How Immigration Policy Impacts Health Equity

Falling through the Coverage Cracks: How Documentation Status Minimizes Immigrants' Access to Health Care

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Abstract Recent policy debates have centered on health reform and who should benefit from such policy. Most immigrants are excluded from the 2010 Affordable Care Act (ACA) due to federal restrictions on public benefits for certain immigrants. But, some subnational jurisdictions have extended coverage options to federally ineligible immigrants. Yet, less is known about the effectiveness of such inclusive reforms for providing coverage and care to immigrants in those jurisdictions. This article examines the relationship between coverage and health care access for immigrants under comprehensive health reform in the Boston metropolitan area. The article uses data from interviews conducted with a total of 153 immigrants, health care professionals, and immigrant and health advocacy organization employees under the Massachusetts and ACA health reforms. Findings indicate that respondents across the various stakeholder groups perceive that immigrants' documentation status minimizes their ability to access health care even when they have health coverage. Specifically, respondents expressed that intersecting public policies, concerns that using health services would jeopardize future legalization proceedings, and immigrants' increased likelihood of deportation en route to medical appointments negatively influenced immigrants' health care access. Thus, restrictive federal policies and national-level anti-immigrant sentiment can undermine inclusive subnational policies in socially progressive places.

Keywords health policy, immigrants, Chapter 58

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Introduction

Recent policy debates have centered on health reform, who should benefit from such policy, and, to what extent, if any, immigrants (especially the unauthorized) should be included in comprehensive health reform. Given federal restrictions to public benefits for certain immigrants, most are excluded from provisions of the 2010 Affordable Care Act (ACA). Yet, some subnational jurisdictions (e.g., Massachusetts) have extended coverage options to federally ineligible immigrants (Joseph 2016). Much less is known, however, about how effective these inclusive health reforms have been in providing coverage and care to eligible immigrants in those jurisdictions. Since previous studies have shown that increasing access to coverage does not guarantee increased use of health services, it is important to understand what factors influence individuals' health service use, particularly when they have coverage.

This article explores the relationship between coverage and health care access for immigrants under health reform, with specific attention to how documentation status presents various challenges to care for this group. Specifically, this article illustrates how health policy's intersection with other types of public policy (e.g., welfare, driving) amid increasing anti-immigrant sentiment influences immigrants' health care decisions. Cumulatively, these sociopolitical dynamics undermine health equity attempts for noncitizens, who comprise 13 percent of the US population. As few studies have qualitatively examined immigrants' health care experiences under state and federal health reform, this article will help researchers, policy makers, and the general public better understand how documentation status and public policy facilitate social inequality in the health care system.

Literature Review

Immigrants' Exclusion in Public Policy

Existing public policy has significantly limited most immigrants'—undocumented and documented—access to various services in recent decades (Fox 2016; Joseph 2016; Park 2011). Notably, the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) and the 1996 Personal Responsibility and Work Opportunity Act (PRWORA) made immigrants of any documentation status more susceptible to deportation and reduced their access to public benefits (Fox 2016; Park 2011). The IIRIRA increased border security, criminalized falsified immigration

documents, and verified employment eligibility (IIRIRA 1996). The PRWORA applied a five-year residency bar for eligibility for public benefits for legal permanent residents (LPRs, or green card holders) (Fox 2016). This also meant that unauthorized immigrants and visa holders became federally ineligible for public benefits (Capps and Fix 2013; Fox 2016).[1] But, states could extend benefits to ineligible immigrants by using state funds and passing legislation for this purpose (Warner 2012). The present-day enforcement of these policies alongside anti-immigrant attitudes generates ongoing exclusion for immigrants (Fox 2016; Marrow and Joseph 2015).

With no comprehensive federal immigration reform since IIRIRA, immigrants are unable to regularize their status. In this absence, presidential executive orders and state-level policies have been created. Former president Obama's 2012 Deferred Action for Childhood Arrivals (DACA) program granted temporary relief from deportation, and work authorization and driver's licenses (in some states) to unauthorized young adults brought to the United States as children.[2] Forty-six states have also passed laws granting or restricting unauthorized immigrants from receiving state-funded public benefits or obtaining housing (Ybarra, Sanchez, and Sanchez 2015).

The Massachusetts and Affordable Care Act Health Reforms

Although the ACA was signed into law in 2010, the policy was modeled after the 2006 Massachusetts health reform known as Chapter 58 (Joseph 2016; Patel and McDonough 2010). Unlike the ACA, Massachusetts included provisions for income-eligible state residents of any documentation status through the Health Safety Net (HSN) and Commonwealth Care (CommCare) programs.[3] Unauthorized immigrants could also directly purchase coverage in the state's health insurance exchange. Some immigrants may likely have had coverage from their employers or spouses.

