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Social welfare grey zones: how and why subnational actors provide when nations do not?

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ABSTRACT
In an era where even citizenship is not a guarantee of access to the welfare state, can non-citizens gain access to social protection? Using health care as a lens, and the United States and Spain as cases, we find that non-citizens do have access to social protection via what we call ‘grey zones’, namely points of disagreement between national and local governments that create opportunities for non-citizens. Grey zones are possible due to processes that are often seen as disenfranchising: the denationalisation of policy and the disaggregation of citizenship. In addition, they tend to open up regardless of the nature or intent of national reforms. That said, we find significant variation in the extent to which subnational governments take advantage of them. While differences are somewhat explained by partisanship, significant outliers warrant further investigation.

1. Introduction
During the last few decades, ideological, institutional, and political changes in many industrialised societies have reshaped the relationship between citizen and state. Responsibility for key policy areas has often shifted downward, to regional and municipal governments, or upwards to supranational institutions – a process dubbed ‘denationalisation’ (Jessop 2002). Within nation-states, the relationship between legal, political, and social citizenship is also changing dramatically and is increasingly subject to market forces. The twin pressures of neoliberalism and economic crisis have weakened welfare policies, creating large holes in the social safety net in many countries.

While these changes pose challenges for everyone, they are particularly onerous for immigrants. Immigrants make up more than 10% of the population in many Western industrialised countries, yet they increasingly find themselves excluded from state-backed social protections in their countries of residence. Because they are not full citizens, they are not eligible for many services and programmes – even though they may work and contribute to social spending through taxes. For international migrants moving to states in the global north, residency status and citizenship strongly influence what their host countries provide, and this varies considerably (Bossert 1998; Holzmann, Koettl, and...
Chernetsky 2005; Avato et al. 2010; Levitt et al. 2015). Undocumented or ‘irregular’ immigrants face even steeper barriers to social protection, as, given their legal status, they are generally ineligible for benefits from their employers or from the state.

In light of these competing changes in the structure of legal and political citizenship, can non-citizens achieve a level of social citizenship, namely access to the welfare state, which helps to counteract their state of permanent impermanence? We argue that the process of denationalisation, and to a lesser extent, the disaggregation of citizenship, has generated what we call ‘grey zones’, or spaces of disjuncture between national and local governments that create opportunities for non-citizens to get protection and care. Our examination of subnational policy responses to national social welfare reforms, reveals that denationalisation is a major catalyst for the emergence of these grey zones. The redistribution of power downward via denationalisation gives subnational governments more financial and institutional leeway to implement their own policies. This shift becomes particularly important if the political beliefs of subnational communities diverge sharply from the national government. The United States where, as we write, many states are pushing back against the federal government’s environmental, immigration, and reproductive health policies, is just one salient example.

That said, it is less clear to what extent the disaggregation of citizenship generates grey zones. The separation of legal and social citizenship has both costs and benefits for non-citizens. When individuals achieve some level of social citizenship via the market as opposed to their legal status, non-citizens can gain access to social protection. However, this can exclude those who are not in the labour market, those who cannot afford to purchase services, or those who are excluded from making claims on the state because of their irregular immigration status. On the other hand, when access to social citizenship is universal, regardless of legal citizenship, there is a clear benefit for non-citizens. This latter scenario, however, is relatively rare and increasingly unstable. What we see emerging in response, however, is increasing disaggregation of social citizenship from legal citizenship at the subnational level, thereby allowing individuals access to protections and services subnationally that they are ineligible for at the national level.

We develop this argument using Spain and the United States as comparative cases and we focus on health care as a type of social protection. While political power in both countries is constitutionally divided between national and subnational governments, since the 1980s, both national governments have increasingly shifted responsibility for social policy downward. Both countries have relatively comparable immigrant populations, although the United States has a much larger undocumented population. Finally, both countries implemented major health care reforms (in 2010 and 2012) that limited social protections for non-citizens at the national level. Subsequently, subnational governments in both nations put in place an array of strategies providing some measure of coverage to non-citizens shut out by national policy.

This article proceeds as follows. In Section 2, we present our theoretical framework highlighting the relationship between state and citizenship in the context of migration. At the end of this section, we explain the methodological focus of the analysis, which relies on a mix of legislative records, demographic and public opinion data, and public records. Sections 3 and 4 present the analysis of the case studies: Spain and United States. Here we place health care reform in the context of broader social policy reforms in both countries and identify the emergence of grey zones. Afterwards, we illustrate
the role played by subnational government in changing the social protection landscape by examining the policy dynamics of high access and low-access states in the United States and those autonomous communities that more closely observe or break from the universality principle in Spain. Finally, we conclude by reflecting on the role of the subnational in health care provision and the political implications of the subnational perspective.

