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Systemic Racism and COVID-19: Vulnerabilities with the U.S. Social Safety Net for Immigrants and People of Color

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America has a mythologized reputation as an accommodative "melting pot" nation that welcomes individuals from all races and countries seeking improved quality of life and reduced material hardship. However, our U.S. social welfare system is more broadly characterized as underdeveloped, restrictive, and exclusionary, especially toward immigrants and people of color. Public health benefits (e.g., Medicaid), food assistance programs (e.g., SNAP), rental assistance (e.g., HCV/Section 8), and cash assistance (e.g., TANF) are oftentimes restricted for immigrants and racial minorities, making them more vulnerable to material hardship and more exposed to pandemic conditions under COVID-19. Moreover, these welfare restrictions are oftentimes rooted in negative social construction and unflattering stereotypes of Black and Latine people. This paper connects deliberately racialized social welfare barriers, developed under the banner of "welfare reform" in the 1990s, to contemporary difficulties accessing benefits by minority groups, and subsequently heightened vulnerabilities around COVID-19. We suggest areas for improvement in social welfare policy development to better address systemic racism and COVID-19, and deepening inequalities from lack of access to the social safety net for immigrants and racial minorities in the U.S

Keywords: Racism, Systemic Racism, COVID-19, Social Welfare, Welfare Reform, Social Equity, Immigration

Heightened exposure and vulnerabilities of the COVID-19 pandemic abound for under resourced and low-income populations in the United States. These COVID-19 vulnerabilities are a direct result of inequalities in health access, housing, income, and wealth that disproportionately impact immigrants and people of color (POC) (Ogedegbe et al. 2020). As a result, material hardship and increased likelihood of illness and death from COVID-19 go

hand-in-hand in the U.S. It is low-income POC individuals residing in disinvested and segregated places that bear the brunt of the COVID-19 pandemic and face widening inequalities in society due to pandemic conditions (Ogedegbe et al. 2020). Unfortunately, the U.S. social safety net, which could potentially provide material relief and reduce COVID-19 have not proven effective as anti-poverty measures during the pandemic conditions (Safawi and Floyd 2020). The context of paltry social welfare benefits and inadequate social safety net for racial minority and immigrant populations can be traced directly back to our founding history of White supremacy, characterized most pointedly by chattel slavery and Jim Crow racial segregation (Katz 1996; Trattner 2007; Minoff 2020). With the ending of de jure Jim Crow systems of overt racist segregation in the 1960s, any glimmers of inclusive multi-racial democracy remain in the shadows today as we face the COVID-19 pandemic under lingering conditions of structural racism. Important lessons for enhancing social equity and racial justice remain for both policymakers and administrators of social welfare programs in the U.S. during the COVID-19 pandemic and beyond.

In more recent decades, social welfare policy in the U.S. has been defined by "welfare reform" (Trattner 2007; Soss, Fording, and Schram 2011), placing new restrictive burdens and conditions on low-income families in order to receive social welfare benefits like cash, food and medical assistance (Katz 1996; Trattner 2007; Soss, Schram, Vartanian, and O'Brien 2001; Soss, Fording, Schram 2011). These developments have occurred due to individualist political culture favoring private charity and self-sufficiency over governmental remedies, but also primarily because the targets of social welfare programs themselves have been cast in decidedly unflattering light by media and policymaking elites (Gilens 1999; Soss, Fording, and Schram 2011; Feagin 2020). The dominant lens of "undeservingness" toward welfare receipt in the U.S. is rooted partially in negative stereotypes of non-White people and immigrants as "deviant" and lacking proper work ethic and personal responsibility (Schneider and Ingram 1993; Gilens 1999; Soss, Fording, and Schram 2011; Feagin 2020; Minoff 2020). Put another way, racism and White supremacy define much of the history and contours of the U.S welfare state and continue to motivate our current slate of social welfare policies (Gilens 1999; Soss, Fording, and Schram 2011; Carten 2016; Michener 2020; Minoff 2020).

In turn, low-income families, disproportionately those from POC and immigrant backgrounds are more likely to feel the brunt of reduced social welfare access, and henceforth the various negative health and financial ramifications of the COVID-19 pandemic. This article traces our history of White supremacy and social welfare policymaking in the U.S., with particular attention given to the last quarter century of federal-level reforms, and subsequently how modern welfare restrictions have made low-income families of color and immigrant families more vulnerable to COVID-19 pandemic conditions. We include a discussion of potential policy reforms to our existing social safety net for improved efficiency, effectiveness, and equity during times of pandemic stress and life under more normal societal conditions.

In the following sections, we will highlight four primary means-tested social welfare programs in the U.S. and their inadequacy to meaningfully alleviate material hardship during the COVID-19 pandemic, while simultaneously increasing exposure to pandemic conditions, in particular for low-income POC and immigrant populations: 1) Temporary Assistance to Needy Families (TANF); 2) Supplemental Nutrition Assistance Program (SNAP); 3) Housing Choice Vouchers (HCV)/Section 8 rental assistance; and 4) Medicaid. As discussed above, the design and implementation of key social welfare programs in the U.S. are rooted partially in racism and negative social construction of welfare beneficiaries, and that the inadequacies

and restrictive nature of social welfare programs have arguably become more glaring during the COVID-19 pandemic. We will demonstrate how the design of U.S. social welfare programs hinders the alleviation of material hardship during COVID-19 and increases exposure to COVID-19 vulnerabilities among low-income POC and immigrant populations in particular.

Racism, Social Welfare, and COVID-19 in the U.S.