Because of Massachusetts' compliance with the ACA, state lawmakers prepared for full ACA implementation in October 2013. Lawmakers recrafted the original Chapter 58 reform to maintain coverage for federally

1. Immigrants with temporary protected status (TPS, or refugee/asylee) can receive public benefits their first seven years in the country.

2. DACA does not provide LPR status and is not a path to citizenship (Batalova et al. 2013). As DACA is an executive order that President Trump and many Republicans oppose, this program (and associated benefits) for DACA recipients may end under Trump's administration.

3. See Joseph (2016) for income-level cutoffs and eligibility for immigrant groups under Chapter 58 and the ACA.

ineligible immigrants. Since HSN and CommCare were state-funded, these programs were not changed substantially immediately after ACA implementation.[4] But, unauthorized immigrants lost their ability to purchase coverage in the Massachusetts exchange under the ACA.

Nationally, under the ACA (in compliant states), only adult US citizens, long-term LPRs, and TPS immigrants were eligible for provisions through the Medicaid expansion or participation in the health exchanges (Capps and Fix 2013; Marrow and Joseph 2015). Most noncitizens' federal ineligibility for ACA provisions stemmed from the PRWORA and IIRIRA policies.[5] Visa holders and income-eligible short-term LPRs could purchase coverage in the exchanges, but undocumented immigrants could not (Joseph 2016). Most immigrants' exclusion from the ACA meant that many remained uninsured (Capps and Fix 2013). Their main option for obtaining health services was in safety net hospitals and clinics, which received fewer funds for indigent health care costs under the ACA as more Americans theoretically obtained coverage (Portes, Fernández-Kelly, and Light 2012). Conversely, the ACA increased federal funding by $22 billion over five fiscal years to Federally Qualified Health Centers (FQHCs), which provide primary care and some specialty care to medically underserved populations (Patel and McDonough 2010). This might have been the only way federally ineligible immigrants could access health services under the policy (Warner 2012).

Ineligible immigrants' lack of access to federally subsidized health care has also yielded an increase in medical repatriations—"the process by which uninsured aliens who suffer from long-term medical care needs are transferred from a United States hospital to a medical care facility in their country of origin" (Donelson 2015: 348; Zoellner 2010). While exact numbers are unknown, estimates suggest that 800 medical deportations occurred in the years 2006–2012 across 15 states (NYLPI 2012; Schumann 2016). These deportations typically happen because hospitals do not receive federal reimbursement for providing nonemergency care to indigent

4. CommCare underwent a name change to ConnectorCare. Funding for HSN has been reduced significantly. On June 1, 2016, HSN income eligibility was reduced from 400 percent FPL to 300 percent FPL, the retroactive eligibility period was reduced from 6 months to 10 days, and deductibles were implemented for HSN patients with incomes of 150 percent FPL and above (Mass.gov 2016; Mass Legal Services 2016). Local health advocacy and immigrant organizations are concerned these changes will negatively affect HSN recipients' health care access, especially federally ineligible immigrants with no other coverage options given their exclusion from the ACA.

5. Low-income DACA recipients under age 18 are eligible for ACA coverage through the Children's Health Insurance Program (CHIP). This may change pending President Trump's anti-immigrant stance and anticipated repeal of the ACA.

immigrant patients (Zoellner 2010). It is likely medical repatriations will increase among immigrants amid their exclusion from ACA provisions and other public benefits.

When comparing the Massachusetts and ACA reforms, Massachusetts immigrants have access to greater coverage relative to immigrants elsewhere nationwide (Joseph 2016).[6] While increased inclusive health coverage reduced the state's uninsured population to 3.1 percent by 2011, this percentage did not include federally ineligible immigrants (Long, Goin, and Lynch 2013).[7] After ACA implementation, the state's uninsurance level fluctuated between 3.1 and 4.0 percent during 2011–2015, remaining the nation's lowest (Chin et al. 2016).[8] But, it is estimated that more than 200,000 residents—low income, Hispanic, young adult, and male—remained uninsured due to being unable to afford coverage, being unaware of how to obtain coverage, becoming unemployed or changing employers, or losing eligibility for public coverage (Chin et al. 2016). Coverage options are also delineated by documentation status, and patients with publicly subsidized coverage (federal or state) experience greater difficulty using it, as physicians can opt out of serving patients with such plans (Decker 2012). In the best-case scenario of Massachusetts, one's documentation status (and income) facilitate differences in health care even *with* coverage.

Pre- and Post-Reform Health Care Barriers for Immigrants

Prior to PRWORA, IIRIRA, and the ACA, federally ineligible immigrants could access health services by obtaining private insurance (on their own or via their own or a spouse's employer), or by receiving required treatment to stabilize severe conditions in the emergency department (Warner 2012).[9] Certain vulnerable populations (e.g., pregnant women, children) could access subsidized care via specific Medicaid programs (Marrow 2012; Warner 2012). However, despite their previous less generous access to health services, noncitizens of different documentation statuses utilize these services less frequently than citizens even when they have coverage (Tarraf, Vega, and González 2014).