2. Disaggregation, denationalisation, and social protection in the reconfigured state

Citizenship is broadly understood as a form of membership in a given nation-state that entitles the holder to certain rights. Traditionally, acquisition of these rights has been conceived as linear: civil, i.e. legal rights (via the nation-state) lead to political rights, which then turn into social rights (Marshall 1964). However, citizenship is increasingly ‘disaggregated’ (Benhabib 2004) as these rights are decoupled from membership in a single nation-state. In other words, an individual’s access to political or social rights may be based on factors other than their legal standing as a citizen. The exclusionary potential of these ‘mutations in citizenship’ (Ong 2006) can be observed most clearly when it comes to the welfare state, as even people with legal and political citizenship may be denied the welfare benefits central to social citizenship, depending on their position in the labour market (Somers 2008; Deneva 2013). Somers (2008) dubs this the ‘contractualisation of citizenship’, whereby the relationship between the state and citizen is reorganised according to the principles of the market, leading to ‘conditional’ rather than universal inclusion. Consequently, new ‘interior’ barriers to access now function alongside the overarching national barrier based on nativity or naturalisation status (Balibar 2004; Somers 2008).

Parallel to the disaggregation of citizenship rights is the denationalisation of the state. Jessop (2002) notes that the nation-state apparatus is being reorganised territorially and functionally. A key byproduct of this reorganisation is the loss, to some extent, of the sovereignty of nation-states as rules and/or decision-making powers are transferred upwards to supranational bodies, such as the European Union or downward to subnational governments such as states, counties, and cities (Sassen 2006). This is not to say that the nation-state is rendered powerless, as it still tries to assert tight control over entry and membership rights (Soysal 1994; Miller 2016). It does mean, however, that nation-states no longer unilaterally control access to political or social rights.1

Finally, in addition to these shifts in access to rights and to the changes in the levels of the state at which rights are available, how we think about social rights has changed tremendously over the last three decades. The Reagan/Thatcherite revolutions in the 1980s witnessed a major reformulation of the role of the state as a source of social protection, leading to an erosion of available social benefits (Jenson 2009). Social rights have also come under pressure from demographic changes. U.S.-based studies suggest that an increase in diversity leads to lower general social trust (Putnam 2007) and a decrease in social spending (Alesina and Glaeser 2004) – both phenomena have a negative impact on social rights. This erosion has been exacerbated by global economic downturns, provoking austerity measures across much of Europe.

Collectively, these changes seem exclusionary, shrinking access to social protection for all residents of a given state regardless of their citizenship status. However, there may also be new spaces of opportunity, particularly when it comes to social rights for non-citizens.
First, the redefinition of citizenship as a status afforded not just to those with civil and political rights, but rather to the economically active, may allow for the inclusion of working non-citizens in social welfare programmes. In the United States, for example, the Bureau of Labor Statistics reports that the immigrant labour market participation rate is actually higher than the native rate. Second, the denationalisation of the state into multiple levels of power and administration creates multiple potential access points to social rights, particularly in countries where political power is decentralised. Third, subnational governments may also differ ideologically from the prevailing ethos in the capital. Most studies of the relationship between neoliberalism and social policy focus on the national or even transnational level, but as national governments have shifted power and administrative responsibilities down to subnational actors, opposition political ideologies can gain traction. This could, in turn, lead to less (or, in some cases, more) restrictive access to social protection. Therefore, we ask if, in light of these competing changes in the structure of legal and political citizenship, can non-citizens achieve a level of social citizenship, namely access to health care?

2.1. The reconfigured state and social protection: the cases of Spain and the United States

In order to explore access to social protection within the reconfigured state we use Spain and the United States as cases. We do this for three reasons. While both are constitutionally two of the most decentralised states in the world, over the last few decades, the central government has devolved even more power over social policy to subnational governments. In the United States, this devolution was accelerated under a Republican administration as part of the 1994 ‘Contract with America’, and is seen as a way to limit the power of the federal government (Downs 1996). In Spain, devolution is a key outcome of the historic tension between Madrid and Spain’s ‘historic communities’, with some autonomous communities enjoying greater control over taxation (and social spending) than others.

Second, their patterns of immigration have interesting parallels. Although the United States has a longer history of immigration, today both are major immigrant-receiving nations: in 2016, 13.1% of the American population and 12.7% of the Spanish population were foreign-born (OECD 2017). In addition, given their proximity to much poorer nations just south of their borders, both countries struggle with relatively high levels of undocumented immigration. However, while 28.7% of immigrants in the United States are undocumented, (US Census Bureau 2012) this figure falls to an estimated 10–15% for Spain (Carrasco Carpio 2015).