Early Origins

The transformation from original indigenous habitation to modern U.S. society is scarred by the forces of racism and White supremacy in the form of European colonialism and "manifest destiny" – propelled by the racial frame of White superiority over "savage" indigenous and non-White populations like Native Americans, Asians, Blacks, and Latines (Feagin 2020). The founding principles of individualism and freedom to openly pursue one's happiness and fortune were contradicted by overtly racist structures and systems that actively oppressed non-White people (Kendi 2016; Feagin 2020). The Federalist Papers, U.S. Constitution and virtuous narratives of liberty and independence were contrasted with Native American genocide, chattel slavery of Black people, alongside exploitation and oppression of Asian and Latine populations. Themes of POC genetic and cultural inferiority and "undeservingness" of rights and legal protections pervaded early America and remain omnipresent in contemporary U.S. society (Kendi 2016; Feagin 2020).

America's early post-indigenous settlers were comprised primarily of White European immigrants, who overwhelmingly held overtly racist views of non-White peoples, and relatedly were also adherents to Protestant principles underlying British Poor Laws (Katz 1996; Trattner 2007). That is, social welfare provision should primarily be left to private charity and religious institutions, and only allocated generously or unconditionally to more "deserving" populations, such as poor children or the elderly (Daniels 2002; Fox 2012; Trattner 2007). Private, localized poverty governance, including austere and discriminatory social welfare provision, would define much of early America. (Trattner 2007; Goldberg 2007).

Continuing from these early origins, citizenship rights and privileges throughout much of American history have been fundamentally determined by skin color, casting non-Whites as genetically and culturally inferior, resulting in overtly racist policies of oppression and apartheid that lasted well into the 1960s (Mills 1997; Kendi 2016; Feagin 2020). The idea that racial minorities, especially indigenous and Black people, were inherently savage, criminogenic and lacking a proper work ethic pervaded early America and arguably remains entrenched as dominate social constructions within society today as part of the White racial contract (Pierce et. al. 2014; Alexander 2012; Peffley and Hurwitz 2010; Mills 1997). Fueled by early dehumanizing perceptions and negative social constructions of vulnerable populations in colonial times, the U.S. welfare state has remained ungenerous and underdeveloped relative to other industrialized democracies, and targets of social welfare benefits have routinely been cast as unfairly benefitting deviant POC, undeserving of public assistance or protection from economic precarity (Trattner 2007; Watkins-Hayes 2009; Soss, Fording, and Schram 2011; Michener 2020).

U.S. Welfare State Development

Although arguably underdeveloped relative to other industrialized democracies, a formal welfare state did eventually develop in the U.S during the New Deal Era. In response to the Great Depression and widespread unemployment and poverty, federal-level welfare response

was born with the Social Security Act of 1935. The legislation guaranteed social insurance payments to elderly and disabled individuals, and additional policies included workforce development initiatives to curb unemployment and put individuals to work on infrastructure and other public projects. Although heralding a shift toward systematic federal-level welfare provision, the protections of the New Deal Era oftentimes excluded POC and immigrants from participation. For instance, Social Security excluded domestic and agricultural workers, who were overwhelmingly Black and immigrants (Trattner 2007). Workforce development initiatives were segregated by race and poorly implemented in minority communities. Put another way, negative social construction around "deservingness" shaped the first ventures of the U.S. welfare state during the New Deal (Pierce et. al. 2014; Goldberg 2007).

For one relatively brief period in the 20th Century, known as the Great Society with its accompanying War on Poverty of the mid-1960s, there was a marked liberalizing shift in U.S. social welfare policy combined with more inclusive civil rights efforts (Katz 1996; Trattner 2007). De jure Jim Crow segregation was broadly eliminated through a series of civil rights laws, namely the Civil Rights Act of 1964, the Voting Rights Act of 1965, and the Housing Rights Act of 1968. Concurrent with more inclusive civil rights legislation, the welfare state was also expanding into areas like food assistance and housing assistance, along with passage of the Medicaid and Medicare programs (Katz 1996; Trattner 2007). During the ensuing years with diminished overt racial discrimination, POC, especially Black citizens markedly increased enrollment in social welfare programs that were previously restricted on racial grounds (Carten 2016). This heightened utilization of social welfare programs among POC populations generally perceived to be deviant and undeserving of public assistance was a welcome development for those inclined toward inclusion and social justice. However, the incorporation of racial minorities into the welfare state, arguably led to a backlash and movement toward welfare retrenchment that still reverberates through restrictive social welfare policies today (Gilens 1999; Soss, Fording, and Schram 2011), ultimately yielding heightened vulnerabilities under contemporary COVID-19 pandemic conditions.

Race and Welfare Retrenchment

As quickly as the welfare state expanded to accommodate historically excluded populations, retrenchment and strictly limiting welfare benefit access for BIPOC rooted in negative social constructions was just as swift and decisive. Typifying the national shift toward racialized welfare state retrenchment then California Governor, Ronald Reagan, came to national prominence in the Republican Party with an explicit anti-government ideology hostile to both racial minorities and the welfare state, and purposeful conflation of the two. On the presidential campaign trail Reagan would tell exaggerative stories about the "welfare queen", a fictional single mother from the Southside of Chicago that lived an undeservedly lavish lifestyle from fraudulent income derived from government benefits (e.g., driving multiple pink Cadillac automobiles derived from cash assistance programs) (Hancock 2003; Hancock 2004; Gilman 2013). Although race might not have been explicitly invoked by Reagan and other conservative elites, the racial coding associated with Chicago's Southside and flagrant welfare fraud was not lost on White voters (Hancock 2004; Gilman 2013), who rewarded Reagan handsomely at the presidential ballot box twice in the 1980s. Although fundamental policy changes to the U.S. social welfare system toward restrictionism were blunted during Reagan's Presidency, this unflattering racialized characterization of welfare beneficiaries as irresponsible, deviant, lacking work ethic, and broadly undeserving of benefits came to dominate social welfare debates and policymaking in subsequent decades (Gilens 1999; Soss

et al. 2001; Soss, Fording, and Schram 2011; Carten 2016; Minoff 2020).

