exchange with a policymaker:

> [Citizen]: I don't think that there's anything wrong with having to be compassionate when someone shows up in your emergency room, no matter the immigration status. And if they are in a life-threatening situation or an emergency type situation, that they should be able to get that care. But then out again.
>
> [State Senator]: Would you have any problem if to get this prenatal care, all of those individuals that we're talking about who are illegal women, showed up in hospital emergency rooms across the state to get that prenatal care?
>
> [Citizen]: Yes, I have a problem with that because it's not an emergency situation. (LB 1110 Hearing, 2/25/10).

This exchange illustrates the challenge of specifying the content of a normative principle when using it to create public policy. Although the citizen shares the belief that an undocumented immigrant should receive emergency care if she is in a "life-threatening situation," she opposes the provision of prenatal care because it is not an "emergency." Unlike this Nebraska citizen, Miller does not require a threat to life in order to establish that a right is urgent, but it is clear that moral intuitions may diverge on this point.

Setting aside this appeal to intuition and basic human rights, it is still possible to ground a duty to provide publicly funded prenatal care in the branch of Miller's theory that explores access to "other benefits." Miller, like Carens, Illingworth, and Parmet, argues that the passage of time is morally relevant, and bases this claim on duties of reciprocity. He writes:

> Residence over time may also matter…The immigrant is likely to have entered into a system of social cooperation centered around the workplace, but extending beyond that to include leisure activities and so forth. These interactions are governed by norms of reciprocity; each person contributes and in return receives benefits. The most obvious practical manifestation of this will be the taxes the immigrant has paid through working, consuming, owning property, and so forth. Once somebody belongs to such a scheme, it

> will be unjust to force them to withdraw from it after having made contributions that have not yet been reciprocated in full…[S]chemes of cooperation of this kind give rise to associative obligations among the participants (D. Miller, 2016, p. 124)

This echoes the social membership theory of Carens and the solidarity-based argument of Illingworth and Parmet, but takes a more transactional tone. For Miller, what matters morally is that even undocumented immigrants pay taxes and participate in the economy, so to deny them the benefits they have participated in generating would be unjust. Empirically, it is the case that, as a group, undocumented immigrants contribute significantly to both the American tax base and the economy, and, as Carens argues, it is preferable to "err on the side of inclusion" (Carens, 2013, p. 25; Gardner et al., 2015). Given these facts, and in the interest of avoiding redundancy, it should suffice to say that the same reasons that justified access to publicly funded prenatal care for undocumented immigrants in the accounts of the other theorists also hold for Miller.

VII. THE KANTIAN CRITIQUE

One possible critique of the justice theories considered above is that they treat the undocumented mother as a mere means to an end, which may seem anathema to the cosmopolitan position, also shared by Immanuel Kant, that all human beings are of equal moral worth. The theories examined so far have emphasized the social membership of the future citizen fetus (Carens), the public health and economic benefits of having healthier undocumented mothers (Illingworth and Parmet), or empirical facts about how undocumented immigrants benefit their citizen neighbors (Young, Illingworth and Parmet, Miller). Ultimately, aside from Miller's appeal to basic human rights, all of these claims appear to hinge on the merely instrumental value of the pregnant immigrant, either for her use in bringing about a citizen baby, a healthy native population, or an economically advantaged society. From a Kantian perspective, this is unacceptable. This section anticipates the Kantian critique of these theories and re-examines them to see if there may be amendments to the reasoning presented above that could satisfy the categorical imperative for stakeholders who reject instrumental arguments. It is important to consider this autonomy-motivated perspective because many political stakeholders demand recognition of the mother's rights, independent of her fetus.

While Carens's social membership theory supports the right to social services for undocumented immigrants who are deeply embedded in their communities as a result of the passage of time, it does not, as we have seen, support the same for newly arrived undocumented immigrants. However, the expectation that the fetus will be born and receive social formation in the community may entail a newly arrived undocumented mother's right to prenatal care. This approach treats the undocumented mother serves merely as a vessel for her future citizen fetus, and by relying on this reason to justify the provision of publicly funded prenatal care, we treat her a "mere means" to the healthy birth of her child. This violates Kant's categorical imperative, which requires that we "use humanity…always at the same time as an end, never merely as a means" (Kant, Gregor, & Timmermann, 2012, p. 41). A Kantian who takes seriously our obligations under the categorical imperative could avoid this problem by considering the parallel expectation that the mother herself will belong someday to the community. Assuming that the mother has settled in her community intentionally and that she has not acted capriciously in choosing to leave her previous home for a new life, she deserves the same respect that is shown to her fetus by assuming her future community membership as well. Indeed, it could be argued that society owes more consideration to the mother's future membership, as she has actively chosen to live in the community she inhabits, while her fetus's future membership is a result of another individual's choice. Therefore, as is the case with her fetus, the mother's social membership may generate obligations to provide her with the same public resources as other community members.

Similarly, the "global public goods" approach adopted by Illingworth and Parmet would treat the undocumented mother as a "mere means" to secure better health outcomes for other community members. It recognizes that the health of one member is deeply tied to others, and argues that we act in our own self-interest when we promote the health of undocumented mothers because their health is key to our own health-related ends. Their solidarity argument that posits that we have reciprocal duties towards undocumented immigrants hinges on their usefulness in the unjustly-structured labor economy, particularly in the health sector, where many newcomers work as nurses or caretakers. As with the global public goods argument, this reasoning treats undocumented immigrants as a means to the ends of natives. Additionally, while Miller's human rights account would very likely prove acceptable to a Kantian, in that it requires the state to protect basic human rights in recognition of the "equal moral worth of all human beings" (D. Miller, 2016, p. 31), his appeal to reciprocity would face similar challenges to those faced by Illingworth and Parmet.

How might a Kantian respond to this line of reasoning? One way might be through a consideration of whether the global public goods, solidarity, and reciprocity-based approaches treat the undocumented mother as a *mere* means, or whether she is treated *at the same time as an end*. Arguably, all three approaches could be reexamined in this light to argue that they meet this Kantian criterion. Although both the global public goods approach and the solidarity approach highlight the utility of healthier immigrants for protecting the health or economic well-being of natives, it is nonetheless also true that promoting better public health *for all* affects natives and newcomers alike. Promoting the health of undocumented immigrants may be good for the health of the community writ large, but it is undoubtedly good for the undocumented immigrants themselves, both as individuals and of members of that same community. In the same vein, promoting the economic well-being of the country in which immigrants reside could also secure economic opportunities for immigrants above those that they might have in their home countries. Thus, it could be argued that these approaches treat undocumented immigrants both as a means and at the same time as ends in themselves.

VIII. CONCLUSIONS AND POLICY IMPLICATIONS

This section returns to the question of the overlapping consensus. Has this analysis located a political judgment that could satisfy stakeholders who hold conflicting conceptions of justice? Consider the different conceptions this paper has examined, bearing in mind that all of these accounts take seriously the equal moral value of all humans. First, Carens's social membership theory would grant an undocumented mother a right to publicly funded prenatal care by virtue of her fetus's future citizenship, as well as, potentially, her own future social membership in the community. Second, Illingworth and Parmet's global public goods approach, which diverges sharply from Carens's account in which social connections were considered inherently valuable, would also support an undocumented woman's right to prenatal care because of its instrumental value in generating public health benefits. Third, their interpretation of Young's solidarity model, which would grant access to prenatal care on the basis of solidarity obligations generated under an unjust social structure, would require those with the power, privilege, interest, and collective ability to address the needs of undocumented pregnant immigrants. Fourth, David Miller's "weak cosmopolitan" human rights position requires the provision of prenatal care because health care is necessary to secure a minimally decent human life, and his reciprocity approach would require it on the basis of reciprocal obligations that allow tax-paying immigrants to access the goods their tax money supports. Thus it seems that this wide variety of accounts of justice converges on a single political judgment with regard to the provision of publicly funded health care for undocumented immigrants: it is morally required.

This exploration of the theoretical justifications for this position could yield a variety of potential arguments for policymakers searching for rhetorical tools to support a prenatal policy in their state. Policymakers who represent constituents with diverse conceptions of justice can use these tools to seek political consensus on the provision of prenatal care for undocumented immigrants, and can even tailor their arguments to the specific policy they hope to promote. For instance, constituencies that hold strong "pro-life" views on the moral status of a fetus might be swayed by Carens's future citizenship argument. These arguments may succeed in promoting the implementation of the CHIP "Unborn Child" option, which grants federal matching funds to states that provide prenatal care to a fetus beneficiary. "Pro-choice" constituencies may reject this reasoning, but could still accept the political judgment that this care should be provided because they agree with Miller that basic human rights must be protected. Alternatively, a policymaker could reject the CHIP Unborn Child option because of its reproductive rights implications, but could seek a state-funded Medicaid expansion for pregnant undocumented immigrants, and bring more conservative voters on board through an appeal to Illingworth and Parmet's account of health as a global public good.

The overlapping consensus is a both an important philosophical construct for identifying areas of agreement across theories and a useful policy tool for arriving at a widely acceptable political judgment. In the case of this particular policy question, it is possible to locate a political solution that should be widely acceptable to philosophically diverse stakeholders, assuming all stakeholders take seriously the equal moral worth of human beings. While the details of how publicly funded prenatal care could be provided to undocumented immigrants may differ from state to state, it should be possible to forge moral progress towards preventing a state of affairs in which some particularly vulnerable human beings are unable to meet their basic health needs.

REFERENCES

Baumrucker, E. P. (2008). *SCHIP coverage for pregnant women and unborn children.* Retrieved from

Carens, J. (2013). *The Ethics of Immigration*: Oxford University Press, USA.

CMS. (2002). State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children (42 CFR 457). *Federal Register, 67*(191), 61956-61974.

Dallard, C. (2002). New SCHIP Prenatal Care Rule Advances Fetal Rights At Low-Income Women's Expense. *The Guttmacher Report, 5*(5), 3-5.

Fabi, R. (2014). Undocumented Immigrants in the United States: Access to Prenatal Care. *The Undocumented Patients Project.* Retrieved from http://undocumentedpatients.org/issuebrief/undocumented-immigrants-in-the-united-states-access-to-prenatal-care/

Fabi, R. (2017). *Manuscript 1 (Working Paper).* Dissertation Working Paper. Health Policy and Management. Johns Hopkins Bloomberg School of Public Health. Baltimore, MD.

Gardner, M., Johnson, S., & Wiehe, M. (2015). *Undocumented Immigrants' State & Local Tax Contributions.* Retrieved from

Hall, M. A., & Perrin, J. (2015). Irregular Migrant Access to Care: Mapping Public Policy Rationales. *Public Health Ethics, 8*(2), 130-138. doi:10.1093/phe/phv016

Henderson, J. W. (1994). The cost effectiveness of prenatal care. *Health care financing review, 15*(4), 21.

Illingworth, P., & Parmet, W. (2017). *The Health of Newcomers.* New York: New York University Press.

Kuiper, H., Richwald, G. A., Rotblatt, H., & Asch, S. (1999). The communicable disease impact of eliminating publicly funded prenatal care for undocumented immigrants. *Matern Child Health J, 3*(1), 39-52.

Ludomirsky, A. (2010). *Access to Prenatal Care for Undocumented Immigrants Under Medicaid and CHIP: A Review of State Prenatal Care Programs* Princeton.

Miller, D. (2016). *Strangers in our midst*: Harvard University Press.

Miller, S., & Wherry, L. R. (2016). The Long-Term Effects of Early Life Medicaid Coverage. *Available at SSRN 2466691*.

Moore, T. R., Origel, W., Key, T. C., & Resnik, R. (1986). The perinatal and economic impact of prenatal care in a low-socioeconomic population. *American journal of obstetrics and gynecology, 154*(1), 29-33.

Passel, J., & Cohn, D. (2015, September 11, 2015). Number of babies born in U.S. to unauthorized immigrants declines. *FactTank*. Retrieved from http://www.pewresearch.org/fact-tank/2015/09/11/number-of-babies-born-in-u-s-to-unauthorized-immigrants-declines/

Rawls, J. (1999). *A Theory of Justice, Revised Edition*: Harvard University Press.

Swartz, J. J., Hainmueller, J., Lawrence, D., & Rodriguez, M. I. (2017). Expanding Prenatal Care to Unauthorized Immigrant Women and the Effects on Infant Health. *Obstetrics & Gynecology, 130*(5), 938-945. doi:10.1097/aog.0000000000002275

Wherry, L. R., Fabi, R., Schickedanz, A., & Saloner, B. (2017). State And Federal Coverage For Pregnant Immigrants: Prenatal Care Increased, No Change Detected For Infant Health. *Health Affairs, 36*(4), 607-615. doi:10.1377/hlthaff.2016.1198

CHAPTER VI: DISCUSSION AND CONCLUSIONS

This chapter presents a summary of the findings of the three manuscripts and discusses the policy and practice implications of this dissertation project as a whole. The policy implications include **(1) there are a variety of ways to frame prenatal policies for the public; (2) there are policy opportunities to extend health care to other undocumented populations;** and **(3) provision of more generous benefits to undocumented immigrants could help reduce moral distress in providers**. The practice implications are **(1) health care institutions should provide workers with a safe environment in which to discuss ethical tensions and workarounds** and **(2) providers should create opportunities for patients to discuss immigration status**. This chapter also lays out a future policy and conceptual research agenda that builds on this work and concludes with a reflection on the relevance of this work to current political discourse.

SUMMARY OF FINDINGS

This dissertation explored the moral relevance of immigration status and pregnancy in the distribution of public resources. The project addressed three specific aims: (1) examine the relationship between the policy narratives, policy requirements, and the use of moral and prudential reasons by legislatures and courts in state policies that provide publicly-funded prenatal care to undocumented immigrants; (2) describe the professional norms and practices of health care workers who serve undocumented pregnant immigrants in states with different prenatal policies and the ethical tensions they encounter when providing or facilitating care under policy restrictions; and (3) apply three normative accounts of distributive justice regarding a society's obligations to non-citizen residents to the duty of the public to provide care to pregnant undocumented immigrants and locate an overlapping consensus across accounts.

MANUSCRIPT 1

The first manuscript addressed Aim 1 of this project through a review and qualitative analysis of the documents that comprise the legislative and judicial histories of the prenatal policies in question in three states. It describes the history of each prenatal policy and traces the development of the policy's content, including the eligibility criteria and benefits covered in each state. This manuscript's main contributions to the bioethics literature are the findings of a range of moral and prudential reasoning employed by policymakers, judges, and citizens who supported or opposed the policies in each state. The types of reasons found in this study included those based on appeals to the principle of respect for persons (opposing or support abortion rights and supporting fetal personhood); the principle of justice (basing deservingness on individual characteristics or actions or social membership); and prudential appeals to the interests of native citizens and legally residing immigrants. The differences between states in the types of moral and prudential arguments demonstrates the diversity of opinion on this controversial public health issue and provides empirical evidence of more and less successful moral arguments used in the political context. This paper also found that many of the state differences can be traced to the state's position on the protection of reproductive rights, and that otherwise the differences in the policies themselves are minor relative to states that lack prenatal policies altogether. This conclusion suggests that there may be areas where policymakers with different political orientations can find consensus on prenatal care for undocumented immigrants.

MANUSCRIPT 2

The second manuscript addressed Aim 2, examining the practice implications of the various prenatal policies through interviews with health care workers who see undocumented patients. This paper describes one particular aspect of the practice of medicine under the benefits restrictions created by each policy. Respondents described their professional attitude and practice norms, as well as the ethical tensions they encountered when policy or institutional constraints prevented them from living up to these norms. The attitude norms that health care workers described included *respect*, *empathy*, and *cultural sensitivity*, and the practice norms included *treating every patient the same*, *advocating for patients*, and *not asking about patient immigration status*. Respondents indicated that the policy restrictions made the *unable to provide necessary services* to undocumented patients, and that often their *patients' fears related to immigration status affected their access to care*. Using Nancy Berlinger's "workarounds" framework, this paper examined health care workers' responses to the misalignment of their professional norms and the policy restrictions in their state. These findings suggest that the prenatal policies in each state raise ethical and professional challenges for the health care workers who implement them.