Finally, both countries are interesting case studies for understanding the shifting dynamics of social protection for non-citizens as they both implemented major health care policy changes over the last few years. In the United States, the passage of the Affordable Care Act (ACA) in 2010 was meant to make coverage more available, but also afforded states significant discretion over how to administer these changes. In Spain, with the Royal Decree implementation in September 2012, the government moved to restrict non-citizen access to public health care in a bid to, in its words, curb health tourism. It too saw significant variation at the subnational level in the response to national policy changes.

However, there is a key difference between the United States and Spain: their very different approaches to the welfare state itself. While access to health care is universally
enshrined in the Spanish constitution, access to health care in the United States for working-age adults is primarily through employment. Prior to the enactment of the ACA, publicly funded health care was generally limited to the elderly (Medicare), the very poor (Medicaid) or vulnerable populations (children and pregnant women). Post-ACA, an estimated 11.4 million Americans are enrolled in health care plans through government-sponsored exchanges set up by the federal government (www.healthcare.gov) or individual states. As we write, a new round of changes is under consideration.

These national differences in social welfare reflect very different views about the role of the state as a social protection provider between Americans and Spaniards. For the 2010–2014 wave of the World Values Survey, Spaniards were more than twice as likely as Americans to believe that ‘The government should take more responsibility to ensure that everyone is provided for.’ While the United States would be classified as a ‘liberal’ welfare state, where limited, means-tested benefits and a strong role for the private sector are the norms. Spain’s focus on state-led universality in health care means it has more in common with Northern European social democratic welfare states (Esping-Andersen 1990; Gal 2010). This fundamental difference affects immigrants as well, for as Sainsbury (2006) notes, non-citizens are less likely to have access to social protection in liberal welfare states than in social democratic or corporatist states.

In light of these competing changes in the structure of legal and political citizenship, can non-citizens in Spain and the United States achieve a level of social citizenship through their access to the welfare state? In order to address this question, we draw both cross-national and subnational comparisons. At the national level, we explore how recent changes to health care policy have further restricted or opened up opportunities for non-citizens to gain access to care – all against the backdrop of the disaggregation of citizenship, denationalisation, and neoliberalism. Once we identify differences in access to care at the national and subnational levels, we then examine access to care in ‘high’ access and ‘low’ access cases. In the United States we focus on California (high) and Florida (low) and in Spain we explore non-citizen access to health care in Andalusia (high) and Madrid (low).4

In order to address the question of whether or not non-citizens can achieve a level of social citizenship, given changes in the structure of legal and political citizenship, our methodological approach is to build cases for comparison using a mix of legislative records, demographic and public opinion data, and public records (newspapers, press statements). As the focus of our analysis is on policy changes and shifting opportunities, we draw heavily from government documents and party statements to identify differences across and within cases. We also use data from each country’s respective statistical services (the U.S. Census Bureau and the Instituto Nacional de Estadística) and the World Values Survey (2010–2014 wave). With key demographic and policy data in hand, we draw from Cimas et al.’s (2016) accessibility index for Spain and extend it to the United States in order to make both cross-national and subnational comparisons. Media coverage and other secondary sources round out our analysis.

3. Immigrants and social protection in Spain

Access to health care in Spain is a constitutionally protected right. Articles 41 and 43 of the Spanish Constitution highlight that ‘public authorities shall maintain a public Social Security for all citizens guaranteeing adequate social assistance and benefits in situations...
of need, especially in cases of unemployment. Supplementary assistance and benefits shall be free. Since the passage of the Constitution in 1978, civil law has further cemented universal health care. Article 1.2 of Law 14/1986 of 25 April, General Health, ‘sets health provision as a universal benefit and it establishes as holders of the right to health protection and health care to all Spaniards and foreigners who have established their residence in the national territory’. Therefore, the right to health care is linked to an individual’s presence in the country rather than to the condition of affiliation in the Social Security System (Lema Añón 2014) or standing as a citizen. Law 16/2003 of 28 May, Of cohesion and quality of the National Health System, went even further, granting irregular immigrants the same access to health care as legal residents.

An important feature of the welfare state in Spain is its high degree of decentralisation, both on political decision-making and managing social programmes (Moreno 2009). Although the 1986 Act created a national system, it is administered by the 17 autonomous communities, in effect creating 17 distinct health services. By 2012, when major reforms to the health care system were proposed by the national government, the autonomous communities administered 90% of public health care funds (Legido-Quigley et al. 2013).