The culmination of "welfare reform" occurred in bipartisan fashion in 1996 under Democratic President Bill Clinton and Republican-led Congress with passage of the Personal Responsibility Work Opportunity Reconciliation Act (PRWORA). As the legislative name implies, most importantly, PRWORA ceased the open-ended entitlement to cash assistance found under Aid to Families with Dependent Children (AFDC) through instituting block grant funding and placing new strict conditions on cash assistance by establishing work requirements for able-bodied recipients. Under the newly formed Temporary Assistance to Needy Families (TANF) cash assistance policy, additional limitations were put in place like a 60-month time limit on cash benefits, family cap provisions, and sanction penalties for failing to adhere to program rules (Soss et al. 2001; Trattner 2007). Additional restrictions and conditions in the 1996 legislation, such as general work requirements, were added to the federal food assistance program, Supplemental Nutrition Assistance Program (SNAP). Moreover, most legal immigrants arriving after PRWORA legislation was enacted were barred from receiving all welfare benefits for their first five to seven years of U.S. residency depending on the particular welfare program. Undocumented immigrants were barred from receiving benefits entirely.

Thus, it is this newly restrictive and racialized welfare regime established 25 years prior that sets the contours of relief under the COVID-19 pandemic today. It is our contention that workfare reforms to cash and food assistance programs, and additional deficiencies in the U.S. social safety net around housing and healthcare benefits like Housing Choice Vouchers (HCV)/Section 8 rental assistance and Medicaid, are leading to magnified vulnerability and hardship around COVID-19, most acutely felt by POC and immigrant populations, yielding ever widening racial inequalities and injustices. In the following section we discuss four primary welfare programs in the U.S., highlighting program and administrative deficiencies that are magnified during the COVID-19 pandemic. Then in later sections we highlight potential remedies to enhance social welfare provision in the U.S.

Race, COVID-19, and U.S. Social Welfare Policies

This section of the paper examines how the four primary social welfare programs increase the vulnerability of low-income families to COVID-19 exposure and hardships: TANF, SNAP, HCV/Section 8, and Medicaid. The specific policy contours of these social welfare programs are summarized in Table 1.

TANF and SNAP

Established in 1996 under PRWORA, Temporary Assistance to Needy Families (TANF) represents the primary cash assistance program for low-income families in the U.S. The previous redistributive program of relatively unconditional, open-ended cash benefits known as Aid to Families with Dependent Children (AFDC) was the focal point of racialized critique (e.g., welfare queens and undeservingness) and targeted workfare reforms in the mid-1990s (Soss et al. 2001; Fellowes and Rowe 2004; Soss, Fording, and Schram 2011; Butz 2016; Minoff 2020). While there is some variation at the state or county-level in how TANF functions, the core programmatic aspects of workfare implementation remain the same. Federal rules mandate that able-bodied TANF clients participate full-time in allowable work-related activities of at least 30 hours per week to receive benefits (Soss, Fording, & Schram 2011; Butz 2016). States and localities have some flexibility in exempting a small fraction of the TANF client pool from workfare rules for "hardship" reasons, but the underlying policy directives mean that most TANF clients must engage in full-time work activities or risk being

punished when failing to remain in compliance with program rules (Kalil, Seefeldt, & Wang, 2002; Riccucci, 2005; Soss, Fording, & Schram, 2011).

Table 1. Summary of U.S. Social Welfare Policies and Restrictions

	TANF	SNAP	HCV/Section 8	Medicaid
Work Requirements	Full-time work activities required	General work requirements	Recipients pay 30% of AMI	States apply for work requirements
Income Eligibility Thresholds	Varies by state; generally below poverty level	<Gross income 130% of poverty; <Net income 100% of poverty	< 50% Local AMI	<Gross income 133% of poverty
Immigration/ Citizenship Status	5-year federal waiting period for most immigrants	5-year federal waiting period for most immigrants	U.S. citizen/ certain immigrant designations	5-year federal waiting period For most immigrants
COVID-19 Access Vulnerabilities	High	Medium/High	High	Medium/Low

Note: The requirements for social welfare programs are complex and can vary from state-to-state. The information in this table is based on the federal requirements. In addition, the requirements can vary from recipient to recipient due to individual factors, for example marital status, age of children, etc. This is not a complete list of requirements for each program, but represents an outline of program contours and vulnerabilities to accessing benefits.

This paternalistic logic of TANF extends to similar reforms made to the nation's primary food assistance program - Supplemental Nutrition Assistance Program (SNAP) that were also added in the 1996 PRWORA legislation. While not as strict or encompassing as TANF, general work requirements now accompany SNAP food assistance benefits for all participants age 16-59, with additional work requirements for able-bodied adults without dependents (ABAWD) aged 18-49 (FNS 2021). For instance, ABAWD participants can only receive SNAP benefits for 3 months total in any 36-month period until meeting more stringent work guidelines of 80 hours per month (FNS 2021). SNAP benefits can also be denied to otherwise eligible individuals if they willingly quit a job or refuse an offer of employment. Unlike TANF with a strict 60-month upper limit of benefit receipt, SNAP benefits can be received in more open-ended temporal fashion if program rules are being adhered to. That said, the theme of conditionality and "forcing" labor participation for relatively meager program benefits runs throughout both TANF and SNAP, leading to greater exposure to COVID-19, likely yielding increased inequalities in health and wealth outcomes. During 2019, the Trump Administration sought to make it harder for states to exempt ABAWDs from SNAP work requirements, even within high unemployment areas, putting hundreds of thousands of able-bodied SNAP recipients at even greater risk of losing benefits (Stanglin

2019).