MANUSCRIPT 3

The third manuscript addressed Aim 3. It did so by considering three accounts of the requirements of distributive justice for non-citizens to determine what they might suggest about the provision of publicly funded prenatal care to undocumented immigrants. Through an application of the accounts of Joseph Carens, Patricia Illingworth and Wendy Parmet, and David Miller to the question of prenatal care for undocumented immigrants, as well as a Kantian objection to the instrumentalism of these accounts, this paper concluded that an overlapping consensus account would suggest that there is a public duty to provide care to pregnant undocumented immigrants.

POLICY IMPLICATIONS

(1) There are a variety of ways to frame prenatal policies for the public

The document review of the legislative and judicial histories in each case state considered in Manuscript 1 suggests that there are wide variety of moral and prudential reasons that policymakers can appeal to in framing a prenatal policy for the public. This implication is reinforced by the theoretical work in Manuscript 3, which also found that multiple philosophical accounts could ground a policy that provides prenatal care to low-income undocumented immigrants. Policymakers wishing to pursue a prenatal policy for undocumented immigrants in one of the 32 states currently without a policy could draw from the successful framing of the policies in Nebraska, California, or New York. The Nebraska legislature's strategy of tying the prenatal policy to a politically popular pro-life platform could be replicated in other conservative states, including those with large numbers of undocumented residents like Arizona and Georgia. Similarly, more liberal states like Nevada and Maryland could look to California for a way to draw down federal CHIP dollars while protecting reproductive rights by implementing a global fee payment structure for pregnancy care. The various policies ultimately provide similar, though not identical, benefits, suggesting that constituencies with different values can cohere around the provision of at least basic prenatal care for undocumented immigrants if given the proper framing.

(2) There are policy opportunities to extend health care to other vulnerable undocumented populations

A significant implication of the findings of Manuscript 1 is the possibility for future immigrant-friendly health policy that benefits other populations of undocumented immigrants. The framing of fetuses as human beings who are future members of society was used to great effect in Nebraska. This suggests that such an approach could be leveraged in other states to promote insurance coverage for other populations who could be framed as future members of their community, such as undocumented children and DACA recipients. More liberal states, which may already provide some amount of coverage to these populations, could similarly emphasize social membership and prudential reasons and downplay the law-breaking involved in undocumented immigration to fight for broader access to health coverage for other undocumented adult populations.

(3) Provision of more generous benefits to undocumented immigrants could help reduce moral distress in providers

The analysis in Manuscript 2 revealed that health care workers in states with more generous prenatal policies were less inclined to mention that they felt they were unable to live up to their professional norms of treating all their patients similarly with regard to their pregnancy-related health needs. In order to address concerns about moral distress in health care workers, policymakers may consider revising prenatal policies that restrict the benefits for which undocumented patients are eligible. Although providing a wider range of benefits is not a panacea, as revealed by the persistence of provider moral distress even in states with more generous prenatal policies, it could alleviate the more severe causes of ethical tension by enabling health care workers to provide all medically necessary services.

PRACTICE IMPLICATIONS

(1) Health care institutions should provide workers with a safe environment in which to discuss ethical tensions and workarounds

It is unlikely that policies are immediately forthcoming that will eliminate the tension between providers' professional norms and the restrictions on their ability to provide all medically necessary services that was commonly described by respondents in Manuscript 2. There are, however, tangible steps that health centers can take to reduce the distress that these tensions cause. Health centers that serve undocumented patients should put in place institutional mechanisms that enable health care workers to critically examine their own attitude and practice norms and to discuss, in a safe environment, their concerns about the systemic constraints they encounter (Berlinger & Raghavan, 2013). These could include discussion groups or grand rounds within the institution that allow providers to discuss the challenges they face when treating undocumented patients and any workarounds they employ to address these challenges. Such options might help to reduce the moral distress of providers who feel that they have a duty to provide similar levels of care to all patients regardless of immigration status and provide a way of bringing workarounds into the institutional discourse. Sharing information about advocacy-motivated workarounds that help health care workers connect patients with necessary services could address some of the ethical issues inherent in both the concealment and individualization of rule-bending for some undocumented patients. If a health center can systematize the (legal) workarounds that achieve better patient access to care in this way, the workarounds become part of the complex system that works for patients rather than against them.

(2) Providers should create opportunities for patients to discuss immigration status

Another finding of Aim 2 was the common practice of not discussing immigration status with patients. In light of the significant effects immigration status can have on health, providers should consider creating confidential opportunities for patients to discuss their stresses related to their immigration status or the immigration status of a family member. Of course, for safety reasons, providers should continue the practice of not recording a patient's immigration status in her medical chart.

FUTURE RESEARCH

This dissertation lays the groundwork for a research agenda that explores what society owe to global migrants in various international and domestic contexts. As this project has demonstrated, policy must respond to the needs of migrants in a way that is informed by considerations of justice while acknowledging the reality of resource constraints. By applying an empirical bioethics approach to these pressing questions, future research in this area will aim to construct and refine a normative theory that produces practical guidance for policy in response to contemporary dilemmas in migrant health. There are several projects that can be pursued in this vein, ranging from the global to the local, but all focus on international migration and the requirements of justice:

1. **U.S. state and federal health policy towards undocumented immigrants.** This dissertation explored a class of state migrant health policies through the lenses of politics, practice, and ethics. This approach can be replicated in the examination of additional state and federal health policies that affect undocumented immigrant populations, including state-level policies that provide publicly funded coverage for dialysis and kidney transplantation despite the lack of federal financial participation and the practice of medical repatriation. Another area of policy that would amenable to this analytic approach is the state-funded expansion of Medicaid to undocumented immigrants, which has been under consideration in California for a number of years. As this policy has not yet been passed, it presents a unique opportunity to study the policy process, and eventually the implementation process, as it emerges in real time.
2. **Refugees and environmental migrants**. While much has been written on the topics of climate justice and obligations towards to refugees, there has been insufficient examination of the requirements of justice at the intersection of these two politically and

morally charged areas. Specifically, there is work to be done in assessing the obligations of the international community towards those forced from their homes by climate disruptions (such as inhabitants of low-lying islands and coastal regions fleeing rising sea-levels, or Syrian refugees escaping conflict that is partially attributable to drought). An empirical bioethics approach to this question could involve fieldwork in one region of environmental migration that engages the perspectives of migrants, NGOs, policymakers, and citizens of receiving states. This research would aim to characterize the range of moral and prudential issues at stake in the response to the climate disruption and the distribution of resources to environmental migrants, and would use these findings to inform a normative framework for an appropriate local and international response to the needs of the migrants.

CONCLUSIONS

This project provides insight into the range of arguments that can be used to support an immigrant health policy, and demonstrates that even stakeholders with diverse political or philosophical viewpoints can sometimes find common ground on policy solutions to complex problems. This project also examined the real-world impact of policy restrictions on the practice of medicine. Health care workers who feel that limitations on the care available to pregnant undocumented immigrants prevent their fulfillment of their professional norms must navigate the line between advocacy and rule-bending, which is ethically unsustainable and causes real moral distress. These findings suggest that there is still a significant gap between the reality of the prenatal policies and the ideal political solution suggested by the normative analysis in Manuscript 3.

At the time of writing, the U.S. Congress is facing a dramatic standoff, pitting the legal status of Deferred Action for Childhood Arrivals (DACA) recipients against the funding of the Children's Health Insurance Program (CHIP), resulting in a historic shutdown of the U.S. government. The political discourse surrounding immigration and health care have become increasingly incendiary, and young immigrants and American citizen children are caught in the crossfire. Although this dissertation focused primarily on access to prenatal care for undocumented immigrants, the findings of this project could have wide-ranging implications for these and other immigration and health policy issues in this deeply divided political era. When arguments supporting or opposing policies are frequently boiled down into tweet-sized sound bites, the language that policymakers use when they defend a policy position matters. The findings of this project suggest that common ground on these issues can be found by appealing to a range of moral and prudential values shared by stakeholders across the political spectrum in the pursuit of justice in the policy, practice, and ethics of immigrant health policy

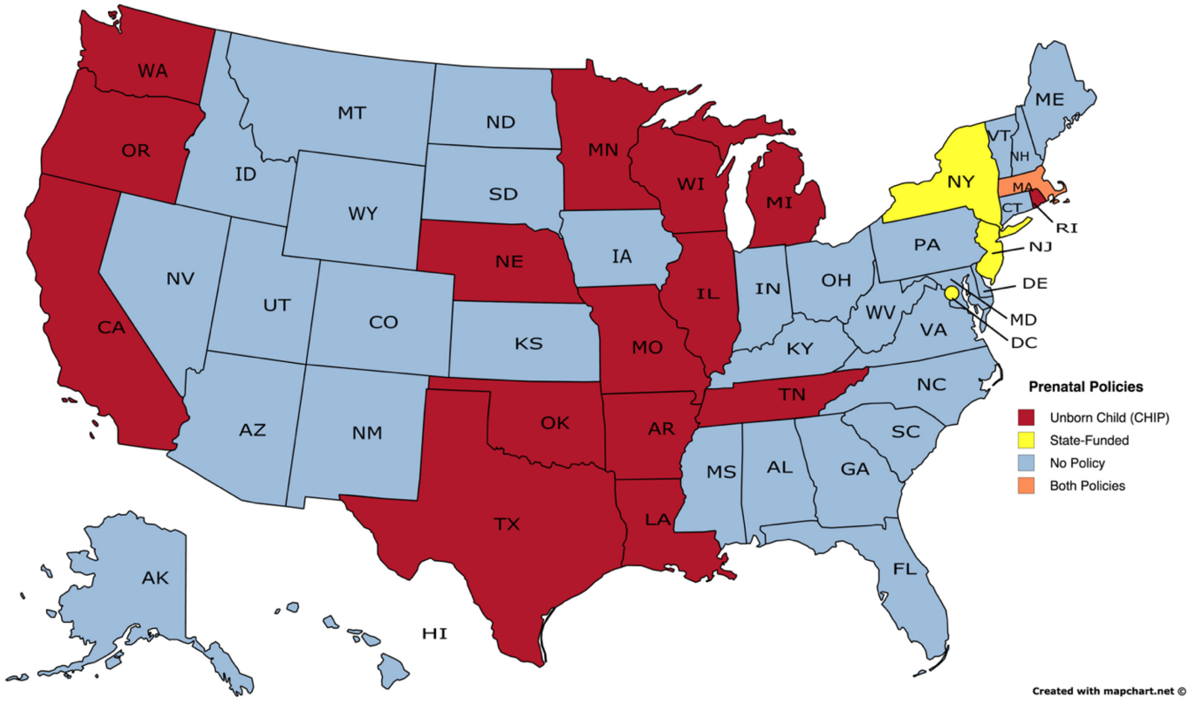
REFERENCES

Berlinger, N., & Raghavan, R. (2013). The Ethics of Advocacy for Undocumented Patients. *Hastings Center Report, 43*(1), 14-17. doi:10.1002/hast.126

Appendix A: Additional Policy Background

Appendix A1: State Policy Map

Figure 1: State Policy Map



APPENDIX A2: POLICY REQUIREMENTS

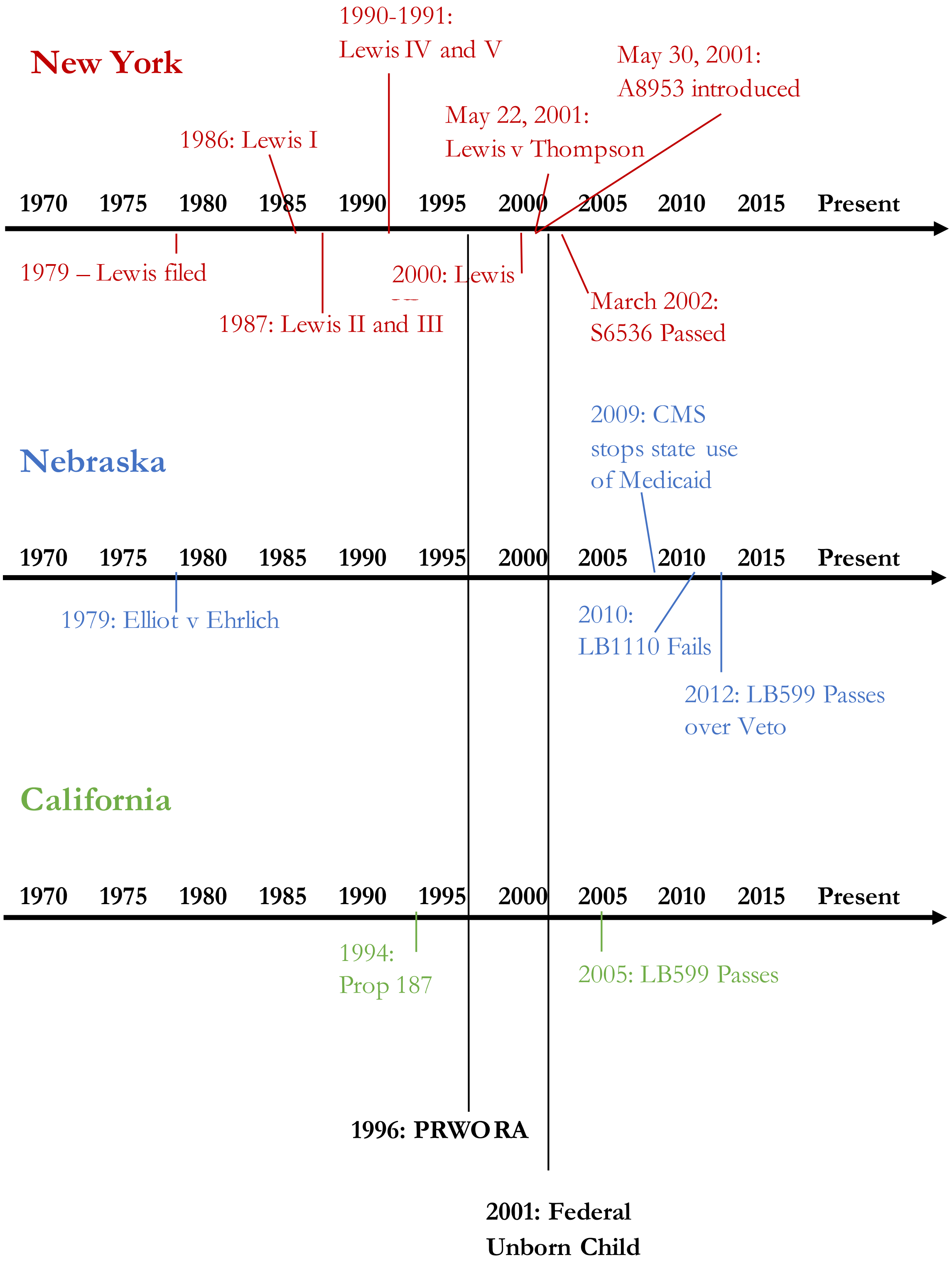
TABLE 2: POLICY REQUIREMENTS

State	Funding	Beneficiary	Services Covered	Abortion
NE	CHIP Unborn Child	Unborn child	• Prenatal care • Labor and delivery • Prescriptions • Imaging and Lab services • Services for conditions that could complicate the pregnancy or delivery	No
CA	CHIP Unborn Child*	Mother	Same as Nebraska, plus: • Mental health services • Dental • Post-partum care (60 days) • Family planning	Yes
NY	State funds	Mother	Same as California, plus: • Homecare • Health education for both parents • Transportation for prenatal care	Yes

*bundled global fee payment allows CA to designate mother as beneficiary despite Unborn Child regulations

APPENDIX A3: POLICY TIMELINES

FIGURE 2: POLICY TIMELINES



APPENDIX B: EXTENDED METHODS

Taken together, Aims 1 and 2 of this project constituted a comparative case study in policy, practice, and ethics. Case study research involves the investigation of a "contemporary phenomenon (the 'case') in its real-world context" using data triangulation to "address the distinctive technical condition whereby a case study will have more variables of interest than data points" (Yin, 2013). For this dissertation, the unit of analysis for the case study was the state policy itself, and the first two manuscripts contributed different types of data to the triangulation process in order to generate a complete picture of the moral content of the phenomenon, or policy, in question. Manuscript 1 brought to bear the empirical data related to the legislative and judicial histories and current content of the various prenatal policies, focusing on the moral and prudential reasons that shaped them. Manuscript 2 contributed empirical data about the real-world experiences of health care workers who provide or facilitate care under the various state policies and the ethical tensions they encounter as a result of the policies. Manuscript 3, which was not an empirical study, contributed a theoretical synthesis of various philosophical accounts of obligations towards undocumented immigrants.