6. See Marrow and Joseph (2015) for more on immigrants' coverage options in other states that have extended coverage to federally ineligible immigrants.

7. Data on the state's public coverage options do not include usage statistics by documentation status (Joseph 2016).

8. Some of this fluctuation was likely due to the MA-ACA transition in which some residents became uninsured when the state's online exchange failed (Cheney 2014; McDonough 2016).

9. The 1986 Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals receiving federal funds to treat emergency department patients regardless of their ability to pay.

Under the ACA, intensified anti-immigrant sentiment in public policy and among the general population has had a profound chilling effect on immigrants' health care access (see Pedraza, this volume). Documentation status concerns for immigrants themselves or family members present a significant barrier to health care access (Fox 2016; Joseph 2016). Documented immigrants, particularly in mixed-status families, may be less likely to use eligible health services out of fear that their naturalization or that of family members will be jeopardized (Park 2011). Using such services may also draw attention to unauthorized relatives, increasing their chances for detention and/or deportation (Castañeda and Melo 2014).

Additionally, lack of English proficiency and provider-patient cultural concordance also limit immigrants' (and some citizens') health care access, yielding lower quality of care and misdiagnoses for minority and immigrant patients (Betancourt and Bondaryk 2014; IOM 2002; Sentell and Braun 2012). While the nation has become more diverse, such diversity is not reflected among predominantly white health care providers (HHS 2015). Societal implicit biases toward minority groups may also inadvertently lead to discrimination in the health care system (Betancourt and Bondaryk 2014; IOM 2002; Shavers et al. 2012).

Finally, complex bureaucratic (re)enrollment procedures constrain immigrants' health care access (López-Sanders 2013; Marrow 2012). Inability to complete health coverage forms available only in English or Spanish, or produce income eligibility information, bureaucratically disentitles immigrants from applying for benefits for which they are eligible (Marrow 2012; Marrow and Joseph 2015). Relatedly, immigrants' lack of literacy of the complex US health care system (i.e., primary versus specialty care) limits their ability to adequately use health services when they have coverage (Tarraf, Vega, and González 2014).

Much of what researchers know about immigrants' health care coverage and access is based on quantitative studies conducted before the implementation of comprehensive federal health reform. However, because immigrants, especially the unauthorized, are difficult to access, quantitative studies are limited in their ability to provide a comprehensive analysis of this population. Thus, small-scale qualitative studies have provided significant insight into the health care challenges immigrants face (Hacker et al. 2012; López-Sanders 2013; Marrow 2012). But, since ACA implementation, few studies have qualitatively explored how changing health and other types of public policy are reshaping immigrants' health care access (Chin et al. 2016). The pre- and post-ACA qualitative assessment of Boston immigrants' health care experiences in this article will make a

significant contribution, enhancing researchers and policy makers' understanding of how macro-level health policy is affecting this population at the micro level.

Methods

Data for this study were obtained from a larger investigation examining how being an immigrant shaped one's qualitative experiences with the health care system from 2012 to 2013 (under Chapter 58) and 2015 to 2016 (after ACA implementation) in Boston, Massachusetts.[10] To assess the influence of comprehensive health reform (pre- and post-ACA implementation) for immigrants, a total of 153 individuals were interviewed, comprising three stakeholder groups: immigrants, health care professionals, and immigrant and health advocacy organization employees. Table 1 shows the composition of the 2012–13 and 2015–16 samples.

The immigrant sample had a total of 70 respondents: 31 interviewed during 2012–13 (21 Brazilians and 10 Dominicans), and 39 interviewed during 2015–16 (15 Brazilians, 14 Dominicans, and 10 Salvadorans). These are three of Boston's largest immigrant groups that have different migration histories to the United States and a range of documentation statuses. Dominicans have migrated to Boston since the 1960s and are typically LPRs or naturalized citizens. However, Salvadorans and Brazilians began migrating in the 1980s in response to political and economic crises in their home countries. Although some Salvadorans received TPS status, the majority of Salvadorans and Brazilians are undocumented. Dominicans, Brazilians, and Salvadorans also are from different parts of Latin America and are racialized as Latinos, which shapes their incorporation and health care experiences.[11] These interviews assessed: (1) the immigrant profile; (2) self-reported physical/mental health pre-migration and in the United States; and (3) insurance coverage/health care access pre-migration and in the United States. See table 2 for immigrant respondents' demographics.