The universality of Spain’s health care regime came under political pressure with two key shifts in the late 2000s. First, Spain entered a deep economic crisis in 2008, and by 2012 nearly a quarter of the workforce was unemployed (OECD 2017). Public debt soared, and budgets imploded at both the national and subnational level. This put enormous pressure on politicians to enact cost-cutting measures. In 2013 alone, the national health and social services budget were slashed by 16.2% (Legido-Quigley et al. 2013).

The second key change was the right’s 2011 parliamentary election victory, which brought the conservative Partido Popular (PP) into power. Within months, the PP introduced Royal Decree-Law 16/2012, intended to ensure the sustainability of the National Health System and enhance the quality and safety of its services. The new law effectively undermined Law 16/2003, and instead recast access to health care for the non-authorised as emergency care for serious illness or accidents. There were two exceptions for vulnerable populations: pregnant women and minors would receive the same health benefits as Spanish citizens, regardless of their immigration status.

This law radically altered the right to healthcare in Spain, by making access an administrative condition rather than a universal right, and therefore leaving undocumented immigrants without health coverage. Despite this change, Prime Minister Mariano Rajoy insisted that health care in Spain was fully universal and more generous than in most European countries (‘Rajoy insiste … ’ 2015). Rajoy added that the health reform aimed to ‘bring order’ to a system being exploited by non-citizens, a position echoed by the Ministry of Health which claimed that the new law would curb ‘health tourism’ and the fraudulent use of health services (Spanish Ministry of Health, Social Services and Equality 2012). Critics argued that an estimated 500,000 immigrants would be without coverage after the reform’s implementation (Legido-Quigley et al. 2013). When the measure was put to a vote in the Cortes, the Spanish Parliament, no opposition party supported it. Nevertheless, it went into law on 20 April 2012.

As outlined in Tables 1 and 2 and detailed by Cimas et al. (2016), the policy response across Spain’s autonomous communities varied significantly, from outright refusal to implement the national reforms to full implementation. Two regions, Andalusia and Asturias, announced that they would continue to provide full services for irregular
immigrants. Eight established ‘special programmes’ to ensure that irregular immigrants had some access to care: Aragon, the Canary Islands, Catalonia, Navarre, the Basque Country, Extremadura, Galicia, and Valencia. On the implementation side, Castilla-La Mancha, strictly applied the reform, while five communities (Madrid, Baleares, Castilla y León, Murcia, and La Rioja) introduced legislation allowing undocumented immigrants some access to services in special cases (documented chronic illness, mental health, and...
infectious risks to public health). These different patterns of access also reflect different strategies of dissent: while some autonomous communities took legal action against the national government, others passed their own legislation or administrative measures in order to maintain undocumented access to the public health system.

What explains these different responses? Competing theories suggest economics, demographics, and ideology all play a part. In times of economic hardship and high unemployment there will be hardening attitudes towards immigrants (Walker and Smith 2002) and opposition to policies that redistribute resources to them (Hansen and Legge 2015). Demographics matter as places that become more diverse may also experience deteriorating levels of social trust (Putnam 2007) and support for the welfare state (Alesina and Glaeser 2004). Finally, cultural and ideological approaches to the welfare state and the role of government may shape political outcomes.

Table 2 reviews these alternative evaluations. The unemployment rate acts as an indicator for the state of the economy. Both the total foreign-born population and the change in the population of the foreign-born over the last decade are included. Political control is used as a proxy for values; the same World Values Survey data that revealed differences in opinion about the welfare state between Americans and Spaniards also shows differences in how self-identified members of Spain’s major political parties understand these issues (Table 3).

Given the literature, we might expect high unemployment autonomous communities to have low access. However, there is variation among the high-access cases. The government of Andalusia, where the unemployment rate was the highest in the nation at the time, strongly supported generous access to care, as did Navarre, which had the second-lowest unemployment rate in the country (Table 2). We might also expect those regions where the foreign-born population is high and/or has changed rapidly over the last decade to resist extending social rights to foreigners most strongly. To some extent this seems to be the case – places with larger immigrant populations are more likely to be low-access regions than places with relatively small foreign-born populations. A clear dividing line, however, is partisanship. Most of the low-access autonomous communities were controlled by the conservative PP at the time – the same party that proposed the Royal Decree in the first place. Conversely, all of the autonomous communities that were controlled by opposition parties allowed medium or high levels of access to irregular immigrants. That said, there are some outliers: Galicia and Valencia, PP strongholds, offered extensive resources to irregular immigrants.

In the following sections we explore the divergent dynamics of two key autonomous communities at opposite ends of the policy spectrum: Andalusia and Madrid.

Table 3. Views on responsibility for social provision by party affiliation in Spain.