STUDY DESIGN - CASE SELECTION

The selection of states for this comparative case study was determined by a number of factors. First, the states chosen needed to have different policies for the public provision of prenatal care to low-income undocumented immigrants so that the case study could highlight the differences between the policies. A survey of every state's prenatal policy was conducted (results in Appendix A1). Initially, the study design included just three states (one state with the Unborn Child policy, one state with a state-funded Medicaid lookalike, and one state without a prenatal policy for comparison in Manuscript 2), but the policy survey revealed significant differences in implementation of the Unborn Child policy across different states, so the design was expanded to include a fourth state. Since only three states use state-funded Medicaid lookalikes, and only New York does so completely independently of the Unborn Child option and as an entitlement rather than a block grant, New York's policy was chosen to represent that category. Of the 19 states that use the Unborn Child policy, Nebraska and California stood out as states with relatively long histories of providing prenatal care to undocumented immigrants (as does New York), having done so long before the creation of the Unborn Child option in 2001. This was thought to increase the richness of the available legislative history data. Finally, Maryland was selected as the comparative case for Manuscript 2 because its legislature had never considered a prenatal policy, and also for convenience, as the researcher's home institution is based there.

MANUSCRIPT 1

OVERVIEW

This paper employed a content analysis of key documents in order to (1) capture the policy and political narrative that led to the passage of the prenatal policy; (2) determine precisely what services each state prenatal policy covers, and (3) examine the broader political and moral context of the policies, which includes the moral and prudential reasons and justifications given by the policymakers, courts, and citizens who argued for or against the policies. As this study did not involve human subjects, it was exempt from IRB review.

DATA COLLECTION

The collection of the documents that comprise the legislative histories of each state involved a lengthy process of database and in-person research. The state of Nebraska has a very thorough, publicly-available internet database of legislative documents, including bills, laws, policy analyses, hearing transcripts, and debate transcripts. For this reason, the collection of documents from Nebraska was straightforward, and involved searching the legislative database (located at https://nebraskalegislature.gov/bills/) for the bills associated with the passage (and attempted passage) of the Unborn Child option in that state, as well as a search on the WestlawNext for related court cases.

California also has a fairly comprehensive online database of legislative information that contains bills and policy analyses (located at http://www.legislature.ca.gov/bill_information.html), but legislative hearings and debates are not available online. In order to access hearings, debates, and other documents not contained in the online database, the California State Archives were contacted for all files associated with AB794 (2005), and the Senate and Assembly TV offices were contacted to obtain DVDs of all hearings and floor debates in each house associated with AB794 (2005).

The state of New York has a less complete publicly available database, which contains bills and some policy analyses and sponsor memos (located at http://public.leginfo.state.ny.us/navigate.cgi). Additional information on the relevant bills was sought in-person at the New York state legislative archives in Albany, but this did not yield new information. A phone conversation with the Assembly member who introduced one of the bills, which was recorded and transcribed with permission, clarified that there were few public documents regarding the bills in question because of the budget-based process through which the policy was passed. The Assembly member indicated that most of the negotiations regarding the policy would have happened in closed-door meetings between legislative aides as they worked to incorporate the policy into the Governor's budget bill. All court decisions analyzed in the New York document review were located using WestlawNext.

DATA MANAGEMENT AND ANALYSIS

All files were sorted by state and labeled according to the state, document type, document title (if applicable), and date of origin. For example, a debate transcript from the floor of the Nebraska state legislature that took place on April 4, 2012 was named "NE-FloorDebate-LB599r2day56-040412," and a court decision from the Second Circuit of the U.S. Court of Appeals relevant to policy in New York issued on May 22, 2001 was labeled "NY-JudicialDecision-Lewis v Thompson-052201." All legislative history materials were then reviewed for references to funding mechanisms, services covered, immigration status, policy goals, and moral language to determine which were relevant to the research questions. Documents that were redundant or unrelated to the policy were excluded from analysis. Key documents, which addressed some or all of these features, were imported into NVivo 10 for Mac software, which is capable of coding PDFs, audio files, video files, and Word documents, for analysis (QSR International, 2017). Audiovisual files were prepared for analysis by importing the audio portion into NVivo and transcribing them by hand using NVivo's transcription function.

Documents were then coded using an iterative emergent thematic coding scheme, in which codes were hierarchically structured such that policy requirements, moral reasons, and prudential reasons could be coded separately. The codes were critically evaluated throughout the coding process to more accurately reflect the relationships between emerging themes. During the reviewing and coding process, memos were drafted that detailed the themes that were prevalent in important documents for each state, as were narrative memos that traced the development of each state policy. The coded data was then reviewed and examined for coding of themes across documents and relative code frequency to determine the most prevalent themes from each state. This was done using the "query" function of NVivo, which allows the researcher to explore the relationships between codes and examine coded text in different contexts. The codebook, which provides a visual representation of the relationships between codes, is available in Appendix F1. Additional analysis was performed using the "matrix" and "hierarchy map" functions of NVivo; examples of the use of these analysis tools are available in Appendices G1 and G2.

MANUSCRIPT 2

OVERVIEW

This paper sought to characterize the effect of the various prenatal policies on the ability of health care workers to live up to their professional norms. It did so through semi-structure in-depth interviews with health care workers at two safety net health centers in each case state. Because this study involved interviews with health care workers in their professional capacities, it was determined to be exempt from IRB review by the Johns Hopkins Bloomberg School of Public Health (JHSPH) IRB (see Appendix C for IRB Exemption Letter).

SAMPLING STRATEGY

The sampling frame for the study were safety net health centers located in urban and rural counties across four states with different prenatal policies. As mentioned above, the four states were purposively selected to represent the range of prenatal policies in the United States: Nebraska uses the Unborn Child option and restricts benefits to pregnancy-related care; California uses the Unborn Child option but provides all "medically necessary" services; New York uses state funds to enroll undocumented pregnant immigrants in a Medicaid lookalike; and Maryland has no public insurance option, so undocumented immigrants may seek subsidized care at safety net health centers. National Center for Health Statistics (NCHS) definitions for urban and rural were utilized to identify urban counties (NCHS urban-rural scheme code of 1-2) and rural counties (NCHS urban-rural scheme code 5 or 6) within each state. Among these counties, eligible safety net health centers were those located in the three urban and three rural counties with the highest percent of foreign-born residents in each state (as determined by the American Community Survey), which served as a proxy for undocumented immigrant populations.

RECRUITMENT

To engage eight health centers, clinic directors and CEOs of 35 health centers were contacted. Four of the eight health centers that opted to participate required the research to be approved by a committee within the organization, while the other four were approve by individuals in leadership positions within the clinic. Leaders of the eight health centers that agreed to participate were asked to identify respondents with relevant experience providing or facilitating prenatal care for undocumented pregnant immigrants in each of the following roles: primary obstetrical provider (e.g. obstetrician, family care doctor, or midwife), nurse or other medical provider (e.g. mental health clinician), patient support worker (e.g. social worker, prenatal educator, or outreach team member), and administrative staff (e.g. billing manager). Within the physician and nurse category, providers who work specifically with pregnant patients were targeted for recruitment. Providers and staff were recruited via email to invite their participation in an in-depth semi-structured interview. This sampling method yielded 8-9 informants per state, for a total of 34 informants (see Table 1). All recruitment materials are available in Appendix D.

DATA COLLECTION

Interviews were conducted with clinical staff in each of the roles mentioned above in order to generate a comprehensive picture of the process through which undocumented pregnant immigrants access prenatal care in each clinic as well as the professional norms and ethical tensions that various providers experience. The interview guide was developed in consultation and pilot-tested with respondents from a safety net health center affiliated with Johns Hopkins University who work with pregnant undocumented patients in the clinical context. The interview guide (available in Appendix E, along with the disclosure script) covered three major domains:

1. Background information about the clinic and the respondent's role within the clinic;
2. Process through which undocumented patients access and pay for care at the clinic;
3. Ethical tensions that the respondent encounters when serving undocumented pregnant patients in her professional capacity.

Because the interview guide was semi-structured, interviews often took a conversational tone, and respondents engaged in frank discussions of the challenges involved in fulfilling their professional duties. At the end of each interview respondents were asked to complete a brief demographic questionnaire. During and after the interview, the interviewer took notes to document questions or points of clarification that needed extra attention, and the interviewer engaged in reflexive memo-writing after interviews on a regular basis. These interviews generally took 30-50 minutes, (mean: 34:40, median: 34:48). Interviews were conducted by phone, recorded using the Tape-A-Call Pro iPhone app, uploaded to a secure Dropbox account, and transcribed. Transcription of most interviews was carried out by the transcription company TopTranscriptions, although some interviews were transcribed by the researcher due to poor audio quality. All transcripts were reviewed against the original recording to check for accuracy. Interviews took place between August 2016 and October 2017.

DATA MANAGEMENT AND ANALYSIS

The transcripts of interviews were imported into NVivo 11 for Mac (QSR International, 2017) to facilitate analysis. All identifying information related to the respondent or the health center at which the respondent worked were removed from the transcripts and replaced by [Name] or [Clinic], and similar bracketed descriptions replaced other forms of identifying information (e.g., geographic locations were replaced with [City] or [County], etc.). Transcripts were stored on a password-protected laptop and backed up to a password-protected Dropbox account.

The broad goal of analysis was to identify themes that emerged within and across the case states. This was accomplished with an iterative emerging thematic coding scheme that employed a preliminary codebook that evolved in response to the data, in which each code corresponded to a "node" in NVivo. Nodes were organized in a hierarchical coding scheme that tracked categorical respondent-level data (e.g. clinical role), health center-level data (e.g. state, urban/rural), and substantive data related to the prenatal process and ethical tensions, which were the two main focuses of the interview. Nodes were nested within this hierarchical structure to enable visualization of relationships between themes (for a visual representation of this structure, see the codebook in Appendix F2 or the Manuscript 2 Hierarchy Charts in Appendix G4). Coding was compared across states to identify trends or patterns using the "matrix" function of NVivo (see Appendix G3 for an example of the matrix coding for Manuscript 2).

A second coder was employed to validate the final codebook through a comparison of code application on five transcripts, which yielded high consistency of coding. Analysis of codes was conducted by examining coding overlaps and coding matrices using NVivo's query function, which allowed for the examination of patterns across and within states and provider categories, as well as the relative frequency of code application. This yielded a rich analysis with several major themes; this paper focuses on only the emergent themes that related to the professional norms at stake for health care workers who provide or facilitate prenatal care and the ethical/professional tensions they encountered in the course of caring for this population, as well as the ways that the practices they develop to respond to these tensions at work. Future work may involve the analysis of additional themes not explored in this manuscript.

MANUSCRIPT 3

OVERVIEW

This paper considered three theoretical approaches to the distribution of public resources to non-citizens and applied them to the case of public funding for the provision of prenatal care for undocumented immigrants. It sought to locate an overlapping consensus on a political judgment regarding the provision of this service. This section will review the method of selection for the three accounts considered in the manuscript, the identification of the overlapping consensus, and the rationale behind the choice to include a Kantian critique.

ACCOUNT SELECTION

The three justice accounts considered in this manuscript were those of Joseph Carens, Patricia Illingworth and Wendy Parmet, and David Miller. Each of these accounts was selected for inclusion because they met a set of criteria that were relevant to the question of how a society should distribute public resources to non-citizen members. First, all three accounts subscribe to a minimally cosmopolitan account of the equal value of human life; this criterion is meant to exclude extremely statist or nationalist accounts that assign less value to the lives of non-nationals. It is important to note that this criterion does not exclude accounts that prioritize the interests of co-nationals, as the inclusion of David Miller's theory indicates. Indeed, Miller subscribes to what he calls "weak cosmopolitanism," which recognizes the equal moral value of all human lives but allows a state to prioritize the interests of its own members except in cases of urgent need.

The second inclusion criterion for justice theories was that they must speak directly to the question of the distribution of public goods to non-citizen residents, which all three of the accounts included in Manuscript 3 do. This criterion was important to include because it significantly narrows the discussion to the area of political philosophy which is most directly related to the question at hand. Many major justice theories take seriously the equal moral value of human life, including those of Michael Walzer (Walzer, 1984), John Rawls (Rawls, 1999, 2001), and Madison Powers and Ruth Faden (Powers & Faden, 2006), . Of these, however, only Walzer speaks directly to a society's obligations towards non-citizen residents. In *A Theory of Justice* and *The Law of Peoples*, Rawls assumes that societies are closed, with no movement in or out, and Powers and Faden do not address distinctions based on immigration status. In his book *Spheres of Justice*, Walzer, discusses the condition of guest workers residing permanently within a state, and concludes that although states have every right to regulate who crosses their borders, justice demands that those people who permanently reside within those borders should gain membership rights (Walzer, 1984). However, Walzer does not address obligations towards undocumented immigrants because he assumes that the "guest workers" about whom he writes were lawfully admitted.

Additionally, because his justice theory is much broader than just an examination of what society owes to immigrants, his account is excluded from this analysis.

OVERLAPPING CONSENSUS

The overlapping consensus is a Rawlsian concept that seeks areas of agreement on political judgments between parties with distinct views in order to enable progress in a democratic society. Rawls uses the overlapping consensus to justify what he calls the "political conception of justice," which is "the framework of basic institutions and the principles, standards, and precepts that apply to the, as well as how those norms are expressed in the character and attitudes of the members of society who realize its ideals" (Rawls, 1987). Rawls writes that "the point of the idea of an overlapping consensus on a political conception is to show how, despite a diversity of doctrines, convergence on a political conception of justice may be achieved and social unity sustained in long-run equilibrium" (Rawls, 1987). Although Rawls employs the overlapping consensus to derive a broad political conception of justice that applies to the structure of society itself, it is possible to use this same tool on a smaller scale to address questions of justice in the policy context. The process involves setting aside differences in fundamental doctrines to locate areas of agreement. Describing the overlapping consensus, Rawls, writes "Since different premises may lead to the same conclusions, we simply suppose that the essential elements of the political conception, its principles, standards and ideals, are theorems, as it were, at which the comprehensive doctrines in the consensus intersect or converge" (Rawls, 1987). This consensus allows political agreement to proceed despite differences of theoretical justification. In this paper, the three accounts of justice hold different values and theoretical starting points, but it is determined that they converge on a political course of action, namely, the publicly funded provision of prenatal care to undocumented immigrants.