To assess institutional factors that shape immigrants' health care experiences, thirty-eight health care professionals were interviewed at The Boston Health Coalition (BHC),[12] a system of safety net hospitals and clinics reputed for providing quality care to minority populations. The

10. As of 2012–13, Chapter 58 health reform had been implemented for six years.

11. Salvadorans were added in 2015–16 as some of them may have had TPS that entitled them to certain benefits from which Brazilian and Dominican noncitizens were excluded.

12. This is a pseudonym for the organization. Nineteen interviews each were conducted during 2012–13 and 2015–16.

Table 1 Respondent Sample Sizes (Total $N = 153$)

Stakeholder Group	Pre-ACA: 2012–2013	Post-ACA: 2015–2016
Immigrants	$N = 31$	$N = 39$
Brazilians	21	15
Dominicans	10	14
Salvadorans	N/A	10
Health Care Providers at BHC	$N = 19$	$N = 19$
Physicians	5	6
Medical interpreters	4	4
Other medical staff	10	9
Immigrant/Health Organizations	$N = 20$	$N = 25$
Brazilian	6	4
Dominican	2	4
Salvadoran	N/A	2
General immigrant organizations	3	5
Health organizations	9	7
City/state officials	0	3
Total	**70**	**83**

thirty-eight respondents were physicians, medical interpreters, social case workers, and psychiatrists across eight different BHC sites (see table 3). Interviews examined respondents' perceptions regarding: (1) difficulties serving immigrants; (2) availability of multilingual staff; (3) influence of health reforms—Chapter 58 and ACA—on serving patients; (4) health problems of immigrant patients; and (5) how being an immigrant affects their patients.

Lastly, to examine how immigration policy and local sociopolitical context influenced immigrants' health care access, interviews were conducted with forty-five employees of immigrant and health advocacy organizations that served different immigrant populations, or were health advocacy organizations that assisted Massachusetts residents in health insurance enrollment.[13] These interviews assessed: (1) sociopolitical climate for immigrants; (2) enforcement of state/federal immigration policy; and (3) difficulties that immigrants face living in Boston and accessing the health care system.

Study respondents were recruited through community events at immigrant and health advocacy organizations. Purposive snowball sampling

13. Twenty interviews were conducted in the 2012–13 period and twenty-five interviews during 2015–16.

Table 2 Immigrant Sample Demographics

	2012–2013 Immigrant Sample ($N=31$)		2015–2016 Immigrant Sample ($N=39$)		
Demographics	*Brazilians ($N=21$)*	*Dominicans ($N=10$)*	*Brazilians ($N=15$)*	*Dominicans ($N=14$)*	*Salvadorans ($N=10$)*
Gender (# women)	12	5	8	10	6
Median age (years)	40	55	43	56	40
Average time in US (years)	12	14	10	21	19
Documentation Status					
- Current undocumented (N)	6	3	6	0	5
- Current visa/green card holders (N)	14	4	8	11	4
- Current naturalized citizens (N)	1	3	1	3	1
Health Insurance Coverage					
- Uninsured (N)	1	0	2	2	3
- Health safety net (N)	7	2	4	1	4
- Mass Health (N)	4	6	6	9	2
- Commonwealth Care (N)	1	0	0	0	1
- Private (N)	8	2	3	2	0

Table 3 BHC Respondent Demographics

Demographics	2012–2013 Sample ($N=19$)	2015–2016 Sample ($N=19$)
Gender (number of women)	14	14
Average age (years)	47	47
Number of years at BHC	13	13
Ethnoracial Classification		
- White (N)	9	10
- Black (N)	2	1
- Latino/Hispanic (N)	7	4
- Asian American (N)	0	1
- Other (N)	1	3

was especially effective amid community concerns regarding immigration enforcement and anti-immigrant sentiment during data collection. For the immigrant sample, women and men who had been in the United States for at least one year and were ages twenty-five to sixty were recruited, as these individuals were more likely to have adapted and to have used the health care system. The BHC respondents were medical professionals with mostly Brazilian, Dominican, Salvadoran, and/or other immigrant patients. Interviews were conducted in Brazilian Portuguese, Spanish, or English, typically lasting sixty minutes, and were audio-recorded and transcribed.[14]

For analysis, each interview transcript was imported into NVivo software, and an extensive list of codes was developed, with one- to three-word phrases describing how respondents felt documentation status influenced immigrants' health care experiences. Sub-codes were created that corresponded to each stakeholder group to compare perspectives across immigrants, health care professionals, and organization employees. Each transcript was re-read and all words, phrases, and sentences were organized under the associated codes, until all of the transcripts were analyzed. Each interview was analyzed in the language in which it was conducted to minimize the loss of nuances in translation. The findings presented reflect the perceptions of the stakeholder groups even if they may not directly correspond to eligibility for coverage based on health policy.