<table>
<thead>
<tr>
<th></th>
<th>PSOE</th>
<th>PP</th>
<th>IU</th>
<th>BG</th>
<th>CC</th>
<th>PNV</th>
<th>CIU</th>
<th>ERC</th>
<th>NaBai</th>
<th>UPyD</th>
<th>Undecided</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–3 (Govt should take more responsibility)</td>
<td>38.8</td>
<td>31</td>
<td>53</td>
<td>100</td>
<td>49</td>
<td>74.4</td>
<td>44</td>
<td>41.1</td>
<td>18.2</td>
<td>46.1</td>
<td>43.5</td>
</tr>
<tr>
<td>4–7 (neutral)</td>
<td>50.4</td>
<td>49</td>
<td>39</td>
<td>0</td>
<td>51</td>
<td>25.6</td>
<td>47</td>
<td>39.5</td>
<td>81.8</td>
<td>45.2</td>
<td>45.9</td>
</tr>
<tr>
<td>8–10 (People should take more responsibility)</td>
<td>7.6</td>
<td>17</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>8.9</td>
<td>19.4</td>
<td>0</td>
<td>8.7</td>
<td>8.5</td>
<td></td>
</tr>
<tr>
<td>(N)</td>
<td>205</td>
<td>304</td>
<td>54</td>
<td>2</td>
<td>2</td>
<td>16</td>
<td>21</td>
<td>12</td>
<td>5</td>
<td>14</td>
<td>189</td>
</tr>
</tbody>
</table>
3.1. Implementation in Andalusia and Madrid

When the decree was issued in April 2012, Andalusia, perhaps more than any other autonomous community, was in the depths of economic crisis. Unemployment reached 28% in 2010, just before the PP swept into power in Madrid. The Andalusian government’s budget was hemorrhaging money. While, from 2010 to 2014, health spending in Spain fell by 10.3%, in Andalusia the percentage was higher (17%) earning it the distinction of being the community where spending decreased the most (Díaz Pérez 2014). Given these conditions, it would not have been surprising if the regional government complied with the national decree. Instead, the Andalusian Health Service (AHS) announced that it would continue service provision to all non-citizens, regardless of their immigration status for humanitarian reasons. Specifically, they argued that they had to continue to serve the undocumented because it would ‘prevent further public health problems and the spread of diseases already eradicated in the community’.

The health service’s commitment to universal coverage reflects the broader political leanings of this autonomous community. The region’s politics have been dominated by left-wing parties since Spain returned to a democracy in 1975. Beyond ideology, the AHS also had institutional arguments for maintaining the universality of their services: the Statute of Autonomy and the Health Law of Andalusia. Article 2 of this law lists that all actions on health protection within the Andalusia Public Health System should be guided by the principle of universality and equity in health standards and equality. Article 3 states that both Spaniards and foreigners residing in any town in Andalusia are eligible for the rights recognised by the law.

In contrast to Andalusia, the PP-controlled government in Madrid did not value universality as a key principle in its response to the new health care directive. Instead, the Madrid Health Service specified categories of care it would make available to key ‘vulnerable’ groups who were not officially registered as residents and/or were not authorised to live in Spain:

1. Emergency care for a serious illness or accident-free of charge. If follow-up is needed, the patient is responsible for paying or a bill will be sent to the country of origin under bilateral Social Security agreements signed by Spain and third countries. Pharmaceutical benefits are not included.
2. Pre and post-natal care
3. Foreigners under 18.
4. Refugees or individuals requesting refugee status
5. Victims of human trafficking who have been authorised to stay in Spain.
6. Additional cases that pose a health risk to the rest of the population.

The decision to deny primary coverage for the majority of the region’s undocumented prompted heated debate. Esperanza Aguirre, the then-President of Madrid, argued that while the law called for the health system to serve all citizens, ‘it is clear that we cannot serve the citizens of the whole world, because that would not be possible’ (RTVE 2012). By contrast, over 1600 doctors announced that they would continue to treat patients regardless of immigration status as part of an initiative launched by the Spanish Society of Family and Community Medicine – and over a quarter of the participating doctors were in Madrid (‘Sanidad gratuita’ 2012).
Why did Madrid implement these changes? Although its unemployment rate was below the national average, Madrid did see a major increase in its foreign-born population, which may have worked to turn public opinion against using public resources to serve foreigners. The perception that medical tourists from other parts of Europe were disproportionately coming to Spain to use its services also led the public to want to tighten its belt. In addition, Madrid has long been a PP stronghold. It would have embarrassed those in power if Madrid pursued policies that directly opposed the national government.