KANTIAN CRITIQUE

Although there are several potential challenges to the arguments presented in this manuscript, the Kantian critique of the individual accounts is addressed as the most significant account due to the dominance of Kantian moral theory in the field of bioethics. Indeed, Kant's moral theory forms the basis of "Respect for Persons," one of the "principles of bioethics" enshrined in the canon of western bioethics (Beauchamp & Childress, 2013). The categorical imperative, in its second formulation, requires that one treat others never as a mere means but always at the same time as an end (Kant, Gregor, & Timmermann, 2012). With the exception of Miller's minimalist human rights account, however, all three of the theories considered in this paper appear to treat the health of undocumented immigrants as instrumentally valuable to achieving the ends of citizens or legally residing immigrants. It could therefore be argued that these instrumental accounts promote policies for reasons that treat undocumented immigrants as mere means to the ends of others. Because Kantian moral theory also requires that the reasons for an act align with the requirements of duty, it is important to consider whether the instrumental accounts considered here leave room for respect for the undocumented immigrant as a moral entity with her own ends. This section concludes that they do.

In the context of the overlapping consensus sought by this paper, this section could have constituted a fourth theoretical account that sought consensus rather than a critique of the other three. The decision to use the Kantian critique as a response to the three main theories stemmed from Kant's failure to meet the inclusion criteria described above. While Kant certainly takes seriously the equal moral value of all human lives, he does not directly address the condition of non-citizen residents (beyond a brief discussion of hospitality towards strangers (Kant, 1970)).

REFERENCES

Beauchamp, T. L., & Childress, J. F. (2013). *Principles of Biomedical Ethics, 7th Ed*. New York: Oxford University Press.

Kant, I. (1970). *Perpetual peace: A philosophical sketch*: Cambridge University Press Cambridge.

Kant, I., Gregor, M. J., & Timmermann, J. (2012). *Groundwork of the Metaphysics of Morals*: Cambridge University Press.

Powers, M., & Faden, R. R. (2006). *Social justice: the moral foundations of public health and health policy*: Oxford University Press.

QSR International. (2017). NVivo 11 for Mac (Version 11.4.2): QSR International. Retrieved from http://www.qsrinternational.com/product/nvivo-mac

Rawls, J. (1987). The Idea of an Overlapping Consensus. *Oxford Journal of Legal Studies, 7*(1), 1-25.

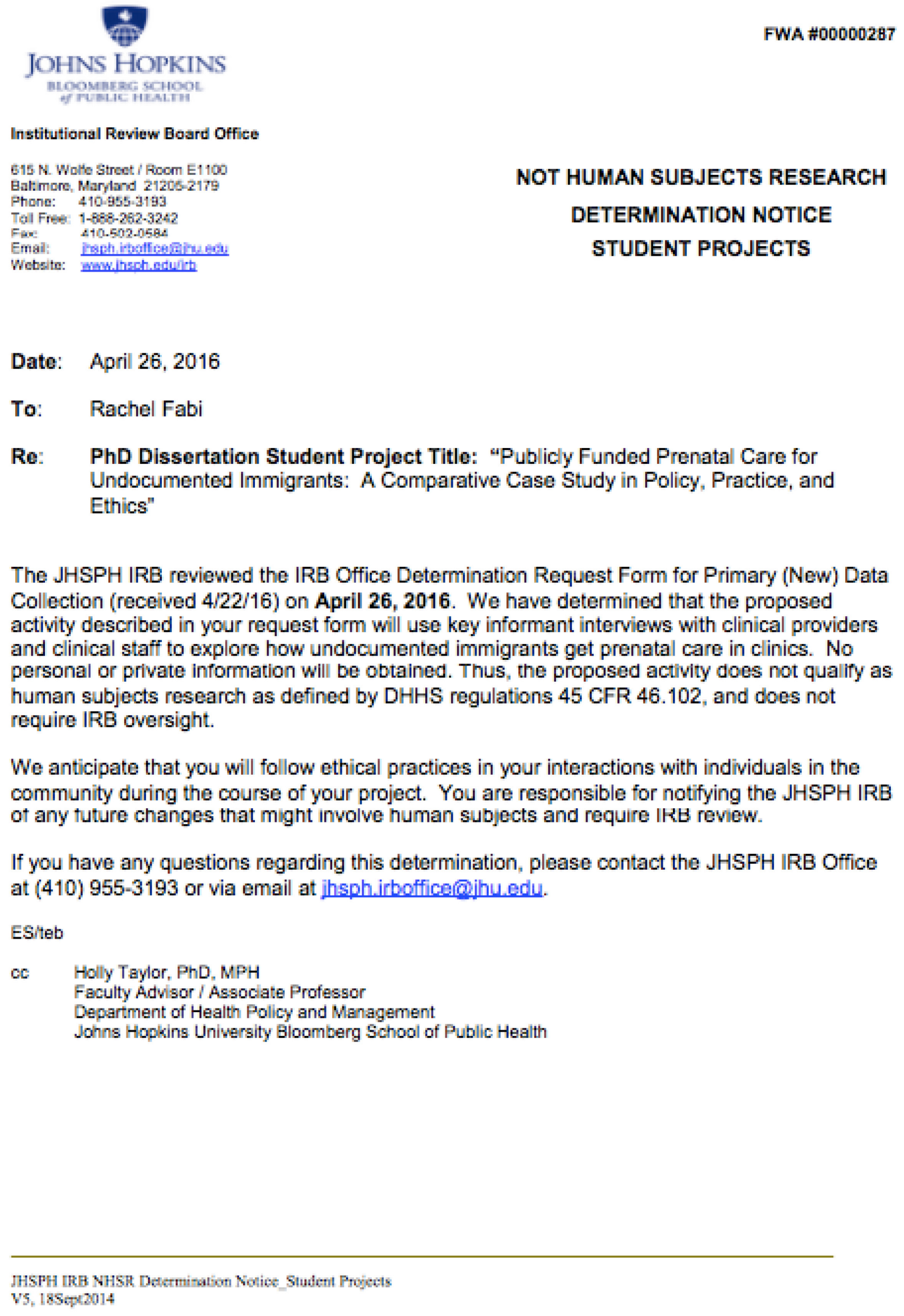
Rawls, J. (1999). *A Theory of Justice, Revised Edition*: Harvard University Press.

Rawls, J. (2001). *The law of peoples: with, the idea of public reason revisited*: Harvard University Press.

Walzer, M. (1984). *Spheres of Justice: A Defense of Pluralism and Equality*: Basic Books.

Yin, R. K. (2013). *Case study research: Design and methods*: Sage publications.

APPENDIX C: IRB EXEMPTION LETTER



JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Institutional Review Board Office

615 N. Wolfe Street / Room E1100
Baltimore, Maryland 21205-2179
Phone: 410-955-3193
Toll Free: 1-888-262-3242
Fax: 410-502-0584
Email: jhsph.irboffice@jhu.edu
Website: www.jhsph.edu/irb

FWA #00000287

NOT HUMAN SUBJECTS RESEARCH
DETERMINATION NOTICE
STUDENT PROJECTS

Date: April 26, 2016

To: Rachel Fabi

Re: **PhD Dissertation Student Project Title:** "Publicly Funded Prenatal Care for Undocumented Immigrants: A Comparative Case Study in Policy, Practice, and Ethics"

The JHSPH IRB reviewed the IRB Office Determination Request Form for Primary (New) Data Collection (received 4/22/16) on **April 26, 2016**. We have determined that the proposed activity described in your request form will use key informant interviews with clinical providers and clinical staff to explore how undocumented immigrants get prenatal care in clinics. No personal or private information will be obtained. Thus, the proposed activity does not qualify as human subjects research as defined by DHHS regulations 45 CFR 46.102, and does not require IRB oversight.

We anticipate that you will follow ethical practices in your interactions with individuals in the community during the course of your project. You are responsible for notifying the JHSPH IRB of any future changes that might involve human subjects and require IRB review.

If you have any questions regarding this determination, please contact the JHSPH IRB Office at (410) 955-3193 or via email at jhsph.irboffice@jhu.edu.

ES/teb

cc Holly Taylor, PhD, MPH
Faculty Advisor / Associate Professor
Department of Health Policy and Management
Johns Hopkins University Bloomberg School of Public Health

JHSPH IRB NHSR Determination Notice_Student Projects
V5, 18Sept2014

APPENDIX D: RECRUITMENT MATERIALS

APPENDIX D1: STUDY DESCRIPTION FOR RECRUITMENT

PUBLICLY FUNDED PRENATAL CARE FOR UNDOCUMENTED IMMIGRANTS: A COMPARATIVE CASE STUDY IN POLICY, PRACTICE, AND ETHICS

Background: The goal of this study is to examine two state-level policy approaches that provide for the public funding of prenatal care for undocumented immigrants through a comparative case study analysis. It will examine the political context through a review of the legislative history of the policies, the implementation context through in-depth interviews with health professionals in clinics that provide care under the different policies, and the ethical context through an examination of the moral language employed by the legislative documents and the professional and ethical tensions described by clinical providers and staff

Collaboration: I need sites with administrators who would be interested in participating. Eligible health centers include FQHCs in one of the four states in the case study (California, Maryland, Nebraska, and New York) that provides access to a specific set of health care services in an area with a larger-than-average immigrant population for your state.

What is required from FQHCs:

- Identify the primary contact at the site
- Facilitate contact with other key stakeholders and help generate support for the project
- Determine if stakeholders are willing to be interviewed

Basic Study Steps:

1. Sites are identified and agree to participate in the study.
2. Participating sites identify key informants at each study site to interview.
3. Researcher contacts key informants to request and set up 30-60 minute in-depth phone interviews. Ideally, at least 1 individual at each position (administrator, physician, nurse, social worker, administrative staff), would be willing to be interviewed.
    a. Interviews will explore the process by which undocumented patients access prenatal care and the professional and ethical tensions encountered while providing this care
    b. Participants will be asked permission to be re-contacted with any additional questions at the end of each interview.
    c. Each informant may be asked to identify other important members of the FQHC staff as potential interview candidates. Interviews will be audio recorded and transcribed for the purpose of analysis, but kept confidential.
4. After all data has undergone an initial analysis, preliminary results will be shared with a small group of participants, who will be asked to confirm, refute, or enhance these findings.

Student Investigator: Rachel Fabi, doctoral student
Principal Investigator: Holly Taylor, MPH, PhD
Sponsoring Institution: Johns Hopkins Bloomberg School of Public Health

This project has been determined "Not Human Subjects Research" by the Johns Hopkins School of Public Health Institution Review Board (IRB), which can be contacted at 410-955-3193, or 1-888-262-3242.

APPENDIX D2: RECRUITMENT EMAIL FOR HEALTH CENTER LEADERSHIP

To: [Clinic Leadership]
From: Rachel Fabi
Cc: Holly Taylor
Email title: Request to Participate in Research

Dear [Clinic Leadership],

I am writing in the hope that your health center and professional staff might be interested in participating in a study I am conducting for my doctoral dissertation at the Johns Hopkins Bloomberg School of Public Health.

The aim of the proposed study is to examine the process by which undocumented immigrants access prenatal care in your state, and to understand the professional tensions that providers and staff encounter while providing this care. The study would involve, with your permission, in-depth interviews with administrators, physicians, nurses, social workers, and/or clinic staff. I would expect the interviews would occur between [date range]. I will be working with up to eight FQHCs in four states. A brief description of the study – focused on what will be asked of collaborators - is attached. The study has been reviewed by my IRB and has been determined to be not human subject research because I will be asking staff to talk about their professional roles rather than personal information.

I will follow up this letter with a phone call in the next week. If you would like to contact me, I would be happy to answer any questions you might have. You can reach me by phone at 412-508-0880 or by email at rfabi@jhu.edu, or you may contact my faculty advisor, Dr. Holly Taylor, at htaylor@jhu.edu.

I appreciate your time.

Sincerely,

Rachel

--
Rachel E. Fabi
PhD Candidate, Bioethics and Health Policy
Department of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health
Email: rfabi@jhu.edu Phone: 412.508.0880

APPENDIX D3: RECRUITMENT EMAIL FOR RESPONDENTS

To: Potential Research Participant
From: Rachel Fabi
Cc: Holly Taylor
Email title: Request to Participate in Research

Dear [Name],

As a doctoral student at Johns Hopkins Bloomberg School of Public Health, I am conducting a qualitative research study for my dissertation work. I am writing in the hope you would be willing to participate in this study. [*Insert name of reference person/website*] indicated that you would be someone helpful to talk to due to your experience with the [Clinic Name].

The purpose of this study is to explore 1) the process by which undocumented immigrants access prenatal care in your state and 2) the professional and ethical tensions that providers and staff encounter while providing this care The study consists of in-depth interviews with individuals involved with the [Clinic Name].

If you are interested in participating, you would be asked to participate in an in-depth phone interview that would take 45-60 minutes of your time, at a time of your convenience between *[dates]*. In this interview, I will ask you about the experience of providing prenatal care to undocumented pregnant women, including the services provided and how this care is typically paid for at [Clinic Name]. I will also ask you to describe the professional norms you adhere to in providing this care and any tensions you encounter in your professional capacity. At the end of the interview, you will be asked if you would be willing to participate in additional future interviews exploring those topics in more detail.

If you have any questions about the study and what it would entail, you can reach me by phone at 412-508-0880 or by email at rfabi@jhu.edu. I appreciate your time.

Sincerely,
Rachel Fabi

--
Rachel E. Fabi
PhD Candidate, Bioethics and Health Policy
Department of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health
Email: rfabi@jhu.edu Phone: 412.508.0880

APPENDIX E: INTERVIEW GUIDES AND DISCLOSURES

APPENDIX E1: DISCLOSURE SCRIPT

Thank you for being willing to speak with me today. This interview is part of a research project. The study is part of my research for my PhD at Johns Hopkins Bloomberg School of Public Health.

The purpose of this study is to speak with individuals who work at health centers that see pregnant patients. We want to find out more about how undocumented immigrants get prenatal care, and we're interested in hearing your thoughts and opinions about both the process through which undocumented immigrants get prenatal care in your clinic and any tensions that you might encounter in your professional capacity when providing care to undocumented immigrants

Our interview today will take 30-60 minutes. At the end I will ask you to complete a brief questionnaire to collect basic background information about you.

This interview is meant to be like a conversation. I am going to record the interview and someone will listen to the tape and type up what we talk about today, and I will also be taking notes.

There are a couple of things you should know before we start the interview: there are no right or wrong answers to any of our questions. Your participation is voluntary, and you can stop the interview at any time. You can also refuse to answer any of the questions I ask you. The answers you give me will be kept confidential. We will be using code numbers to identify the recordings and transcripts from the interviews. Any names you mention will be deleted from the transcript.

I need your e-mail address in case I need to re-contact you with additional questions, but I will destroy it once the study is complete.

Are you ready to begin? I am going to turn the recorder on now.

APPENDIX E2: INTERVIEW GUIDE

A. BACKGROUND INFORMATION AND CLINICAL ROLE

1. What is your job title? What are your duties in that role?
2. Tell me how you came to be working in [clinic]
3. Tell me about the patient population that you see at [clinic]
   If not covered, ask the following probes:
   - Can you describe the neighborhood [clinic] is in?
   - If you had to guess, about what percent of the patients at [clinic] are uninsured? On Medicaid?
   - If you had to guess, about what percent of the patients at [clinic] are immigrants? Undocumented immigrants?

Ok, now I'm going to ask you about the process by which undocumented immigrants access prenatal care in your clinic.

B. PRENATAL PROCESS FOR UNDOCUMENTED IMMIGRANTS

1. Tell me what happens, from your perspective, when an undocumented pregnant woman comes to [clinic] for the first time
   If not covered, ask the following probes:
   - How does [clinic] attempt to verify insurance status? Immigration status?
   - What services are available to help with language barriers?
   - What resources does [clinic] have to support undocumented patients?
2. Describe the services that [clinic] provides to undocumented pregnant women
   If not covered, ask the following probes:
   - Tell me which, if any, services differ from those provided to citizens? Other groups of immigrants?
   - Tell me which, if any, services that [clinic] cannot provide to undocumented immigrants?
3. How is care for undocumented pregnant women usually paid for at [clinic]?
   If not covered, ask the following probes:
   - Tell me about any public insurance that cover the cost of any services (e.g. Medicaid, CHIP)?
   - Tell me about any charities that cover the cost of any services?
   - Tell me about any other programs that help cover the cost of services?