Access to the stakeholder groups allowed for qualitative exploration of the experiences of Brazilian, Dominican, and Salvadoran immigrants, who are underrepresented in immigration, health, and policy research. The data were collected in Boston, which is a progressive city that benefited from health reform prior to the ACA. However, previous studies of the Massachusetts health reform before ACA implementation in 2014 were used to project the potential national impact of the ACA. Although this small nonrandom sample limits the generalizability of the results, the findings may have implications for understanding how various populations navigate the health care system under health reform.

Findings

Results reveal that immigrants' awareness of their marginalized documentation status minimizes their enrollment in and use of health coverage even when they have eligibility. This awareness stems primarily from all stakeholders' perceptions that: (1) the intersection of different types of

14. Immigrants' interview anecdotes are translated from Brazilian Portuguese or Spanish.

public policy limits immigrants' health care access; (2) using local health care services may lead to deportation or jeopardize future federal legalization proceedings; and (3) increased local and federal immigration enforcement indirectly affects immigrants' health due to receiving delayed or no care. These concerns increase fear within immigrant communities that diminishes the effectiveness of inclusive local-level health reforms. Each of these concerns is discussed here, with interview anecdotes.

Regarding respondents' perceptions of how policy shapes immigrants' health care access, the different stakeholder groups often discussed how the intersection of policy—at municipal, state, and federal levels—as well as among health, immigration, and welfare policy, limited access to health care at the local level. Because these policies shift constantly, some stakeholders acknowledged that their perceptions of the impact of policies on immigrants may not always be accurate. Nevertheless, immigrants tend to err on the side of policies being punitive and alter their routines accordingly. This means that sometimes they will not use benefits despite being eligible for them. Regardless of whether policies were passed at the federal, state, or municipal levels, these policies are enacted and "lived" locally, affecting immigrants' immediate surroundings. Among respondents, the multifaceted intersection of policy was most apparent when it came to undocumented immigrants' inability to obtain driver's licenses under current state law, which limited their mobility. Federally, the 2005 Real ID Act was passed to standardize driver's licenses and government-issued identification (DHS 2015). Although states must verify "evidence of lawful status," they can issue licenses to undocumented immigrants. Only ten states currently do, and Massachusetts is not one (Pew Charitable Trusts 2015).

As Boston's public transportation system is not the most efficient, some immigrants feel they must drive without licenses to maintain their livelihoods, attend medical appointments, and transport family members to school, work, etc. This palpable risk leads to significant fear of law enforcement since being pulled over by police could lead to arrest and deportation. José, a Salvadoran immigrant, talked about the difficulty that driving illegally poses:

> If a person doesn't have [papers], is not legal, you cannot get a driver's license, you cannot have a Social Security number, or get loans if you need credit. These things, I think, make life more difficult.

This fear was more often expressed by Brazilian and Salvadoran immigrants who were more likely to be undocumented and consequently unable to obtain driver's licenses. As Dominican respondents were usually LPRs

or naturalized citizens, the inability to legally drive did not affect them in the same way. Thus, each ethnic group's immigration history and related documentation status led to different experiences under Massachusetts driving policy.

Intersecting policies also complicate lawmakers' compliance with federal policy alongside competing goals to create access for federally ineligible immigrants. Immigrant advocacy organizations and Boston government officials have petitioned Massachusetts lawmakers to pass a Safe Driver Bill that would require every motorist to have a license regardless of documentation status. Respondents from advocacy organizations perceive that the current state administration has been unsupportive of the Safe Driver Bill or other proposed bills that would benefit immigrants. At the same time, the Boston mayor's office recently created an Office of Immigrant Advancement to make the city more welcoming to immigrants, illustrating how state and municipal legislators are on opposing sides of this issue. Darlene, a representative from the office, discussed the challenge of providing resources for Boston immigrants amid state and federal constraints:

> There are many offices that receive a significant amount of federal funding that are tied to federal policy. There is not much our office can do except give an opinion on it. If you're undocumented, it's very hard to get any amount of services that come through federal dollars. The policies are already set and we have to know what they are and be able to navigate people when they come. The state has a fairly new governor [and] the change in eligibility for Health Safety Net is something that was very significant. The governor does not support driver's license[s] for the undocumented. The mayor was a co-sponsor [as a previous state representative], but it's something that the mayor is where he is and the governor is where he is.

Being on conflicting sides affects policy making and implementation, which leaves potential beneficiaries hanging in the balance. And immigrants are especially vulnerable to being left out of the policy equation, although not necessarily intentionally so in Massachusetts.