4. Immigrants and social protection in the US

Unlike Spain’s universal approach, access to health care in the United States is largely a function of the individual’s stage in the life cycle and their socioeconomic status. The federal government provides coverage for the elderly (Medicare), the very poor (Medicaid), and some vulnerable groups (children, pregnant women). For most Americans of working age, however, access to health care is a discretionary employee benefit, not a guaranteed right via the government. Subsequently, there tends to be significant variation in employee coverage based on the sector of employment, with low-wage non-union service jobs having below-average levels of coverage and large, multinational companies offering comprehensive coverage. In 2013, a year before the ACA went into effect, over 18% of Americans reported that they had no insurance coverage (Kaiser Family Foundation 2014).

While the pre-ACA system lets many Americans fall through the cracks, access to health care was even more precarious for non-citizens. The uninsured rate for immigrants was and is consistently higher than that for citizens. This is due to several factors. First, although the workforce participation rate for immigrants is higher than that for natives, immigrants disproportionately work in low-paying service sector jobs that do not offer employer health coverage. Second, under the 1996 Personal Responsibility and Work Opportunity Act (PROWRA), only non-citizens with permanent residency (colloquially referred to as ‘green card’ status) were eligible for federal health benefits. This meant that many immigrants who would have been eligible for Medicaid given their low-wage service-sector jobs were barred from public coverage. Finally, while the United States has a large undocumented population, estimated at around 11–12 million, the undocumented are explicitly barred from accessing federal health benefits (with some exceptions for vulnerable groups). Therefore, despite their deep integration into the American labour market, non-citizens in the United States still faced steep hurdles to public health coverage.

The enactment of the ACA in 2010 was meant to address the significant gaps in health coverage. First, it mandated that individuals carry coverage. Second, in order to facilitate the coverage requirement, the government called for the creation of health exchanges, either at the state level or through the federal HealthCare.gov portal. The ACA also carried provisions regulating how insurers could treat pre-existing conditions and the extent to which children could be covered by their parents’ insurance. Finally, it sought to expand coverage through the expansion of Medicaid. For all of its attributes, however, the ACA was clearly not a programme designed to benefit non-citizens without permanent residency; in fact, it had explicit guidelines for restricting non-citizen access based on their immigration status.

Reaction to the ACA was starkly partisan. The legislation passed without a single vote from Republicans, and was the target of lawsuits filed by several Republican-controlled
states. Once the ability to opt out of the Medicaid expansion was confirmed by the courts, many did. Today, 19 states have not expanded access to care via Medicaid.\(^6\)

As the ACA gave states the opportunity to opt out of certain provisions, serious policy differences began emerging at the subnational level (see Table 4). First, states could opt to expand Medicaid coverage to their poorer populations by loosening the eligibility requirements. In addition, states could choose to set up their own health care exchanges, or they could default to the federal government’s market, www.healthcare.gov. Finally, states could decide to what extent they wanted to loosen the eligibility requirements for key programmes targeting vulnerable populations, such as the federal Children’s Health Insurance Program (CHIP).

As with Spain, patterns of high and low access began to emerge. First, states with foreign-born populations above the national average are more likely to be high access than states with smaller immigrant populations (Table 5). This is in contrast to Spain, where high-access autonomous communities tended to have lower than average immigrant populations. This difference is likely explained by the fact that in the U.S., states with large immigrant populations are also states with longstanding, multi-generational immigrant communities. As a new destination, Spain lacks politically powerful immigrant communities. However, Spain and the United States are similar in that partisanship also seems to explain policy differences: high-access states are uniformly under Democratic control and low-access states are almost uniformly Republican (Table 5).

### 4.1. Implementation in California and Florida

With the passage of the ACA, California went above and beyond the federal mandate and put in place some of the most generous state-level policies in the United States. First, policy-makers extended federal and state supplementary benefits, primarily to vulnerable populations. Second, they opted to expand Medicaid. By changing the income eligibility limit to 138% of the federal poverty level (about $33,500 for a family of four), California extended comprehensive health care to an additional 4.7 million Californians via Medi-Cal (the state’s Medicare programme). California also set up its own state insurance exchange, Covered California. While the undocumented were not eligible for full coverage under the federal rules, they were eligible for emergency treatment, maternity care, and state-funded long-term care. California is also one of the five states that provide state medical assistance to legal immigrants who do not qualify for federal programmes.