This next set of questions focuses on your job as [x] and the tensions you might encounter at work

C. TENSIONS ENCOUNTERED IN PROFESSIONAL CAPACITY

1. When you think about your role as [x], what are the professional norms or guiding principles that come to mind? [What are some guiding principles that all [x] are supposed to follow? For instance, a doctor might say "do no harm"]

2. What professional norms or guiding principles might apply to [x]s providing/facilitating care for pregnant undocumented immigrants?
3. Sometimes our personal beliefs conflict with the requirements of our job or our professional norms. Tell me about a time you experienced this kind of tension related to providing/facilitating care for undocumented immigrants

   If not covered, ask the following probes:

   - Describe a specific instance when you felt you could not act in the way you felt was right?
   - What are some of the stresses or frustrations of working with this population?
   - How distressing has this been for you?
   - Probe for external tensions in the workplace environment ("the nurse")
   - Positives or joys of working with this population?
   - Burnout?

D. CONCLUSION

As you know by now, we are interested in the provision of prenatal care to undocumented women. Is there anything else you think it would be important for us to know or think about as we move forward with our project?

E. DEMOGRAPHIC QUESTIONNAIRE

1. How long have you been a [x]?
2. How long have you worked at [clinic]?
3. What is your age?
4. What is your religious affiliation, if any?

APPENDIX F: CODEBOOKS

APPENDIX F1: MANUSCRIPT 1 CODEBOOK

Source-Level Codes

1. **Current or Historic**
   - 1.1. Historic Policy – Policy prior to 2016
   - 1.2. Current Policy 2016 – Policy as of 2016
2. **Data Type**
   - 2.1. Policy Brief or Note – document is analysis of policy
   - 2.2. Policy or Bill – document is the policy or a bill prior to the final policy
   - 2.3. Legislative Record – document is from legislative journal
   - 2.4. Hearing Transcript – document is a transcript of a legislative hearing
   - 2.5. Judicial Decision – document is a judicial decision
   - 2.6. Provider Manual – document is a Medicaid or CHIP provider manual
   - 2.7. Fiscal Analysis – document is a legislative fiscal analysis of the impact of a policy
   - 2.8. News Coverage – document is coverage of a policy from a news source

Content Codes

3. **For or Against Policy**
   - 3.1. For Policy – supports or is in favor of policy
   - 3.2. Against Policy – opposes or is against policy
4. **Policy Content**
   - 4.1. Amendment – legislative amendment to policy
   - 4.2. Services – description of services covered by policy
   - 4.3. Funding Mechanism – description of how services are paid for
   - 4.4. Eligibility – description of eligibility criteria for coverage under policy
   - 4.5. Beneficiary – description of intended beneficiary of policy (e.g. mother or fetus)
   - 4.6. Immigration Status – mention of the immigration status of the beneficiary
5. **Judicial Content**
   - 5.1. Holding – identifies the central holding of the ruling
6. **Moral Reason** – reasons for supporting or opposing the policy based in ethical/normative claims
   - **6.1. Autonomy or Respect for Persons**
     - 6.1.1. Dignity – mention of the dignity of the mother, fetus, or baby
     - 6.1.2. Vulnerability – mention of the vulnerable condition of the mother, fetus, or baby
     - 6.1.3. Rights
       - 6.1.3.1. Rights of the Unborn – mention of the rights of the unborn fetus
       - 6.1.3.2. Rights of the Mother – mention of the rights of the mother
         - 6.1.3.2.1. Privacy – specific mention of the right of the mother to privacy
     - 6.1.4. Personal Responsibility – mention of the personal responsibility of the mother for her own health condition

- 6.1.5. Mother as Environment – mention of the mother as the environment in which the fetus is developing
- 6.1.6. Abortion – general mention of abortion
  - 6.1.6.1. Pro-Life – pro-life argument opposing abortion
    - 6.1.6.1.1. Fetal Personhood – explicit mention of the fetus as a person
  - 6.1.6.2. Pro-Choice – pro-choice argument in favor of abortion rights

6.2. Miscellaneous Moral Argument

- 6.2.1. The Right Thing – appeal to a course of action as being simply "the right thing to do"
- 6.2.2. Religion – appeal to religion or religious texts
- 6.2.3. Values – generic mention of "values" without specific content

6.3. Justice or Fairness

- 6.3.1. Equal Protection – appeal to the legal concept of equal protection
- 6.3.2. Cosmopolitan – appeal to the equal moral worth of all people regardless of nationality
- 6.3.3. Nationalist or Statist – appeal to priority of the interests of co-nationals
- 6.3.4. Minimalist Humanitarian – appeal to obligation to prevent severe harm
- 6.3.5. Communitarian – appeal to community membership
  - 6.3.5.1. Time and Social Integration – appeal to meaningfulness of time spent in state or degree of integration into community
  - 6.3.5.2. Future Citizen – appeal to the future citizenship of the fetus or mother
  - 6.3.5.3. Social Responsibility – appeal to the obligations of society to its members
    - 6.3.5.3.1. Role of Government – appeal to the distinction between obligations of a government and obligations of society
  - 6.3.5.4. Deservingness – appeal to different levels of desert
    - 6.3.5.4.1. Not tax paying – argument that undocumented immigrants do not pay taxes and therefore do not deserve care
    - 6.3.5.4.2. Tax paying – argument that undocumented immigrants DO pay taxes and therefore deserve car
    - 6.3.5.4.3. Illegality and Innocence – argument that one who has committed a crime deserves less than one who is innocent

7. **Prudential Reason** – reasons for supporting or opposing the policy based in claims of state or citizen self-interest
   - 7.1. Liability – appeal to legal liability concerns for the state
   - 7.2. Political Reason – appeal to political pros or cons of a particular policy
     - 7.2.1. Immigration Issue – argument that the policy infringes on the jurisdiction of immigration policy or enforcement
     - 7.2.2. Jeopardizes Funding – concern that passage of the policy will jeopardize the receipt of federal funds
     - 7.2.3. Federal Issue – argument that the policy infringes on the jurisdiction of the federal government
     - 7.2.4. Trust – concern that the policy will diminish trust between the federal government and the state
   - 7.3. Health Promotion – appeal to the ability of the policy to promote health
     - 7.3.1. Health of Baby – specifically, promoting the health of the fetus or baby

        - 7.3.2. Health of Mother – specifically, promoting the health of the mother in her own right
    - 7.4. Magnet – argument that the policy will attract additional immigrants
        - 7.4.1. Anchor Baby – specific use of the derogatory term "anchor baby" to refer to children born to undocumented immigrants in the United States
    - 7.5. Economic Argument – appeal to economic benefits or harms of policy
        - 7.5.1. Cost effective – appeal to cost effectiveness of prenatal care

Marker Codes

8. **Anecdote** – marker code indicating that speaker is telling an anecdote
9. **Return to this** – marker code indicating that I should return to this specific piece of text for further consideration or analysis

APPENDIX F2: MANUSCRIPT 2 CODEBOOK

1. **Anecdote**: identifies when respondent is telling an anecdote about experience
2. **Ethics**: response to questions in the "ethics" section of interview guide
   - 2.1. **Ethical Argument**: miscellaneous normative statements related to Aim 1 codes
     - 2.1.1. **Cost Effective Care**: provide care that is cost effect
     - 2.1.2. **Deserve Care**: statement suggesting that someone deserves or is entitled to care
     - 2.1.3. **Future Citizen**: any reference to the fetus as a future citizen
     - 2.1.4. **Illegality**: any reference to patient having broken the law
     - 2.1.5. **Personal Responsibility**: suggestion that patient needs to take some ownership for care/health
     - 2.1.6. **Rights**: mention of patient or fetal rights, or human rights
   - 2.2. **Frustrations or Challenges**: frustrations or challenges of treating this population (in response to question about frustrations or otherwise)
     - 2.2.1. **Fear of Deportation**: issues related to immigration status affect patient health
     - 2.2.2. **No-Shows**: women do not come for appointments
     - 2.2.3. **Overwhelming**: complex needs of patients can be overwhelming
     - 2.2.4. **Staff Issues**: coworkers or staff display prejudice towards patients
     - 2.2.5. **Unable to Provide Necessary Treatment**: state or clinic policy prevents provision of all necessary services
     - 2.2.6. **Women Present Late**: undocumented women present for treatment late in pregnancy
     - 2.2.7. **Patients Take Advantage**: patients take advantage of or abuse health center or insurance
   - 2.3. **Joys**: joys of treating this population (in response to question about joys or otherwise)
     - 2.3.1. **Appreciated**: provider feels appreciated or valued by patients
     - 2.3.2. **Make a Difference**: provider feels that work with this population is impactful
     - 2.3.3. **Relationships**: provider values relationships with patients and their families
   - 2.4. **Norms**: in response to question about ethical norms
     - 2.4.1. **Attitude Norms**: norms related to a way of thinking of patients
       - 2.4.1.1. **Cultural Sensitivity**: be respectful of patients' cultural differences
       - 2.4.1.2. **Empathy**: empathize with patients; try to "understand where they are coming from"
       - 2.4.1.3. **Respect**: generic "be respectful"
     - 2.4.2. **Practice Norms**: norms related to a way of doing things
       - 2.4.2.1. **Advocate for Patients**: attempt to get patients all care/services they needs
       - 2.4.2.2. **Confidentiality**: maintain patient confidentiality
       - 2.4.2.3. **Educate or Empower**: provide patients with necessary information about pregnancy and otherwise, or empower patients

      - 2.4.2.4. **Do not ask about immigration status**: providers do not ask patients about their immigration status
      - 2.4.2.5. **Extra Support for Undoc**: provide undocumented patients with extra support
      - 2.4.2.6. **Respect for Autonomy**: explicit reference to patient autonomy or informed consent
      - 2.4.2.7. **Treat Everyone the Same**: norm of treating all patients the same
      - 2.4.2.8. **Workaround**: respondent identified a workaround that enables them to live up to their professional norms

3. **FQHC Background**
   - 3.1. **FQHC Characteristics**
     - 3.1.1. **% Immigrant**
       - 3.1.1.1. **% Undocumented**
       - 3.1.1.2. **Country of Origin or Ethnicity**
     - 3.1.2. **% Medicaid**
     - 3.1.3. **% Uninsured**
     - 3.1.4. **Neighborhood** – describes the neighborhood in which FQHC is located
4. **Process**
   - 4.1. **Payment**
     - 4.1.1. **Charity**
     - 4.1.2. **CHIP**
     - 4.1.3. **Employer**
     - 4.1.4. **Grant**
     - 4.1.5. **Medicaid**
       - 4.1.5.1. **Emergency Medicaid**
     - 4.1.6. **Out Of Pocket**
       - 4.1.6.1. **Sliding Fee Scale**
       - 4.1.6.2. **Subsidized Pricing**
     - 4.1.7. **Presumptive Eligibility**
   - 4.2. **Services**
     - 4.2.1. **Ambulatory Prenatal**
     - 4.2.2. **Case Work: includes**
     - 4.2.3. **Doula**
     - 4.2.4. **Family Planning**: birth control, including tubal ligation
       - 4.2.4.1. **Abortion**: any reference to abortion
     - 4.2.5. **Group Classes**
     - 4.2.6. **Individual Education**
     - 4.2.7. **Labor and Delivery**
     - 4.2.8. **Labs or Ultrasounds**
     - 4.2.9. **Language Services**
     - 4.2.10. **Legal Services**
     - 4.2.11. **Post-Partum: care after delivery**

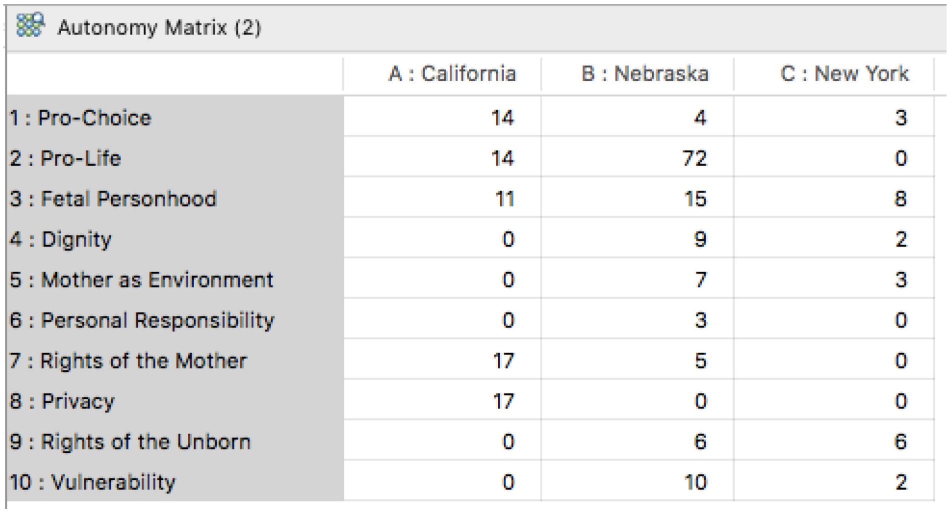
        - 4.2.12. **Specialty Care**
        - 4.2.13. **Substance Use Counseling**
        - 4.2.14. **Unrelated to Pregnancy**: in response to question about unrelated care or otherwise
            - 4.2.14.1. **Dental**
            - 4.2.14.2. **Mental Health**
            - 4.2.14.3. **Vision**

- **5. Respondent Background**
- 6. **Return to This**: signal code that I use when something is particularly interesting
- **7. Source Codes**
    - 7.1. **FQHC Type**
        - 7.1.1. **Rural**
        - 7.1.2. **Urban**
    - 7.2. **Position**
        - 7.2.1. **Admin or Billing**
        - 7.2.2. **Nurse or Medical Assistant**
        - 7.2.3. **Physician or Midwife**
        - 7.2.4. **Social Worker or Case Worker**
    - 7.3. **Transcript Cleaned**: has the transcript been cleaned yet

Appendix G: Analysis Figures

Appendix G1: Manuscript 1 Analysis Matrices

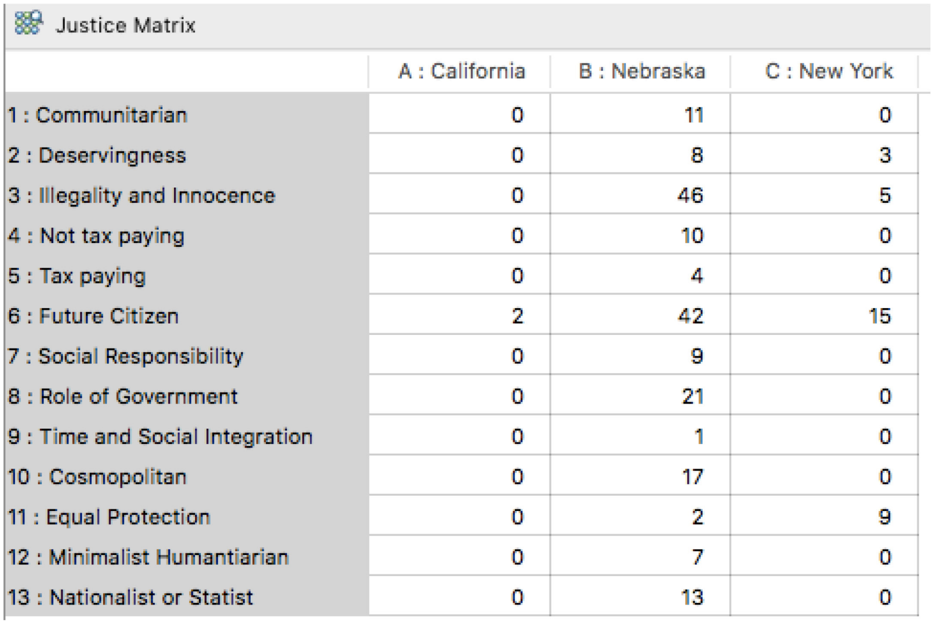
Figure 3: Coding Matrix for Justice-Based Arguments by State