Another concern that stakeholders mentioned as minimizing immigrants' health care access was immigrants' perceptions that their use of health care services would lead to deportation or jeopardize future legalization proceedings for themselves or relatives applying for LPR status or citizenship. This concern has been noted in previous research due to the 1996 PRWORA and IIRIRA reforms that represented a more restrictive intersection between the immigration, welfare, and health care systems

(Fox 2016; Park 2011). Concerns about this intersection, especially for Brazilian and Salvadoran noncitizens, created fear that using services and inability to pay for services could lead to deportation. This perception was also expressed among health care providers and immigrant/health advocacy organization employees. Maria, a Brazilian immigrant, told me how this affected her health care behaviors:

> Every time I would [consider going to the doctor,] I thought I would get like a $2,000 bill and if I did not pay, the police would go to my house and deport me. Like when you are illegal you are afraid. You do not know that Homeland Security is not attached to [health care system]. So I would be, really I was very afraid to have [medical] debt because you know immigration forces will find me and kick me out of the country.

Unaware that there was no direct connection between Immigration and Customs Enforcement (ICE) and the health care system, Maria believed she would be deported for inability to pay medical bills. She revealed later in the interview that, instead of receiving treatment in a formal health care setting, she had a friend in Brazil send her medication.

Elisa, a Dominican immigrant, also made a connection between immigrants' use of health services and deportation, although she does not feel personally affected by this as a long-term LPR:

> Those who don't have papers experience a lot of discrimination, especially when you have children because you cannot go see a doctor or have insurance. Sometimes, your child gets sick and you have to take the risk of getting him to the doctor without knowing if you will be deported to your country.

The implicit and underlying theme in Elisa and Maria's quotes as well as the first finding regarding the intersection of public policy allude to the health implications for immigrants. The impact of policy and misconceptions about the relationship between deportation and health service use is that local immigrants seek delayed health care or none at all. Respondents across all groups also mentioned how heightened racialized immigration enforcement and anti-immigrant sentiment at the national level is affecting local immigrants' health through shaping their health care behaviors.[15] Compared to the interviews conducted during 2012–13,

15. The Obama administration's enforcement of existing immigration policy alongside increased racialized profiling by law and immigration enforcement yielded a record number of deportations for Latino and black male immigrants (Golash-Boza 2015). Deportations may increase under the Trump administration given his campaign promises to get tough on immigration.

stakeholders interviewed in 2015–16 felt that the social climate for immigrants was comparatively worse, specifically citing the ethnoracial profiling of immigrants. A Salvadoran immigrant was shot and killed by police in April 2016 while a legal Mexican immigrant (presumed to be undocumented) was attacked by two young white men in August 2015 (Anderson and Sacchetti 2016; Walker 2015).

Whenever ICE raids occur in immigrant communities, or immigrants hear through social media that ICE will be patrolling certain areas, immigrants do not leave home for work or anywhere else. Terrorism concerns also yield fear for immigrants when they see police officers checking passengers in subway stations even though local law enforcement has no immigration enforcement authority. Whatever the circumstance may be, multiple respondents in each group discussed how this decreases the likelihood that immigrants will seek health care. Meghan, a social case worker at the Boston Health Coalition, shared:

> We face issues with patients who are facing deportation because they were coming to the clinic and they were pulled over. [When] the new law [Secure Communities] was put in place that the police were going and stopping people and doing raids and stuff. So a lot of our patients got caught. We had a patient who was coming to the clinic one day, and they called to say, "I'm not going to make it to the visit because on my way to the clinic I saw a police car, so I'm turning around." So they just turned around. So all that plays in with the patients.[16]

While BHC providers like Meghan and immigrant respondents who are BHC patients consider BHC sites to be culturally competent, safe spaces to receive care, immigrants' concerns about arriving at BHC without being apprehended by police sometimes outweigh their medical needs. This has also been the case in other parts of the country where immigrants are afraid to receive care at culturally competent FQHCs due to immigration enforcement (Hacker et al. 2012; López-Sanders 2013; Marrow 2012).

Given that immigrants are excluded from ACA provisions and consequently more likely to be uninsured, the remaining health care option available to most is emergency departments (ED) (Newton et al. 2008; Tarraf, Vega, and González 2014). But, immigrants' ED use is lower than

16. Secure Communities (S-Comm) allows information-sharing between local authorities and Immigration and Customs Enforcement (ICE) when immigrants are arrested. S-Comm sends the fingerprints of locally arrested individuals to the Federal Bureau of Investigation (FBI) and ICE for placement in a database. If the arrested individual is an undocumented immigrant, ICE may ask the local authorities to detain the individual, after which s/he may be deported. S-Comm has created fear in immigrant communities (Golash-Boza 2015; Hacker et al. 2012).

that of naturalized and native-born citizens (Tarraf, Vega, and González 2014). Among most BHC health care professionals and a few immigrants in this study, ED use is not considered to be "safer" in terms of immigration enforcement, as patients may still be stopped on their way to culturally competent EDs like those at BHC. But, some immigrant respondents considered ED use to be cheaper, especially for low-income patients, who, despite having low/no co-pays, are unable to afford them for physician visits and prescription medications. Meghan, the BHC employee quoted earlier, also provided specific examples of how low-income immigrant patients came to BHC EDs to avoid the co-pays associated with a visit to their physicians. Despite having publicly subsidized coverage, immigrants in this study were unaware that their ED use would result in higher health care costs for the state and health care facilities, who paid for those ED services. Thus, affordability was another motivating factor (alongside immigration enforcement concerns) in ED use compared to other types of health services among immigrants in this study.