California’s policy interventions had an appreciable effect on overall health care coverage. According to the Department of Health and Human Services (HHS) (Smith and Medalia 2015), the percentage of Californians without health coverage fell from 21.6% in 2013 to 15.3% in 2014. In addition, over three million Californians were able to gain access via Medicaid or the CHIP expansion. However, under federal law, California’s undocumented population was still largely unable to take advantage of most ACA-related programmes. While they currently make up the bulk of uninsured Californians (an estimated 1.4–1.5 million people), if they were eligible for Medi-Cal, almost half would meet the income qualifications (McConville et al. 2015). To some extent, programmes targeting vulnerable populations such as children and pregnant women provide some level of coverage, but the social safety net is still relatively threadbare.
Prior to the enactment of the ACA, Florida had one of the largest uninsured populations in the country, albeit with significant variation between groups. According to a 2013 report by the Kaiser Family Foundation, 20% of the population – 3.8 million people – were uninsured in 2011, the fourth highest rate in the country. Pre-ACA,
Table 5. Economic and political dynamics of states and access to health care.

<table>
<thead>
<tr>
<th>State</th>
<th>Level of access to public health</th>
<th>Unemployment (2)</th>
<th>Foreign-born population in 2010–2014 (3)</th>
<th>Change in foreign-born population, 2000–2010 (%)</th>
<th>Political control of state government 2010 (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Low</td>
<td>9.5</td>
<td>3.5</td>
<td>75.0</td>
<td>Republican</td>
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Notes: The column ‘level of access to public health’ is based on Table 4. States with 0–1 programmes are coded as ‘Low’, states with 2–3 programmes are coded as ‘Medium’ and states with 4–5 programmes are coded as ‘High’.

Florida did provide some state-backed coverage for what are considered ‘vulnerable’ communities, most notably, children. Florida Healthy Kids, created in 1990, was a public–private partnership that extended health care to low-income children that did not qualify for Medicaid. It was merged with a number of other state initiatives to create Florida Kid Care (FKC) in 1998. FKC targeted families that earned too much to qualify for Medicaid, but not enough to purchase market-rate insurance. On average, FKC cost between $15 and $20/month at the subsidised rate, and families that did not meet income requirements could buy into the programme at a rate between $205 and $299 per month (depending on the level of coverage). The other key requirement was for citizenship status: only citizens and ‘qualified non-citizens’ were eligible. The latter group did not include the undocumented.

Despite its high levels of uninsured, Florida, under the control of a Republican Governor and state legislature, was opposed to the ACA. In 2010, Florida and 25 other states challenged the constitutionality of the law in court. With the passage of the ACA, Florida opted out of several policies that could dramatically extend coverage for state residents. First, the state decided not to set up its own health care exchange; instead, Floridians were directed to the federal government’s exchange HealthCare.gov. Florida also opted out of expanding Medicaid. However, even under the existing Medicaid programme, the eligibility rules in Florida are far less generous than in California: only families that make less than 34% of the poverty level – as opposed to over 138% in California – qualify (Garfield and Damico 2015). Subsequently, only an additional 300,000 Floridians gained health care access through federal programmes like Medicaid and CHIP. In contrast, the federal Department of HHS estimates that had Florida expanded Medicaid coverage, over 848,000 residents would have gained additional coverage.

Nevertheless, according to HHS, the ACA has facilitated the expansion of health care in Florida significantly. In 2015, 1.55 million Florida residents were enrolled in plans via HealthCare.gov (Smith and Medalia 2015). Of enrollees, 72% paid less than $100 per month after tax credits. Families USA, an NGO that advocates for expanding Medicaid and ACA access, argued that if Florida accepted Medicaid expansion it would hugely benefit low-income working families, over half of whom were uninsured in 2014 (defined as $27,310 for a family of three) (Mahan and Stoll 2014). Notably, sales, food service, office administration, cleaning and maintenance, and construction were the occupations with highest uninsured rates – and these are the same sectors of the labour market where immigrants are over-represented. Unfortunately, with no extension programmes that Florida’s significant undocumented population could benefit from, and no state-managed exchange that they could potentially buy into, the ACA had a relatively limited effect on Florida’s immigrant population, particularly compared to California.

5. Conclusions

Analyses of social protection generally focus on services provided by national governments. In this article, we call attention to the increasingly prominent role of actors operating at other scales of governance, including cities, states, provinces, and supranational actors and the need to better understand how their activities complement or substitute for what nations no longer provide (Dobbs and Levitt 2017). We also stress the need to go beyond health to look at how the provision of other forms of protection, such as
education, legal rights, or pensions are being delegated to subnational and supranational actors.

The health reforms we have described in Spain (2012) and the United States (2010) clearly created points of disagreement between national and subnational governments. However, they also created opportunities for the inclusion of non-citizens under the umbrella of state-backed social protection. We characterise these opportunistic gaps as ‘grey zones’, places where inclusion is possible even in the face of legislation that was intended to exclude. These grey zones are surprising in two important ways. First, they are largely possible due to processes that are often seen as disenfranchising: the denationalisation of policy and the disaggregation of citizenship. Second, these grey zones tend to open up regardless of the nature or intent of national reforms. While the primary intent of the Spanish legislation was to block access to care among undocumented immigrants, and the primary intent of the American ACA was to expand access to health care for citizens and residents, both prompted subnational responses that ultimately included individuals excluded from coverage.