Autonomy Matrix (2)

	A : California	B : Nebraska	C : New York
1 : Pro-Choice	14	4	3
2 : Pro-Life	14	72	0
3 : Fetal Personhood	11	15	8
4 : Dignity	0	9	2
5 : Mother as Environment	0	7	3
6 : Personal Responsibility	0	3	0
7 : Rights of the Mother	17	5	0
8 : Privacy	17	0	0
9 : Rights of the Unborn	0	6	6
10 : Vulnerability	0	10	2

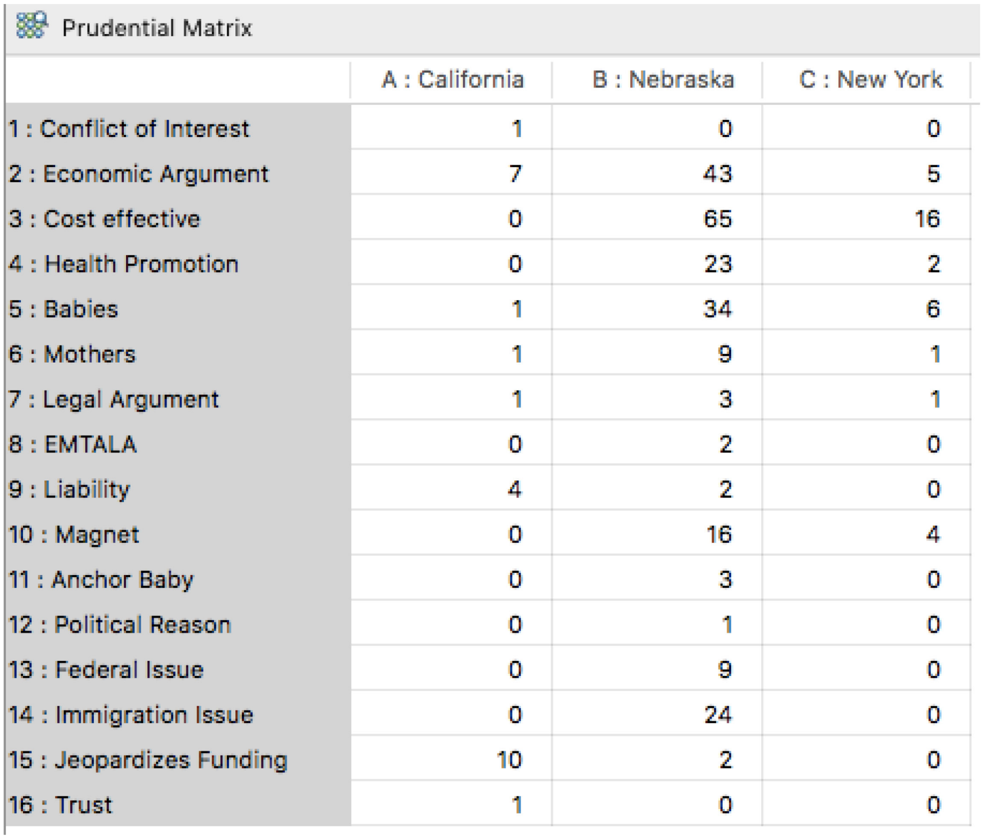
Figure 4: Coding Matrix for Autonomy-Based Arguments by State



Justice Matrix

	A : California	B : Nebraska	C : New York
1 : Communitarian	0	11	0
2 : Deservingness	0	8	3
3 : Illegality and Innocence	0	46	5
4 : Not tax paying	0	10	0
5 : Tax paying	0	4	0
6 : Future Citizen	2	42	15
7 : Social Responsibility	0	9	0
8 : Role of Government	0	21	0
9 : Time and Social Integration	0	1	0
10 : Cosmopolitan	0	17	0
11 : Equal Protection	0	2	9
12 : Minimalist Humantiarian	0	7	0
13 : Nationalist or Statist	0	13	0

FIGURE 5: CODING MATRIX FOR PRUDENTIAL ARGUMENTS BY STATE



Prudential Matrix

	A : California	B : Nebraska	C : New York
1 : Conflict of Interest	1	0	0
2 : Economic Argument	7	43	5
3 : Cost effective	0	65	16
4 : Health Promotion	0	23	2
5 : Babies	1	34	6
6 : Mothers	1	9	1
7 : Legal Argument	1	3	1
8 : EMTALA	0	2	0
9 : Liability	4	2	0
10 : Magnet	0	16	4
11 : Anchor Baby	0	3	0
12 : Political Reason	0	1	0
13 : Federal Issue	0	9	0
14 : Immigration Issue	0	24	0
15 : Jeopardizes Funding	10	2	0
16 : Trust	1	0	0

Appendix G2: Manuscript 1 Hierarchy Charts

Figure 6: Nebraska Moral and Prudential Reasons Hierarchy Charts

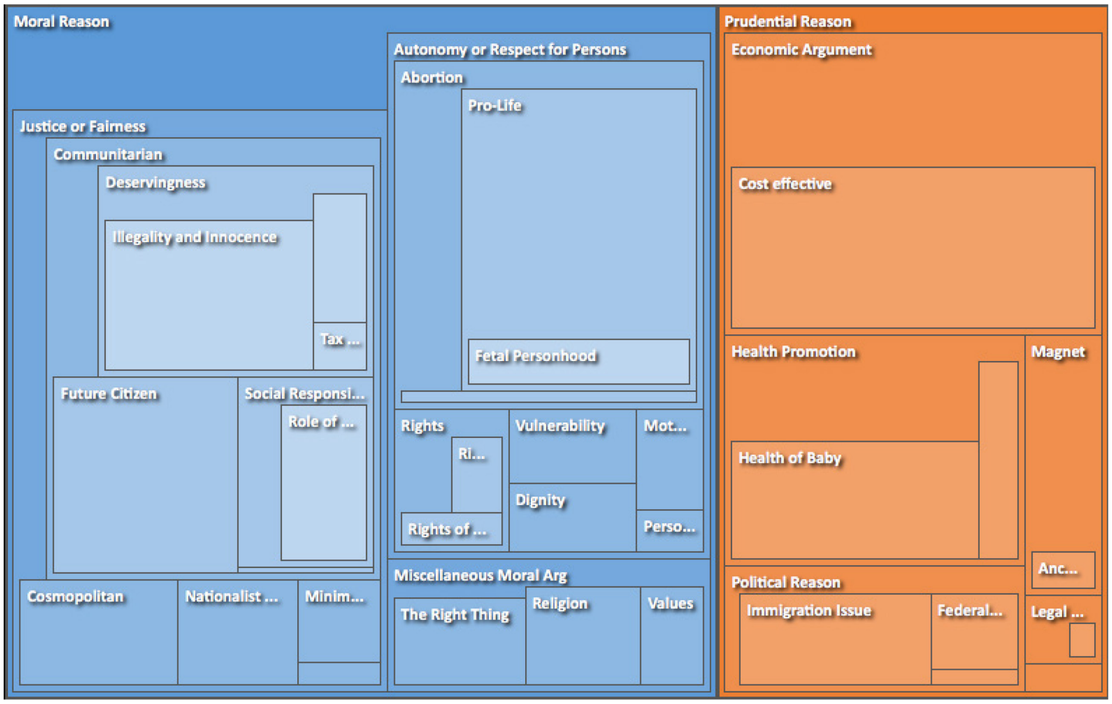


Figure 7: California Moral and Prudential Reasons Hierarchy Charts

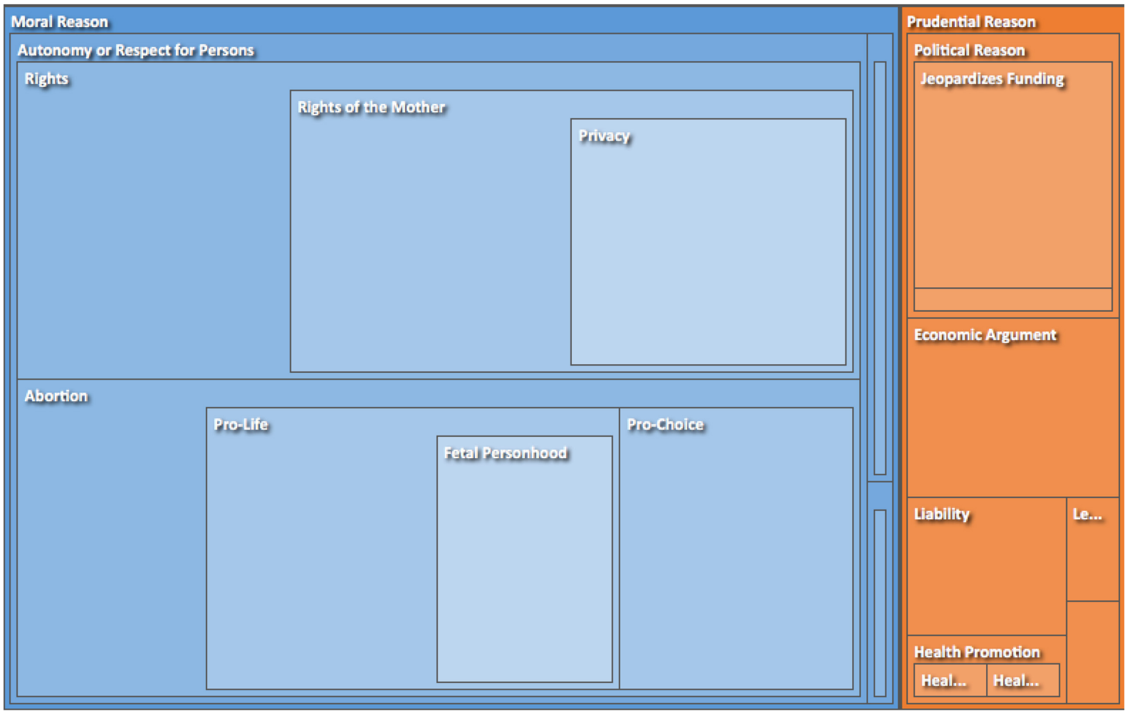
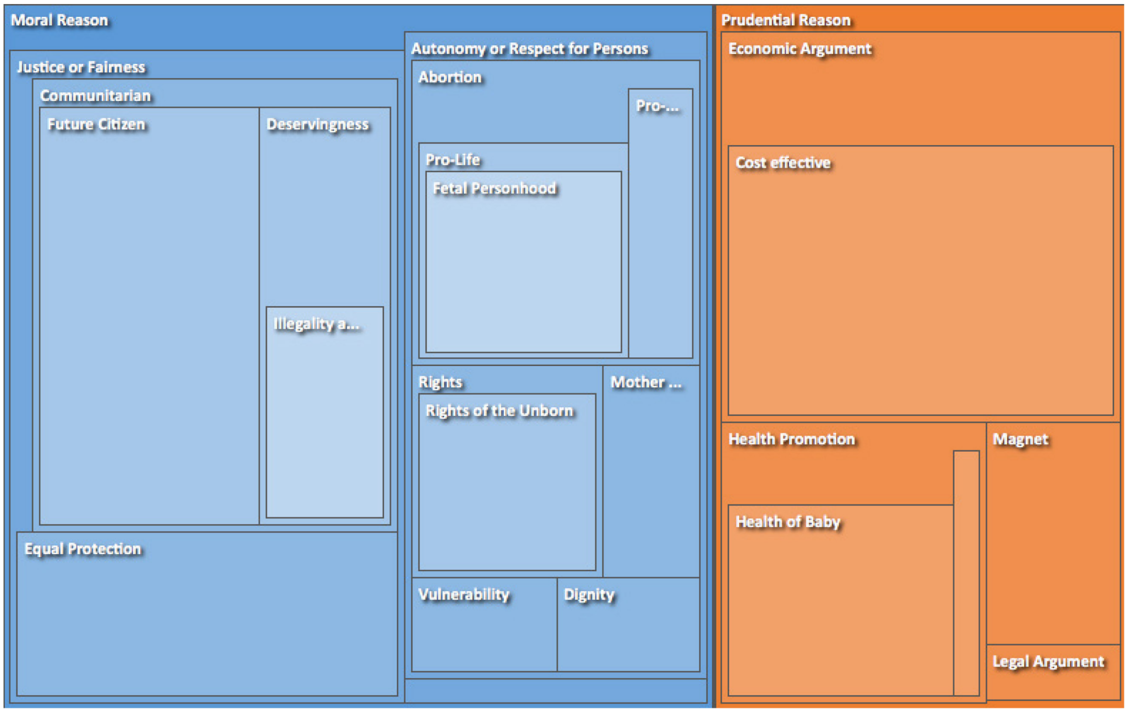
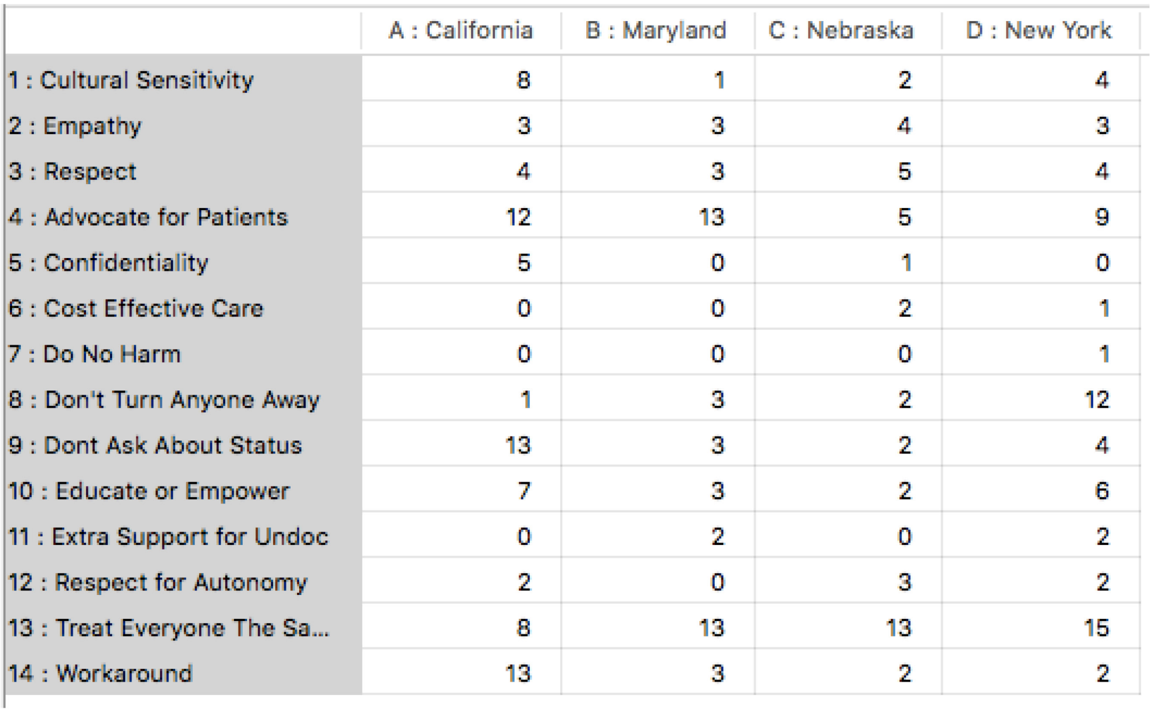