Voluminous research since the 1996 workfare reforms demonstrates that social welfare restrictions in program eligibility, sanction penalties, and reduced cash benefit levels have a stark racial bias, and more likely to be levied when serving non-White populations (Watkins Hayes 2009; Soss, Fording, and Schram 2011; Carten 2016). For instance, in street-level implementation, Black TANF participants have been found to be sanctioned or penalized by case managers at significantly higher rates than White counterparts, oftentimes resulting in total loss of cash benefits (Soss, Fording, and Schram 2011; Watkins-Hayes 2009; Monnat 2010; Schram, Soss, Fording, & Houser 2009). Theories of street-level bureaucracy emphasize the role of frontline discretion in selectively administering benefits and punishment, with social categories like race and gender oftentimes shaping street-level interactions and outcomes (Lipsky 1980; Nothdurfter & Hermans, 2018; Butz & Gaynor 2022). When welfare program clients face negative stereotypes in society, this can leak into the actions taken by frontline administrators, such as police officers, teachers, or case managers. According to public administration scholars Maynard-Moody and Musheno (2003), "if street-level workers judge citizen-clients as unworthy—as ''bad guys''—then rules are used to withhold or minimize services or at times to punish, even to be brutal" (p.156). The routinely punitive treatment of racial minorities in the social welfare system is likely rooted in unflattering perceptions of POC clientele due to history of White supremacy and the White racial contract (Mills 1997; Soss, Fording, and Schram 2011), creating a form of "racemaking" as a racial policy regime (Schram 2005; Wacquant 2009). This strikes directly at the core of social equity values in public administration (Frederickson 2005; Gooden 2015), which although a "nervous" area of government, should strive for targeted supportive efforts directed toward disadvantaged populations in order to provide a more equal societal playing field (Gooden 2015).

Unequal treatment and outcomes in the social welfare system is not particularly surprising when we understand the racialized origins of neoliberal workfare reforms (Minoff 2020; Soss, Fording, & Schram, 2011). The White racial frame and racial contract of the U.S. (Mills 1997; Feagin 2020) projects and acts upon negative stereotypes of POC and immigrant populations as savage in nature, lacking rigorous work ethic and personal responsibility, requiring strict paternalistic program rules in order to control these "deviant" target populations (Schneider and Ingram 1993; Ingram, Schneider, and DeLeon 2007; Watkins Hayes 2009; Soss, Fording, and Schram 2011; Minoff 2020). Thus, it is cash and food benefit restrictions under welfare reform, partially rooted in negative stereotypes of POC and immigrant populations that reverberates and widens inequalities today in an age of the COVID-19.

Additionally, monies from the TANF program are oftentimes siphoned away from cash benefits and put toward adult education or family formation programs (Schott, Pavetti, and Floyd 2015). Research has found that TANF spending and welfare efforts are oftentimes reduced in states with higher numbers of Black welfare recipients (Rodgers and Tedin 2006; Parolin 2019). Not surprisingly, the number of low-income families receiving TANF benefits has declined steadily since the passage of PRWORA. For instance, in 2015, only 23 of every 100 low-income families were receiving TANF benefits; whereas, under AFDC that number routinely reached ~70 of every 100 low-income families receiving cash benefits (Meyer and Floyd 2020). In a general sense, TANF is arguably not very responsive to the material needs of low-income families in the U.S. and the porous nature of the program lets otherwise eligible low-income families fall through the cracks during the COVID-19 pandemic. Not only is there arguably not enough direct cash assistance provided by the TANF program to

low-income families, who are disproportionately from POC and immigrant backgrounds (either in total number of monthly benefit dollars allocated or the total percentage of eligible families served), but having benefits tied to strict work requirements during a global pandemic is arguably inefficient, counter-productive and yields further racial inequities.

It is disproportionately low-income Black, Latine, Middle Eastern, Asian, and Native American populations who are required to participate in low-wage service-sector employment to receive TANF and SNAP benefits, more readily exposing themselves and their families to COVID-19, due to the necessary nature of working in commercial kitchens, retail settings, and housekeeping roles to remain in program compliance. We argue that the structure of the social safety net for cash and food assistance, especially benefits conditioned upon full-time labor force participation, is inherently limiting and ineffective during COVID-19 pandemic conditions. Material hardship is not meaningfully alleviated, and exposure to COVID-19 is almost assuredly heightened when fulfilling neoliberal workfare reforms. In a way, we view current TANF and SNAP workfare policies as adding insult to injury – that is, monthly benefits remain relatively paltry and easily removable, while strict program rules largely remain in place for full-time labor force participation that increase exposure to COVID-19 pandemic conditions.