Alcione, an employee at a community organization that assists Brazilian immigrants with social services enrollment, also spoke about how immigration enforcement fears causes her constituents to put their health at risk by not seeking care, except under dire circumstances:

> I saw a post [Facebook] that said "I live in Rhode Island, please don't drive on I-495 at night if you don't have a license. ICE is pulling over everyone." [This post is] causing a new terror in our communities. And what about health? If a person can't drive on I-495, and is this afraid, they will not go to the doctor if they live in Marlborough [MA] and have to go to Worcester [MA]. But the police have nothing to do with health care, and people don't know that.[17]

Despite living in Massachusetts and being eligible for health coverage, some immigrants will not use health services due to fear generated by federal immigration policy and assumptions they will be profiled and deported en route to receiving care.

Discussion and Health Equity Implications

Boston and Massachusetts have reputations for being progressive and more immigrant-inclusive relative to other parts of the country. But, they are not immune to the broader national sociopolitical climate that has become

17. Rhode Island borders Massachusetts and many people there cross the state lines every day.

increasingly anti-immigrant and is affected by budget constraints. These national trends are shaping local immigrants' ability to apply for health coverage and use health services. Concerns among immigrants, health care providers, and immigrant/health organization employees in this study suggest that immigrants, particularly the undocumented, are delaying or not seeking health care despite their local-level eligibility. The qualitative examination of the region between 2012 and 2013 and 2015 and 2016 presented here is one of the first to demonstrate how macro-level changes in health reform and anti-immigrant attitudes is affecting local immigrants at the micro level.

The findings also reveal the indelible relationship between local, state, and federal policies, and their impact on immigrants' health care in Boston. This intersection of policy creates a perfect storm of systematic de jure and informal de facto exclusion for immigrants, many of whom are low-income and ethnoracial minorities. This nuanced combination of de jure and de facto discrimination has severe health equity implications for immigrants not only in Massachusetts, but also across the country where most immigrants are excluded from health coverage and live in overtly anti-immigrant states.

Under the ACA and other federal policies that limit noncitizens' access to public benefits, immigrants' exclusion represents legally sanctioned discrimination on the basis of documentation status. Given that the historic de jure race-based discrimination of the pre–Civil Rights era has influenced contemporary health disparities for ethnoracial minorities, similar legal discrimination toward immigrants will likely have a profound impact on their health care access and outcomes for years to come. Although Massachusetts immigrants fare better than immigrants elsewhere through their legal inclusion (for the time being) in the state's health policy, their federal legal exclusion in other types of policy reduces their ability to fully benefit from their health care inclusion.

Legal distinctions between classes of individuals based on documentation status also spills over into the social realm, affecting interpersonal relations and facilitating de facto discrimination in people's health care experiences. This was the case for some immigrants in the study, who felt the weight of being mistreated by "Americans" due to their presumed immigrant status. Implicit in this mistreatment was a sense of "otherness" that stemmed from being perceived and racialized as a foreigner, which might have led to being profiled en route to receiving health services. Given that Brazilians, Dominicans, and Salvadorans are racialized differently on the basis of their phenotypes, each group's perceptions of their "otherness"

is tied to their ability to physically blend into the white population. Though Brazilians in the sample had physical features that spanned from white to black, lighter Brazilians' ability to pass for white made them less likely to be profiled than darker Brazilians and Dominicans, who are racialized as black, and Salvadorans, who are racialized as Latino.[18] The privilege of white Americans alongside the social stigma of blacks and Latinos differentially affects Brazilian, Dominican, and Salvadoran immigrants' encounters with law and immigration enforcement, health care professionals, and everyday Americans.

The heterogeneity of the Latino immigrant sample also provides insight into how language differences may be implicit barriers to care that have not been explored in depth in other studies. The fact that Brazilians speak Portuguese and some Salvadorans speak indigenous languages means that enrollment forms and interpreter assistance available only in English or Spanish further minimize their ability to access coverage and care. Thus, lawmakers and health care providers should also be careful to consider how the diversity of more recent immigrants creates linguistic and cultural needs that are different from immigrant groups with a larger presence and established history in the country.

Additionally, when considering that most contemporary immigrants are people of color, the ongoing significance of race and ethnicity in US society makes them more likely to experience de facto racial discrimination (Golash-Boza 2015). These study findings illustrate how distinctions encoded in policy also create social, symbolic, and racialized boundaries between eligible citizens and ineligible noncitizens (Marrow and Joseph 2015). And as health disparities in the post–Civil Rights era suggest that de facto racial discrimination continues to drive those disparities, it is likely the same will occur for immigrant-based de facto discrimination.