Figure 8: New York Moral and Prudential Reasons Hierarchy Charts


Moral Reason
Justice or Fairness
Communitarian
Future Citizen
Deservingness
Illegality a...
Equal Protection
Autonomy or Respect for Persons
Abortion
Pro-...
Pro-Life
Fetal Personhood
Rights
Rights of the Unborn
Mother ...
Vulnerability
Dignity
Prudential Reason
Economic Argument
Cost effective
Health Promotion
Health of Baby
Magnet
Legal Argument

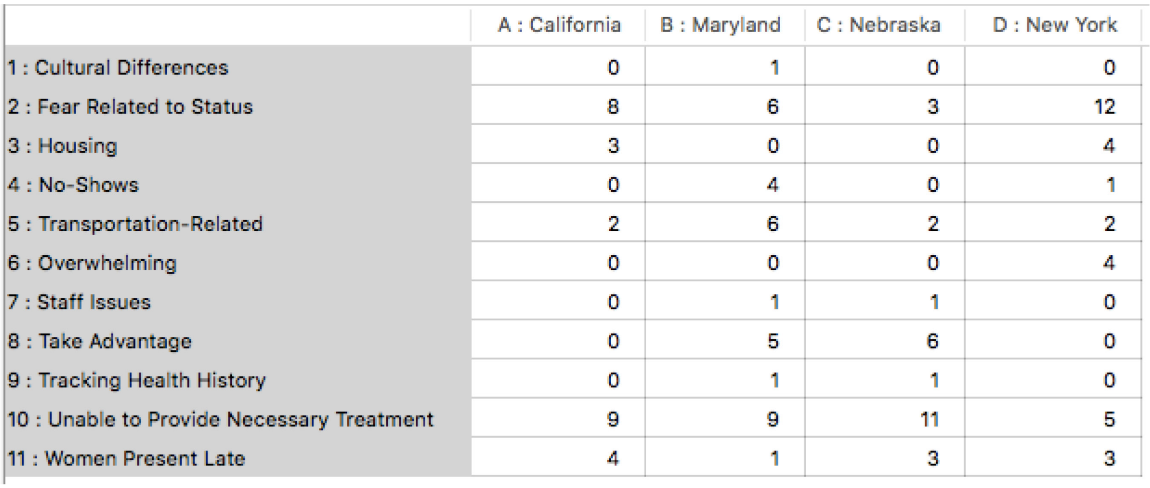
APPENDIX G3: MANUSCRIPT 2 ANALYSIS MATRICES

FIGURE 9: CODING MATRIX FOR PROFESSIONAL NORMS BY STATE



	A : California	B : Maryland	C : Nebraska	D : New York
1 : Cultural Sensitivity	8	1	2	4
2 : Empathy	3	3	4	3
3 : Respect	4	3	5	4
4 : Advocate for Patients	12	13	5	9
5 : Confidentiality	5	0	1	0
6 : Cost Effective Care	0	0	2	1
7 : Do No Harm	0	0	0	1
8 : Don't Turn Anyone Away	1	3	2	12
9 : Dont Ask About Status	13	3	2	4
10 : Educate or Empower	7	3	2	6
11 : Extra Support for Undoc	0	2	0	2
12 : Respect for Autonomy	2	0	3	2
13 : Treat Everyone The Sa...	8	13	13	15
14 : Workaround	13	3	2	2

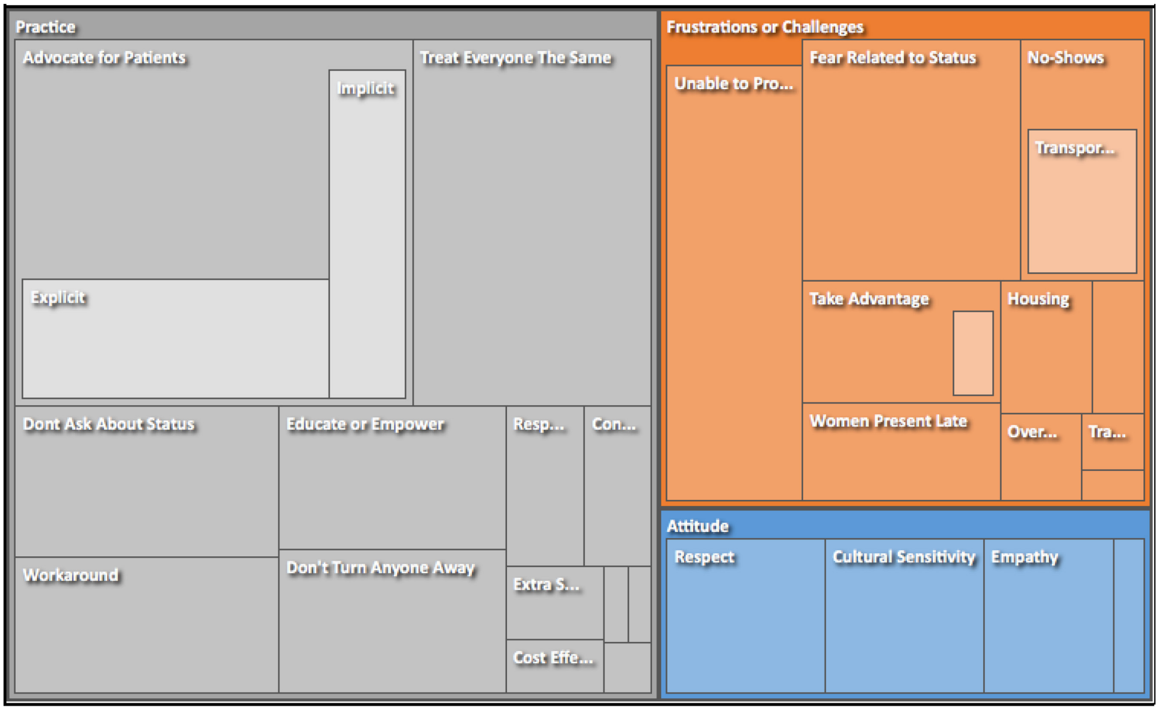
FIGURE 10: CODING MATRIX FOR ETHICAL TENSIONS OR CHALLENGES BY STATE



	A : California	B : Maryland	C : Nebraska	D : New York
1 : Cultural Differences	0	1	0	0
2 : Fear Related to Status	8	6	3	12
3 : Housing	3	0	0	4
4 : No-Shows	0	4	0	1
5 : Transportation-Related	2	6	2	2
6 : Overwhelming	0	0	0	4
7 : Staff Issues	0	1	1	0
8 : Take Advantage	0	5	6	0
9 : Tracking Health History	0	1	1	0
10 : Unable to Provide Necessary Treatment	9	9	11	5
11 : Women Present Late	4	1	3	3

Appendix G4: Manuscript 2 Hierarchy Chart

Figure 11: Professional Norms and Ethical Challenges Hierarchy Chart (All States)



BIBLIOGRAPHY

American Academy of Pediatrics. (2017). *Immigration Child Health Toolkit*. Retrieved from https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Council-on-Community-Pediatrics/Pages/Immigrant-Child-Health-Toolkit.aspx

Arbona, C., Olvera, N., Rodriguez, N., Hagan, J., Linares, A., & Wiesner, M. (2010). Acculturative Stress Among Documented and Undocumented Latino Immigrants in the United States. *Hisp J Behav Sci, 32*(3), 362-384. doi:10.1177/0739986310373210

Atkins, D. N., Barroso, C. S., Anderson, A. J., Meadows, J. T., & Lindley, L. C. (2017). Maternal Health of Undocumented Women With and Without Medicaid Access in Nebraska, 2007-2011. *Hispanic Health Care International, 15*(1), 13-19.

Baumrucker, E. P. (2008). *SCHIP coverage for pregnant women and unborn children*. Retrieved from

Beauchamp, T. L., & Childress, J. F. (2013). *Principles of Biomedical Ethics, 7th Ed*. New York: Oxford University Press.

Berlinger, N. (2016). *Are Workarounds Ethical?: Managing Moral Problems in Health Care Systems*: Oxford University Press.

Berlinger, N., & Raghavan, R. (2013). The Ethics of Advocacy for Undocumented Patients. *Hastings Center Report, 43*(1), 14-17. doi:10.1002/hast.126

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public health reports*.

Bosniak, L. (2007). Being here: ethical territoriality and the rights of immigrants. *Theoretical inquiries in law, 8*(2), 389-410.

Bosniak, L. (2008). *The citizen and the alien: dilemmas of contemporary membership*: Princeton University Press.

Brock, G. (2015). Global Justice, Cosmopolitan Duties and Duties to Compatriots: The Case of Healthcare. *Public Health Ethics, 8*(2), 110-120. doi:10.1093/phe/phu039

Buchbinder, M., Lassiter, D., Mercier, R., Bryant, A., & Lyerly, A. D. (2016). Reframing Conscientious Care: Providing Abortion Care When Law and Conscience Collide. *Hastings Cent Rep, 46*(2), 22-30. doi:10.1002/hast.545

Cain, J. M. (1993). Is deception for reimbursement in obstetrics and gynecology justified? *Obstet Gynecol, 82*(3), 475-478.

Camarota, S. A. (2009). Illegal Immigrants and HR 3200. *Center for Immigration Studies*.

Carens, J. (2013). *The Ethics of Immigration*: Oxford University Press, USA.

Carter, J. (2012). Timeline of Prenatal Care Coverage in Nebraska. Retrieved from https://neappleseed.org/blog/5924

Chishti, M., & Bolter, J. (2017). *The Trump Administration at Six Months: A Sea Change in Immigration Enforcement*. Retrieved from https://www.migrationpolicy.org/article/trump-administration-six-months-sea-change-immigration-enforcement

CMS. (2002). State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children (42 CFR 457). *Federal Register, 67*(191), 61956-61974.

Cordasco, K. M., Ponce, N. A., Gatchell, M. S., Traudt, B., & Escarce, J. J. (2011). English language proficiency and geographical proximity to a safety net clinic as a predictor of health care access. *J Immigr Minor Health, 13*(2), 260-267.

Dallard, C. (2002). New SCHIP Prenatal Care Rule Advances Fetal Rights At Low-Income Women's Expense. *The Guttmacher Report, 5*(5), 3-5.

DuBard, C. A., & Massing, M. W. (2007). Trends in emergency Medicaid expenditures for recent and undocumented immigrants. *Jama, 297*(10), 1085-1092. doi:10.1001/jama.297.10.1085

Dwyer, J. (2004). Illegal immigrants, health care, and social responsibility. *Hastings Cent Rep, 34*(1), 34-41.

Dwyer, J. (2015). On Taking Responsibility for Undocumented Migrants. *Public Health Ethics, 8*(2), 139-147.

Edwards, J. R. (2010). The Medicaid Costs of Legalizing Illegal Aliens. *Center for Immigration Studies. Retrieved December, 18*, 2012.

Fabi, R. (2014). Undocumented Immigrants in the United States: Access to Prenatal Care. *The Undocumented Patients Project*. Retrieved from http://undocumentedpatients.org/issuebrief/undocumented-immigrants-in-the-united-states-access-to-prenatal-care/

Fabi, R. (2017). *Manuscript 1 (Working Paper)*. Dissertation Working Paper. Health Policy and Management. Johns Hopkins Bloomberg School of Public Health. Baltimore, MD.

Fiory, J., Landsberg, E., Sanematsu, S., & Tawatao, M. (2016). *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates*. Retrieved from

Fortuny, K., & Chaudry, A. (2011). A comprehensive review of immigrant access to health and human services. *Washington, DC: Urban Institute*.

Frisbie, W. P., Echevarria, S., & Hummer, R. A. (2001). Prenatal care utilization among non-Hispanic Whites, African Americans, and Mexican Americans. *Matern Child Health J, 5*(1), 21-33.

Fuentes-Afflick, E., Hessol, N. A., Bauer, T., O'Sullivan, M. J., Gomez-Lobo, V., Holman, S., . . . Minkoff, H. (2006). Use of prenatal care by Hispanic women after welfare reform. *Obstet Gynecol, 107*(1), 151-160. doi:10.1097/01.AOG.0000191299.24469.1b

GAO. (2004). *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs*. (GAO-04-472). Washington, DC: U.S. Government Accountability Office.

Gardner, M., Johnson, S., & Wiehe, M. (2015). *Undocumented Immigrants' State & Local Tax Contributions*. Retrieved from

Gusmano, M. K. (2012). *Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care*. Retrieved from Garrison, NY:

Hadley, J., & Cunningham, P. (2004). Availability of safety net providers and access to care of uninsured persons. *Health services research, 39*(5), 1527-1546.

Hall, M. A., & Perrin, J. (2015). Irregular Migrant Access to Care: Mapping Public Policy Rationales. *Public Health Ethics, 8*(2), 130-138. doi:10.1093/phe/phv016

Henderson, J. W. (1994). The cost effectiveness of prenatal care. *Health care financing review, 15*(4), 21.

Illingworth, P., & Parmet, W. (2017). *The Health of Newcomers*. New York: New York University Press.

Kant, I. (1970). *Perpetual peace: A philosophical sketch*: Cambridge University Press Cambridge.

Kant, I., Gregor, M. J., & Timmermann, J. (2012). *Groundwork of the Metaphysics of Morals*: Cambridge University Press.

Kelaher, M., & Jessop, D. J. (2002). Differences in low-birthweight among documented and undocumented foreign-born and US-born Latinas. *Soc Sci Med, 55*(12), 2171-2175.

Korinek, K., & Smith, K. R. (2011). Prenatal care among immigrant and racial-ethnic minority women in a new immigrant destination: exploring the impact of immigrant legal status. *Soc Sci Med, 72*(10), 1695-1703. doi:10.1016/j.socscimed.2011.02.046

Krogstad, J. M., & Passel, J. (2015, September 23, 2014). 5 facts about illegal immigration in the U.S. *FactTank*. Retrieved from http://www.pewresearch.org/fact-tank/2015/07/24/5-facts-about-illegal-immigration-in-the-u-s/

Kuiper, H., Richwald, G. A., Rotblatt, H., & Asch, S. (1999). The communicable disease impact of eliminating publicly funded prenatal care for undocumented immigrants. *Matern Child Health J, 3*(1), 39-52.

Kullgren, J. T. (2003). Restrictions on undocumented immigrants' access to health services: the public health implications of welfare reform. *Am J Public Health, 93*(10), 1630-1633.

Lu, M. C., Lin, Y. G., Prietto, N. M., & Garite, T. J. (2000). Elimination of public funding of prenatal care for undocumented immigrants in California: a cost/benefit analysis. *Am J Obstet Gynecol, 182*(1 Pt 1), 233-239.

Ludomirsky, A. (2010). *Access to Prenatal Care for Undocumented Immigrants Under Medicaid and CHIP: A Review of State Prenatal Care Programs* Princeton.

Martin, J. (2012). Deterring illegal immigrant settlement: a guide to state and local action: Washington (DC): Federation for American Immigration Reform.

McKie, J., & Richardson, J. (2003). The Rule of Rescue. *Social Science & Medicine, 56*(12), 2407-2419. doi:http://dx.doi.org/10.1016/S0277-9536(02)00244-7

Mejias-Beck, J., Kuczewski, M., & Blair, A. (2017). Sanctuary Doctoring. Retrieved from https://hsd.luc.edu/bioethics/content/sanctuary-doctor/

Miller, D. (2016). *Strangers in our midst*: Harvard University Press.

Miller, S., & Wherry, L. R. (2016). The Long-Term Effects of Early Life Medicaid Coverage. *Available at SSRN 2466691*.