Although we demonstrate that grey zones exist, we also show that there is significant variation in the extent to which subnational governments seek to take advantage of them. While the literature points to multiple reasons why this may be, in the case of non-citizens and health care coverage, differences in political ideology, as expressed through partisanship seems to be a consistent explanatory factor. The role of political ideology is particularly striking in Spain, where Andalusia – traditionally one of the country’s poorest regions – was one of the most generous in protecting access to health care for irregular migrants. And unlike California, Andalusia does not have a well-organised, politically powerful immigrant community that could successfully demand greater coverage for non-citizens. Instead, this autonomous community has not only been a consistent supporter of the Spanish Socialist Party (PSOE) but has institutionalised its universalistic principles, giving politicians clear local guidelines to follow when faced with challenges from the national government.

Since we know that grey zones exist, another question may arise: how stable are they? In Spain, for example, the national government under the PP has sought to reclaim some of the powers divested to the autonomous communities. In the United States, the Department of Justice under the current Trump administration has sought to cut funding to ‘sanctuary cities’, places where disagreements over federal immigration policy has led to alternative local policies of immigration enforcement. While in both cases, many questions of power and control are answered in the courts, it seems unlikely that determined state and local actors will give up on carving out grey zones. Instead, as these issues are raised and contested, grey zones may expand or shrink depending on political factors such as the party in power at the national and subnational level. We do not, however, see them disappearing completely, especially in cases where there is some constitutional protection for the devolution of power to subnational governments.

Ultimately, grey zones created by changes at the national level create opportunities for localised citizenship, where rights are not determined by birthplace or labour market status, but by spatial residence. While this may seem less surprising in politically liberal subnational territories like California and Andalusia, even politically conservative places are not immune. In Spain, the autonomous community of Galicia, a traditional PP stronghold, defied the national government by continuing to offer services to irregular migrants.
In the United States, Georgia has surprisingly broken with most of its neighbours in the generally conservative South to offer some services to non-citizens not generally eligible for federal health programmes. Surprisingly, Georgia is a ‘new destination’ within the United States: unlike California, long a magnet for immigrants, immigration to Georgia (and other neighbouring states) is a relatively new phenomenon. While these cases may seem to be outliers, they warrant further investigation to deepen our understanding of the ways in which grey zones liberalise access to social protection in politically conservative subnational locales which may, in turn, generate new insights into state-society relations and theories of political representation.

Notes

1. Spain has also experienced a degree of denationalization upwards, as its membership in the European Union carries with it non-negotiable obligations when it comes to social policy and the rights of EU citizens living in Spanish territory.
2. For notable exceptions, see Yeates (2006), Harmes 2006, for work on neoliberalism and multilevel governance. Harmes, in particular, notes that neoliberalism is a key driver of the push to decentralize the welfare state. See López-Santana (2015) for a contemporary comparative analysis of the politics of decentralization in Europe and the United States.
3. Although it is European, Spain is often coded outside of the social democratic or corporatist paradigm as a Mediterranean welfare state (Gal 2010). Mediterranean welfare states have three key features: fragmented social protection, particularistic welfare states, and universal public health coverage complemented by a thriving private health care market (Ferrera 1996). While the Mediterranean welfare states certainly have their limitations vis-à-vis the social democratic states of Northern Europe, the universality of the public health care system is an interesting commonality and puts it in sharp contrast to liberal welfare states like the U.S.
4. Although Catalonia also has a significant immigrant population, and is in many ways similar to California, the multi-level governance causes division and confrontation in a context of nationalist and separatist policies. Thus, decisions like the exclusion of undocumented immigrants from health system can become a factor of political affirmation against the state decisions, so this significantly should complicate the analysis (Moreno Fuentes 2015).
5. Circular of the Division of Management and Health Outcomes Assessment, under the Directorate General of Health Care of the Andalusian Health Service, of 3 September 2012 (Circular de la Subdirección de Gestión y Evaluación de Resultados en Salud, dependiente de la Dirección General de Asistencia Sanitaria del Servicio Andaluz de Salud, de 3 de septiembre de 2012.) cited by (Foro para la integración social de los inmigrantes 2012)
7. The ACA did not go into full effect until 2014.
8. The household income eligibility rate was defined as between 133% and 200% of the federal poverty benchmark.

Disclosure statement

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