Housing Choice Vouchers/Section 8 Rental Assistance

While not having the same exact work requirements and time limits that accompany TANF and SNAP benefits, Housing Choice Vouchers (HCV) – originally known at "Section 8" rental assistance for low-income families, represents a similar set of safety net limitations rooted in negative stereotypes and unflattering social construction of target populations (see Hayat 2016). HCV/Section 8 is not an entitlement program like SNAP food assistance. Thus, unlike SNAP, which is open-ended and benefits can be allocated to all eligible participants (and be more responsive to recessionary conditions with increased caseloads), HCV has a strict participant limit oftentimes with long waiting lists for rental assistance benefits (HUD 2021). Once the federal Housing and Urban Development (HUD) HCV allocation is exhausted, individuals and families must enter a local public housing agency waiting list and will likely not receive housing support for a substantial period of time (HUD 2021). In certain high-demand residential locations, such as around the Los Angeles metropolitan area, the HCV waiting list is closed entirely to new entrants as they deal with a backlog of potential beneficiaries (Los Angeles County Development Authority). These limitations are not accidental.

Similar to TANF and SNAP recipients, HCV/Section 8 recipients also face negative social construction in society as deviant and undeserving of benefits (Badger 2015). While not as extensive as research examining unflattering perceptions of cash and food assistance recipients, recent research does demonstrate that Section 8 participants are generally perceived to be undeserving POC, especially Black people, who bring problems of crime and reduced property values (Badger 2015; Hayat 2016). Like TANF and SNAP participants, the negative social construction of HCV recipients, rooted in racist stereotypes of criminality and dependency, likely in part leads to the underfunded and limited nature of the program (Badger 2015). We argue that the lack of rental support afforded by HCV, including lengthy waiting lists, leads to a set of residential vulnerabilities for otherwise eligible low-income families, especially those from POC and immigrant backgrounds. In particular, the lack of rental assistance for low-income families likely leads to more co-habitation and conditions of residential overcrowding. In turn, overcrowding leads to increased vulnerability of

contracting and spreading COVID-19 (Gray et al. 2020). For instance, articles in various periodicals have highlighted residential overcrowding in the Los Angeles metropolitan area, where HCV waiting lists for rental assistance are perpetually lengthy, and how residential overcrowding has been linked to heightened levels of COVID-19 illness, spread, and death occurring among L.A.'s Black and Latine populations in particular (Arango 2021; Lin II and Money 2021; Schmidt 2021).

Medicaid

Lastly, Medicaid, passed in 1965 as an amendment to the Social Security Act of 1935, represents the primary health insurance coverage program extended to low-income families, in the U.S. Under the Patient Protection and Affordable Care Act "ACA" or "Obamacare" passed in 2010, expansion of Medicaid to cover all adults at or below 133% of the poverty line was a cornerstone of the policy framework. In summer of 2012, the Supreme Court upheld the ACA framework as constitutional, but ruled that states could not be compelled to expand their Medicaid programs (Rosenbaum and Westmoreland 2012). In turn, multiple states have refused to expand Medicaid, leaving millions of low-income individuals and families without access to health insurance coverage and healthcare services. While Medicaid arguably does not have the same level of racist vitriol directed toward it as TANF cash assistance, SNAP, or HCV/Section 8 rental assistance, there does remain a negative veneer of "free stuff" for undeserving populations participating in means-tested programs that also extend to Medicaid benefits (Michener 2020; Tesler 2012). For instance, the bulk of states who refuse to expand Medicaid are those that disproportionately house Black populations in the U.S. South (Grogan and Park 2017). In turn, it is low-income Black and immigrant populations who disproportionately lack access to healthcare benefits, increasing the exposure to vulnerabilities around COVID-19 illness and death.

Additionally, Republican officials in several states have proposed the idea of attaching work requirements to Medicaid benefits, similar to those observed for TANF and SNAP (Musumeci, M., Garfield, R., & Rudowitz, R. 2018) – neoliberal conditions of labor force participation oftentimes informed by negative stereotypes of racial minorities as lacking personal responsibility and having propensity for lavish, superfluous welfare usage. It's not clear at this juncture how prevalent Medicaid work requirements will become in the future. Many state legislatures are controlled by Republican office holders with an ideological penchant for neoliberal workfare reforms; however, work requirements for Medicaid benefits are less popular than for other public assistance programs and the Medicaid workfare efforts of states like Arkansas have been struck down by federal appellate courts as "arbitrary and capricious" (Hill and Burroughs 2019). Nonetheless, this recent development toward embracing Medicaid work requirements could yield increased barriers to access healthcare benefits for POC populations during the COVID-19 pandemic and beyond.

COVID-19, Racial Equity, and Policy Reforms

Now that we have established the baseline contours and enduring inequities associated with major U.S. social welfare programs, this next section will discuss some potential policy reform ideas to improve the effectiveness and equity of social welfare provision, especially as it relates to the COVID-19 pandemic. Policy reforms are centered within four key support areas for reducing material hardship: financial, nutrition, housing, and medical assistance.

In terms of cash assistance interventions, TANF policy in the U.S. almost assuredly needs a fundamental rethink in the short-term as cash cushion responding to pandemic conditions, but also in the long-term as more viable anti-poverty policy options might exist. In the short-term,

states working in partnership with the federal government should be devising ways to increase unconditional cash assistance toward low-income populations, especially POC and immigrant populations living more on the economic margins. For instance, several states have relaxed TANF program rules including broadening the range of acceptable work-related activities, including some virtual options. Other states have relaxed sanction penalties for non-compliance with program rules (Shantz, Hahn, Nelson, Lyons, & Flagg 2020). With a steady rise in TANF and SNAP rolls increasing by millions of people starting during the spring and summer of 2020 (see Hembre 2020) states need to remain aware of the acute need to alleviate material hardship and economic risk with robust cash and food benefits, while remaining sensitive to difficulties with fulfilling strict work requirements. Inflationary concerns from increasing consumer demand are present, but responding to short-term material hardship brought on by pandemic conditions needs to remain the priority of U.S. social policy at federal, state, and local levels.