Moore, T. R., Origel, W., Key, T. C., & Resnik, R. (1986). The perinatal and economic impact of prenatal care in a low-socioeconomic population. *American journal of obstetrics and gynecology, 154*(1), 29-33.

Munro, K., Jarvis, C., Munoz, M., D'Souza, V., & Graves, L. (2013). Undocumented pregnant women: what does the literature tell us? *J Immigr Minor Health, 15*(2), 281-291. doi:10.1007/s10903-012-9587-5

Nandi, A., Loue, S., & Galea, S. (2009). Expanding the universe of universal coverage: the population health argument for increasing coverage for immigrants. *J Immigr Minor Health, 11*(6), 433-436. doi:10.1007/s10903-009-9267-2

National Health Law Program, & National Association of Community Health Centers. (2006). *Role of State Law in Limiting Medicaid Changes*. Retrieved from http://www.healthlaw.org/issues/medicaid/defending-medicaid/role-of-state-in-limiting-medicaid-changes - .WaV61XeGPdQ

National Immigration Law Center. (2017). *Health Care Providers and Immigration Enforcement: Know Your Rights, Know Your Patients' Rights*. Retrieved from Los Angeles: https://www.nilc.org/issues/immigration-enforcement/healthcare-provider-and-patients-rights-imm-enf/

New York Times Editorial Board. (2012, April 24, 2012). The Undocumented and the Unborn, Editorial. *The New York Times,* p. A22.

Nickel, J. W. (1986). Should undocumented aliens be entitled to health care? *Hastings Center Report, 16*(6), 19-23.

Novack, D. H., Detering, B. J., Arnold, R., Forrow, L., Ladinsky, M., & Pezzullo, J. C. (1989). Physicians' attitudes toward using deception to resolve difficult ethical problems. *Jama, 261*(20), 2980-2985. doi:10.1001/jama.1989.03420200070040

Page, K. R., & Polk, S. (2017). Chilling Effect? Post-Election Health Care Use by Undocumented and Mixed-Status Families. *New England Journal of Medicine, 376*(12), e20.

Pantoja, A. (2006). Against the tide? Core American values and attitudes toward US immigration policy in the mid-1990s. *Journal of Ethnic and Migration Studies, 32*(3), 515-531.

Passel, J., & Cohn, D. (2015, September 11, 2015). Number of babies born in U.S. to unauthorized immigrants declines. *FactTank*. Retrieved from http://www.pewresearch.org/fact-tank/2015/09/11/number-of-babies-born-in-u-s-to-unauthorized-immigrants-declines/

Powers, M., & Faden, R. R. (2006). *Social justice: the moral foundations of public health and health policy*: Oxford University Press.

QSR International. (2017). NVivo 11 for Mac (Version 11.4.2): QSR International. Retrieved from http://www.qsrinternational.com/product/nvivo-mac

Rawls, J. (1987). The Idea of an Overlapping Consensus. *Oxford Journal of Legal Studies, 7*(1), 1-25.

Rawls, J. (1999). *A Theory of Justice, Revised Edition*: Harvard University Press.

Rawls, J. (2001). *The law of peoples: with, the idea of public reason revisited*: Harvard University Press.

Reed, M. M., Westfall, J. M., Bublitz, C., Battaglia, C., & Fickenscher, A. (2005). Birth outcomes in Colorado's undocumented immigrant population. *BMC Public Health, 5*, 100. doi:10.1186/1471-2458-5-100

Rhodes, S. D., Mann, L., Siman, F. M., Song, E., Alonzo, J., Downs, M., . . . Hall, M. A. (2015). The impact of local immigration enforcement policies on the health of immigrant hispanics/latinos in the United States. *Am J Public Health, 105*(2), 329-337. doi:10.2105/ajph.2014.302218

Siskin, A. (2004). *Federal Funding for Unauthorized Aliens' Emergency Medical Expenses*. Retrieved from

Sommers, B. D. (2013). Stuck between health and immigration reform--care for undocumented immigrants. *N Engl J Med, 369*(7), 593-595. doi:10.1056/NEJMp1306636

Swartz, J. J., Hainmueller, J., Lawrence, D., & Rodriguez, M. I. (2017). Expanding Prenatal Care to Unauthorized Immigrant Women and the Effects on Infant Health. *Obstetrics & Gynecology, 130*(5), 938-945. doi:10.1097/aog.0000000000002275

UN. (1948). Universal Declaration of Human Rights. *United Nations General Assembly*.

Walzer, M. (1984). *Spheres of Justice: A Defense of Pluralism and Equality*: Basic Books.

Watson, T. (2014). Inside the Refrigerator: Immigration Enforcement and Chilling Effects in Medicaid Participation. *American Economic Journal: Economic Policy, 6*(3), 313-338.

Wherry, L. R., Fabi, R., Schickedanz, A., & Saloner, B. (2017). State And Federal Coverage For Pregnant Immigrants: Prenatal Care Increased, No Change Detected For Infant Health. *Health Affairs, 36*(4), 607-615. doi:10.1377/hlthaff.2016.1198

Wild, V. (2015). Universal Access to Health Care for Migrants: Applying Cosmopolitanism to the Domestic Realm. *Public Health Ethics, 8*(2), 162-172. doi:10.1093/phe/phv014

Wolff, J. (2012). Global Justice and Health. *Global Justice and Bioethics*, 78.

Wynia, M. K., Cummins, D. S., VanGeest, J. B., & Wilson, I. B. (2000). Physician manipulation of reimbursement rules for patients: Between a rock and a hard place. *Jama, 283*(14), 1858-1865. doi:10.1001/jama.283.14.1858

Yin, R. K. (2013). *Case study research: Design and methods*: Sage publications.

CURRICULUM VITAE

EDUCATION

JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH, Baltimore, MD **2018 (EXP)**
Ph.D. Candidate, Health Policy and Management (Bioethics & Health Policy track) – 4.0 GPA

YALE UNIVERSITY, New Haven, CT **2011**
B.A., Political Science (Health Policy & Bioethics concentration)

PROFESSIONAL EXPERIENCE

NATIONAL MARROW DONOR PROGRAM (BE THE MATCH) **2015 – PRESENT**

- Consultant, High Priority Donor Messaging Evaluation Project
    - Analyze ethical issues related to communication of high priority donor status and identify options to resolve these issues
- Co-investigator, High Priority Donor Messaging Evaluation Project
    - Collaborate across multiple institutions on pilot study of high priority donor messaging, analyzing qualitative patient interview data using NVivo 10
    - Draft manuscript reporting qualitative findings for publication

JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH **2015 – 2017**

- Research Assistant to Brendan Saloner
    - Researched and refined measures of state policy to fund prenatal care for immigrants
    - Collaborated on manuscript reporting findings from analysis of vital statistics data

MARYLAND DEPARTMENT OF HEALTH **2015**

- HRSA Public Health Practice Fellow, Maryland Office of Immigrant Health
    - Communicated with refugee resettlement agencies and state health officials about the effect of the Affordable Care Act on refugee access to health insurance and reported on findings
    - Created educational materials about blood lead for refugee families

JOHNS HOPKINS BERMAN INSTITUTE OF BIOETHICS **2013 – 2015**

- Research Assistant to Nancy Kass and Ruth Faden
    - Piloted study materials for PCORI-funded project assessing acceptability of various models of informed consent for comparative effectiveness research in a learning healthcare system

    - Coded and analyzed qualitative data from deliberative engagement sessions using NVivo 10
    - Drafted manuscript reporting qualitative findings for publication

JOHNS HOPKINS BERMAN INSTITUTE OF BIOETHICS 2014 – 2015

- Research Assistant to Jeffrey Kahn
    - Organized the 2015 Hecht-Levi Symposium on the commodification of the human body
    - Created background materials for the symposium, including a detailed literature review

THE HASTINGS CENTER 2014 – 2015

- Research Assistant on the Undocumented Patients Project
    - Researched and created an issue brief on state policies affecting access to prenatal care for undocumented immigrants
    - Compiled briefing materials for End of Life Conference in Hong Kong

YALE INTERDISCIPLINARY CENTER FOR BIOETHICS 2009 – 2011

- Research Assistant to David H. Smith
    - Performed independent research on western and non-western research ethics
    - Published a weekly newsletter section on bioethical issues in the news
- Research Intern, Summer Internship Program 2009
    - Conducted independent research on the ethical implications and racially disparate impact of HLA-based cadaveric kidney allocation

UNIVERSITY OF PITTSBURGH CENTER FOR BIOETHICS AND HEALTH LAW 2010

- Research Assistant to David Barnard
    - Collaborated on research projects involving women's empowerment in Malawi, the use of simulated patients in medical instruction, and the creation of a research ethics program

INSTRUCTIONAL EXPERIENCE

GORDIS TEACHING FELLOW, JOHNS HOPKINS KRIEGER SCHOOL OF ARTS & SCIENCES

- *Beyond Borders: Migration, Ethics, and Public Health* Spring 2017, Fall 2017
    - Designed and taught upper-level undergraduate seminar as faculty of record

COURSE INSTRUCTOR, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

- *Foundations of Bioethics* (Co-instructor. Faculty of record Jeffrey Kahn) Fall 2016

TEACHING ASSISTANT, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

- *Ethics of Public Health Practice in Developing Countries*, Prof. Maria Merritt Spring 2014
- *Introduction to Bioethics in Public Health Practice and Research*, Prof. Nancy Kass Summer 2014-17
- *PhD Seminar in Health Policy I and II*, Prof. Ellen Mackenzie Fall and Winter 2014, 2015
- *Research Ethics and Integrity*, Prof. Nancy Kass Spring 2015, 2016
- *Ethical Issues in Public Health*, Prof. Jeffery Kahn Spring 2015, 2016
- *Crisis and Response in Public Health Policy and Practice*, Prof. Joshua Sharfstein Fall 2015, 2016
- *Ethical Issues in Health Policy: Public Health and Health Care*, Prof. Holly Taylor Fall 2015
- *State Healthcare Policy*, Prof. David Helms Spring 2016

TEACH FOR AMERICA, MISSISSIPPI DELTA CORPS 2011 – 2013

- Math Teacher, Broad Street High School, North Bolivar School District, Shelby MS
    - Pre-Algebra, Algebra I, Algebra II, Geometry
    - Directed 21st Century after-school program

GRANTS AND FELLOWSHIPS

- Gordis Teaching Fellowship ($12,000) 2016, 2017
- Barbara Starfield Scholarship ($8,500) 2017
- Carefirst Hal Cohen Memorial Scholarship Award ($3,500) 2016
- CQSHM Dissertation Enhancement Award ($2,000) 2016
- Health Resources and Services Administration Trainee Fellowship ($5,000) 2015
- Agency for Healthcare Research and Quality NRSA Training Grant #T32HS000029 2013-15

HONORS AND AWARDS

- Charlotte W. Newcombe Doctoral Dissertation Fellowship, Finalist 2017
- American Society for Bioethics and Humanities Student Paper Award, Finalist 2015
- Marcia G. Pines Award in Bioethics and Public Health 2014
- Passed Comprehensive Doctoral Examination with Honors 2014
- Nominated for Sue Lehmann Excellence in Teaching Award 2013

ACADEMIC SERVICE

JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

- Elected Student Representative to Schoolwide Doctoral Tuition Taskforce 2016-2017
- Elected Departmental Representative to Doctoral Student Council 2016-2017
- Student Representative to PhD Program Committee, Bioethics Track 2015-2017
- Student Representative to PhD Curriculum Committee, Bioethics Track 2016-2017
- Elected Social Chair, Departmental Student Coordinating Committee 2014-2015

CERTIFICATIONS

- Preparing Future Faculty Teaching Academy 2017
- Collaborative Institutional Training Initiative (CITI) Training Certification 2013
- Academic and Research Ethics Certification at JHSPH 2013

PUBLICATIONS

Fabi, R. (forthcoming). Public Health Ethics and Issues Related to Immigrants and Refugees in *The Oxford Handbook of Public Health Ethics*, Kahn, J., Kass, N., Mastroianni, A. (eds). Oxford University Press.

Rieder, T., **Fabi, R**. (under review). Compounding Injustice: The Multiple Moral Failures of an America-First Agenda.

Wherry, L. R., **Fabi, R**., Schickedanz, A., & Saloner, B. (2017). State And Federal Coverage For Pregnant Immigrants: Prenatal Care Increased, No Change Detected For Infant Health. *Health Affairs, 36*(4), 607-615.

Fabi, R., & Saloner, B. (2016). Covering Undocumented Immigrants — State Innovation in California. *New England Journal of Medicine, 375*(20), 1913-1915.

Fabi, R. (2016). "Respect for Persons," Not "Respect for Citizens". *American Journal of Bioethics 16*(10), 69-70.

Kass, N., Faden, R., **Fabi, R.**, Morain, S., Hallez, K., Whicher, D., . . . Pitcavage, J. (2016). Alternative consent models for comparative effectiveness studies: Views of patients from two institutions. *AJOB Empirical Bioethics, 7*(2), 92-105.

Fabi, R. (2014). Undocumented Immigrants in the United States: Access to Prenatal Care. Undocumented Patients Project of The Hasting Center. http://www.undocumentedpatients.org/issuebrief/undocumented-immigrants-in-the-united-states-access-to-prenatal-care/

Fabi, R. & Banarjee, M. (2014). What Do We Owe to Child Migrants? Bioethics Forum. http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=6943&blogid=140

BOOK REVIEWS

Fabi, R. (2017). "The Health of Newcomers, by Patricia Illingworth and Wendy Parmet". *American Journal of Bioethics 17*(12), W4-W5.

PRESENTATIONS:

Fabi, R. (2017). Provider Perspectives on Prenatal Care for Undocumented Immigrants: A Case Study in Practice and Ethics. 19^{9h} Annual American Society for Bioethics and Humanities Meeting, Kansas City, MO (Podium).

Fabi, R. (2017). High Priority Donor Messaging Evaluation Project. National Marrow Donor Program Annual Spring Summit, Minneapolis, MN (Podium).

Fabi, R. (2016). Prenatal Care for Undocumented Immigrants: A Comparative Case Study in Policy and Ethics. 18th Annual American Society for Bioethics and Humanities Meeting, Washington, DC (Podium).

Fabi, R. (2015). Bioethicists or Bunglers? The Role of Empirical Bioethics in Kant's Moral Law. 17th Annual American Society for Bioethics and Humanities Meeting, Houston, TX (Podium).

Fabi, R. (2015). Ethical and Policy Implications of State Variation in Publicly Funded Prenatal Care for Undocumented Immigrants. 17th Annual American Society for Bioethics and Humanities Meeting, Houston, TX (Podium).

Fabi, R. (2015). Ethical and Policy Implications of State-Level Variation in Access to Publicly Funded Prenatal Care for Undocumented Immigrants. 21st Annual NRSA Trainees Conference, Minneapolis, MN. (Podium)

Fabi R., Kass N., Morain S., Hallez K. Faden R. (2015). Alternative Consent Models for Comparative Effectiveness Research: Patient Perspectives. 21st Annual NRSA Trainees Conference, Minneapolis, MN. (Podium)

Fabi R., Kass N., Morain S., Hallez K. Faden R. (2015). Alternative Consent Models for Comparative Effectiveness Research: Patient Perspectives. Academy Health Annual Research Meeting, Minneapolis, MN. (Poster)

Fabi, R. (2011). The Devil is in the Details: Research Ethics Policy and Practice in Non-Western Nations. 14th Annual National Undergraduate Bioethics Conference at Duke University, Durham, NC. (Podium)

Fabi, R. (2010). The Dialectic of Utility and Justice in Kidney Allocation: Crafting an Ethical Balance. 13th Annual National Undergraduate Bioethics Conference at the University of Puget Sound, Tacoma, WA. (Podium)

PROFESSIONAL AFFILIATIONS

- American Society for Bioethics and the Humanities