Instead of plunging low-income heads of household into low-wage service sector work opportunities in order to fulfill welfare work requirements, which then leaves many families as the precarious working poor, social services should focus on structural reforms - boosting long-term human capital building and inclusive career initiatives into management and professional roles. Policies such as race-based reparations and affirmative action could also work as equity enhancing social policy for POC populations (Darity and Mullen 2020; Bittker 2003). Although pursing race-based remedies remain a relatively difficult and conflictual political endeavor, in the pursuit of social justice, race specific remedies should accompany cash and food assistance programs in advancing social equity for historically marginalized populations. For instance, enhancing income and food security among vulnerable populations residing in historically disinvested, isolated, and redlined neighborhoods should be a priority of policymakers and administrators with a greater eye toward correcting structural racism in U.S.

In terms of housing assistance and access, alleviating residential overcrowding should be prioritized during pandemic conditions and could be accomplished with expansion of the HCV program funding at the federal-level, making benefits available to more eligible HCV program participants. The federal government has been an active policymaking body during the COVID-19 pandemic, but with little effort or changes to housing assistance programs like HCV. Legislation like the American Rescue Plan demonstrates an ability to offer direct cash injections to American families. Similar urgency could be shown toward expanding housing benefits to low-income families. Apart from expanding HCV benefits to cover more eligible participants, creating more of a housing entitlement structure, additional housing protections and options could be put in place to protect low-income populations from pandemic conditions. For instance, state and local governments could partner with local hotels and provide rooms to individuals living in crowded residential conditions, similar to efforts made to shelter homeless individuals during the pandemic across several states and localities.

In a general sense, federal, state, and local governments should be working to actively increase housing options and affordability for low-income populations, especially POC and immigrants, who lack equity in accessing safe and stable housing options. This could take several forms. For instance, on the supply side, building more public housing and social housing “projects” in mixed income and high-opportunity neighborhoods could be one approach. Reforming zoning and land use regulations, such as ending exclusionary single-family zoning, parking requirements and allowing accessory dwelling units (ADUs), in order to increase the overall supply of housing options (Trounstine 2018). POC and immigrant

families oftentimes lack robust networks and resources for proper housing searches due to history of racist residential exclusion (Rothstein 2018). Systemic racism leads in part to limited HCV benefits rooted in negative social construction of Section 8 recipients. Then limited HCV benefits yield precarious housing arrangements and overcrowding among low-income POC and immigrant families, which yields greater exposure to COVID-19 illness and death, which further exacerbates racial inequities and injustices in the U.S.

Thus, additional reforms to HCV could include the assistance of realtors or housing specialists to assist low-income POC and immigrant families in navigating housing searchers and ideal residential locations (National Association of Realtors 2021). Additionally, reforms directed toward property owners could also be part of the equation. For instance, in California starting in 2020, landlords are no longer able to deny housing to a Section 8 recipient just for having a housing voucher, a move that could potentially increase housing options for POC and immigrant families (Brinklow 2020). In many ways, housing is arguably a foundational piece of social justice, because housing arrangements and the immediate neighborhood conditions that surround individuals and families have significant reach and externalities (Sharkey 2013; Wilson 2010) – including access to high(er)-quality schooling, healthcare, internet access, cleaner water and air, robust social and job networks, etc., all of which can reduce the exposure to COVID-19 and lead to greater equality of treatment and opportunity for disadvantaged families. Challenges around racial and economic housing segregation, originating in slavery and Jim Crow and exacerbated by exclusionary zoning rules, remain entrenched throughout the U.S. (Rothstein 2018; Trounstine 2018), and solving these key structural issues will have positive ramifications under COVID-19 pandemic conditions and beyond for racial and economic justice.

Lastly, under a galvanizing banner of "Medicare for All", a movement toward universal healthcare coverage or national insurance system could be a major improvement over our patchwork status quo in the U.S. Expanding national healthcare coverage to low-income families irrespective of localized state-level or municipal-level approaches could assist vulnerable families during the COVID-19 pandemic and also extend to improving health outcomes and family security after pandemic conditions have passed. Programs like the State Children's Health Insurance Program (SCHIP) arguably do a relatively admirable job of providing guaranteed healthcare coverage for low-income children in the U.S.; while Medicare benefits assist elderly populations; however, coverage gaps for non-elderly low-income adults remain entrenched in a patchwork of strict Medicaid benefit rules and barriers to healthcare access, heightening vulnerabilities to COVID-19 for low-income adult POC in particular. Improving healthcare access, especially to low-income adults falling outside of current benefit programs like CHIP or Medicare needs to remain a priority.

Without a more dramatic movement toward universal single-payer alternatives at the federal level, having states continue the expansion of Medicaid to all adults at 133% of poverty line and below should likely continue being the preferred approach in the short-term. This can assist with expanding healthcare coverage for vulnerable adult populations, which can help with COVID-19 related concerns, while also providing more of a health access backbone for issues related to mental health and addiction, and maladies that might hinder productivity and entrepreneurialism. The real fear of bankruptcy and poverty from medical bills exists for POC populations in particular (McKernan, Brown, and Kenney 2017), increasing economic risks and precarity, which can hinder overall human vibrancy. Policymakers and administrators could and should continue working to improve cultural competency and inclusive outreach efforts to help promote and enroll POC populations into state Medicaid programs and other public health initiatives. For instance, targeted initiatives

and mobile clinics in underserved Black, Latine, Native American, and Asian communities that assist with enrollment in healthcare services. Guaranteed access to healthcare is a core aspect of social equity, mobility, and human flourishing and needs to remain a priority during not only COVID-19 but after the pandemic recedes.

The final section of the paper focuses on the unique and vulnerable role of immigration, welfare reforms, and the COVID-19 pandemic.

Immigration, Welfare Reform, and COVID-19

Similar to how welfare systems and other public assistance programs in the U.S. have become "racialized" (Gilens 1999; Soss, Fording, and Schram 2011; Carten 2016; Minoff 2020), these same programs have become "immigrationalized" (Garand et al. 2015). In turn, a distinct yet similar set of welfare restrictions exist for immigrant populations in the U.S. as they do for citizens. Both processes connect negative attitudes of POC and immigrants to perceptions of social benefits creating immigrant "dependency", resulting in public pressure to restrict access to these programs in what has been describe as the "new politics of immigration" (Calavita 1996). As government reforms responded to anti-immigrant public sentiment in the 1990s, residency and citizenship restrictions were adopted to limit immigrant access to social welfare programs like TANF, SNAP, SSI, and Medicaid (Butz and Kehrberg 2015, 2016, 2019; Hero and Preuhs 2007; Kehrberg 2017). As a result, immigrants residing in the U.S. have additional barriers to accessing social welfare programs and these barriers can increase their exposure to COVID-19 related hardships.

In 1996, PRWORA formalized strict immigrant access to certain welfare programs based on the "magnet hypothesis narrative" that restrictive welfare programs would attract only self-sufficient and hard-working immigrants (Fix, Capps, and Kaushal, 2010). Immigrants arriving after enactment of PRWORA faced the additional requirement of a five-to-seven-year residency requirement for most federal welfare programs and, in some states, a full citizenship requirement was put in place. At the time, the dominate political frame argued that these restrictions would decrease immigrant dependence on government benefits, stop immigrants from draining government resources from more "deserving" citizens, and increase the number of self-sufficient and hard-working immigrants into the country (Fix, Capps, and Kaushal, 2010). Additionally, PRWORA and other federal acts permitted state governments to create similar and additional barriers for immigrants to access state-funded social welfare programs (Hero and Preuhs 2007).

More recent federal and state policies continue to restrict immigrant access to government welfare programs, including many policies adopted to help decrease COVID-19 vulnerabilities and to aid individuals economically impacted by the pandemic. For example, the Patient Protection and Affordable Care Act (ACA) of 2010 included restrictions on undocumented immigrants and some legal immigrant groups from receiving benefits in the Medicaid expansion and insurance exchanges (Joseph 2015; 2016; 2017). The lack of medical insurance, access to Medicaid benefits, and state-level health insurance benefits make immigrants vulnerable to the spread of COVID-19 (Wilson and Stimpson 2020). The initial COVID stimulus package passed in March 2020 under the Trump Administration may have benefited most U.S. citizens, but unnaturalized immigrants lacking a Social Security number and U.S. spouses of these individuals were ineligible for cash payments. The more recent stimulus legislation passed in late 2020 allowed these mixed-status families to receive stimulus funds, but undocumented immigrants remain wholly ineligible. Additional recent policy change makes immigrants more hesitant to accept government benefits. Public Charge

Grounds require immigrants to be self-sufficient and one's citizenship case can be harmed by accepting public benefits like cash, food, and medical assistance. The Trump Administration expanded the "public charge" policy to include food and medical assistance programs, ones historically excluded from public charge provisions, which likely had a chilling effect on immigrant usage of welfare programs during the Trump years, leading to heightened levels of precarity and exposure to COVID-19 conditions. This policy change received extensive media attention and political rhetoric in favor and opposition. What received less media attention are the court rulings restricting the government from applying public charge provisions to COVID-19 treatment, testing, and preventive healthcare.

The creation of these welfare restrictions has "hardened" American domestic policies toward immigrants (Boehme 2011; Bosniak 2006) and limit the socioeconomic status and mobility of many immigrants. Despite immigrants having a lower unemployment rate than natives in 2019, immigrants are more likely to be living in poverty (14.6%) compared to native born Americans (11.8%) and more likely to lack health insurance (19.6%) (Budiman et al. 2020). Immigrants are more likely to work in labor and service sectors, increasing exposure to COVID-19 related illness from intimate exposure to other co-workers and customers. In 2018, immigrants were 24.1% of the construction workers, 19.0% of the manufacturing workforce, and 20.8% of the arts, entertainment, recreation, accommodation, and food services sector (Kosten 2018). Many of the jobs in these economic sectors are considered low-skilled and provide lower financial and medical benefits, and as a result, many immigrants financially qualify for government assistance, but fail to receive benefits due to strict citizenship and residency requirements. In addition, immigrants have been found to disproportionately live in crowded residential arrangements heightening precarity (Burr, Mutchler, and Gerst 2010).

All told, the factors of employment requiring contact with others, living in overcrowded housing, and lacking health insurance are shown to increase immigrant vulnerability to COVID 19 alongside POC like Black, Latine, and Indigenous populations (Ogedegbe et al. 2020), and the likelihood of immigrants being in these suboptimal conditions increases due to the barriers preventing many immigrants from accessing social welfare programs. In short, the safety net is particularly precarious for immigrant populations in the U.S., even legal immigrants with Green Card status, with potentially serious hardship ramifications from the COVID-19 pandemic and beyond for immigrants and their families.

Potential Policy Reforms

As discussed above, immigrants face additional barriers to receiving public welfare benefits and are more likely to work in industries with higher COVID-19 vulnerabilities, such as the service sector and also more likely to have multi-generational housing arrangements. Removal of the residency and citizenship requirements for government programs such as TANF, Medicaid, and SNAP, would help unnaturalized, recently arrived immigrants even though these programs provide inadequate resources during a pandemic. In order to help with these resources, we recommend that immigrants receive access to the additional benefits we suggested earlier for other policy reforms regardless of citizenship, residency, and legal status. For instance, through expansionary measures beginning in 2022, undocumented immigrants will be covered under California's Medi-Cal program, expanding healthcare access first for those over age 50, then younger undocumented populations in subsequent years (Ibarra 2022). Programs also need to be developed particularly for the immigrant communities. These programs should encourage early detection and monitoring of COVID-19 through the development of free clinics due to immigrants either lacking health insurance

or being under-insured (Clark et al. 2020). In addition, access to government housing assistance programs like Housing Choice Vouchers/Section 8 rental assistance can decrease the higher rate of crowded housing among many immigrant households. For the employment sector, programs that can help develop social distancing and provide personal protective equipment can decrease workplace vulnerabilities for immigrant populations. In the end, government agencies will need to encourage immigrant communities to access social benefits ideally through targeted outreach efforts with community stakeholders and local advocates and institutions. Immigrant fears of the federal-level public charge provisions, deportation by ICE, and other legal repercussions from accepting government aid will need to be addressed by limiting, if not eliminating, these consequences and making those policy changes well known among immigrant communities.

Discussion and Conclusion

From our prior discussion in this paper, we argue that, 1) The U.S. social safety net is rooted foundationally in racism and systems of White supremacy that construct non-Whites as lacking proper work ethic and personal responsibility, shaping the design and implementation of social welfare policies (Gilens 1999; Watkins-Hayes 2009; Soss, Fording, and Schram 2011; Carten 2016; Minoff 2020). Thus, yielding restricted and underdeveloped social welfare programs that oftentimes fail to reach target populations who require resource access, especially those from low-income POC or immigrant backgrounds. This restrictive dynamic is observed across several established means-tested, redistributive social welfare programs in the U.S., such as TANF, SNAP, HCV/Section 8, and Medicaid. 2) The underdeveloped, limited, and oftentimes punitive nature of the U.S. social safety net leads to heightened exposure to current COVID-19 pandemic conditions – including financial hardship, illness, and deaths – among POC and immigrant populations in particular, further exacerbating racial inequalities in society stemming from structural racism (Ogedegbe 2020).

The underdeveloped American welfare state likely impacts the social determinants of health in general and have magnified consequences during the COVID-19 pandemic. A significant and increasingly large body of research show that social factors, environmental stressors, and health status are related (Braveman, Egerter, and Williams 2011; Braveman and Gottlieb 2014; Navarro 2009). External determinants, such as immediate economic resources and environmental circumstances, shape overall health, including access to healthcare services and that in the United States, overall health is related to race with POC having lower levels of access (Braveman et al. 2011). U.S. social welfare programs examined in this article in many ways are limited in their ability to improve the social determinates of health and in several important ways status quo policies keep racial minorities and low-income families in degenerative contexts that decrease their overall health.

We argue that policy reforms in the short-term should be more responsive to the COVID-19 pandemic and seek to immediately reduce short-term vulnerabilities specific to COVID-19, both related to health issues and material hardship more broadly. In the near-term, federal, state, and local policymakers should be expanding access to direct cash and food assistance, housing vouchers, and medical coverage, blunting the immediate impact of COVID-19 on POC and immigrant populations. Taking a longer-term view, policy approaches should center on reforming the accessibility of social welfare programs, working to meaningfully decrease material hardship while improving equality of opportunity and access to resources needed for survival and human flourishing. In pursuit of social equity and racial justice, policymakers and administrators, need a more fundamental rethinking of our

social safety net – moving beyond a stifled colonial mindset that routinely casts welfare recipients in unflattering perceptions of deviance and irresponsibility (and undeservingness of public benefits).

U.S. social policy reforms need a reimagining that works toward liberation and more genuine social equality and racial justice. These policies could include more "radical" structural pieces like monetary reparations for historically oppressed groups, especially Black descendants of slaves, which could help to correct centuries of oppression and enhance societal leveling in resource access. Affirmative action initiatives in housing, education, and employment could potentially boost historically underrepresented groups in public goods access and wealth building vehicles like housing and business ownership. Myriad potential policy prescriptions could improve our current array of social welfare provision in the U.S., which remain suboptimal in terms of efficiency, effectiveness, and equity considerations. Our current labyrinth of social welfare programs represents something of a "residual" patchwork welfare state, that takes a backseat to markets and private institutions. The inadequacy of this approach to social welfare provision has been exposed during COVID-19 pandemic, showing holes in the safety net and lack of basic protections for low-income families, irrespective of racial and immigration status.

Instead of a reactive, residual approach to welfare provision in the U.S., now is a time for a fundamental rethink of the assumptions and delivery of social welfare provision. Taking lessons from mature social democracies of Europe and Scandinavia with a more guaranteed set of social benefits and resource transfers to low-income populations in the form of easier more automatic enrollment in social programs, universal basic income, generous refundable tax credits and child allowance, baby bonds, guaranteed access to startup housing and entrepreneurial business capital, healthcare benefits, improvements to the unemployment insurance system. etc. This could represent more of a sturdy social welfare backbone and promote more equitable human flourishing than our current mix of limited patchwork social welfare provision rooted in systemic racism and neoliberal paternalism, leaving low-income POC and immigrant populations particularly in a state of economic and social precarity, more susceptible to harmful aspects of the COVID-19 pandemic.

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