Aside from highlighting the nuances of de jure and de facto discrimination, the findings also reveal the challenges associated with maintaining an inclusive local health reform for a population whose access to benefits has been federally curtailed since the 1980s. A consequence of Massachusetts' commitment to providing public coverage to its income-eligible residents of any documentation status is that the state's health care costs are the nation's highest (Song and Landon 2012). This has led lawmakers to make difficult decisions to meet the state's fiscal responsibilities each budget year (Song and Landon 2012). Historically, those decisions have

18. Racial inequality in Brazil has granted white Brazilians more structural access for immigration compared to brown and black Brazilians (Joseph 2015).

come at the expense of federally ineligible immigrants and low-income state residents (Joseph 2016). Over the years, the income eligibility bar for public coverage has been reduced, making federally ineligible immigrants more vulnerable to losing coverage through programs like the Health Safety Net.

While respondents have noticed a shift to less inclusive state-level policies that they fear will affect immigrant, ethnoracial, and low-income communities, they all expressed a perception that Massachusetts is in a much better position on these issues than other states. This sentiment was echoed often when stakeholders in each group provided anecdotal stories of immigrants who considered moving to other states and learned they would be unable to access the same types of benefits. Respondents also reflected on how being in a progressive state and having a strong coalition among various nonprofit organizations translates to greater receptiveness and communication from state policy makers on a range of issues.

The Massachusetts case also illustrates the health equity implications for other marginalized groups nationwide when considering the impact of imperfect ACA implementation. This is particularly the case for low-income and/or ethnoracial minority populations. Just as documentation status and income delineate health coverage options in Massachusetts, these factors worked similarly in the national-level ACA. A key difference was that eligible citizens' exclusion in non-Medicaid expansion states could have been overcome within the framework of the ACA. But, with conservative lawmakers' promises to repeal the ACA, eligible citizens' exclusion may spread to Medicaid expansion states. But, most immigrants, who were overtly excluded from the original law, will remain excluded (Marrow and Joseph 2015). In both cases, eligible citizens in non-expansion states and most immigrants in all states will be excluded on a de jure basis. However, the stakes of exclusion for citizens will not be as high as for immigrants, as citizens can currently access other benefits (e.g., welfare) that immigrants cannot. Citizens also will not be subject to deportation for being public charges when using benefits or accruing high health care costs.

Just as race influences the experiences of contemporary immigrants accessing health care, gender and age also play a role. Some populations are considered more vulnerable, like women and children, which entitles them to certain federal health care benefits regardless of documentation status. Income-eligible children can receive coverage through the Children's Health Insurance Program while pregnant immigrant women can receive emergency Medicaid for prenatal care and delivery. However, men

who are undocumented or in other federally ineligible categories cannot receive similar benefits. These dynamics of documentation status, income, race/ethnicity, and gender are reflected within the context of Boston under inclusive state and federal health reforms. But these factors, in addition to state of residence, also shape eligibility and delineate health coverage among the national population. Consequently, these factors exacerbated health disparities under the ACA (Garfield and Damico 2016). Without the ACA, these disparities will worsen.

Finally, Boston (and Massachusetts) may be considered a best-case scenario for continuing to provide state-funded coverage for federally ineligible immigrants amid budget constraints. Massachusetts is not alone in this regard, as other countries have made efforts to include certain, usually documented, immigrants in their national coverage provisions (Gray and van Ginneken 2012). The situation for undocumented immigrants is more precarious, although the United States has the largest undocumented population among Western nations (Gray and van Ginneken 2012). Canada's universal health coverage program includes documented immigrants, who fare similarly to Canadian citizens and insured American citizens in terms of health care access (Siddiqi, Zuberi, and Nguyen 2009). But, undocumented immigrants are ineligible for national health insurance (Elgersma 2008). Unauthorized immigrants have access to emergency care in 20 of 27 European Union countries as of 2011 (Björngren-Cuadra and Cattacin 2011). However, they must pay for this emergency care in 11 of these 20 countries (Björngren-Cuadra and Cattacin 2011). Beyond emergency care, there is considerable variation in what individual countries provide for immigrants in their jurisdictions (Björngren-Cuadra and Cattacin 2011; Gray and van Ginneken 2012). Much of this care, as in the United States, is delineated by certain conditions, such as having been previously documented (Gray and van Ginneken 2012).

Like Massachusetts, EU countries struggle to fund health coverage for federally ineligible immigrants. Budget downturns usually yield cuts to such coverage, illustrating the expendability of this population. Even when coverage is provided, immigrant populations in these places still face challenges navigating the system and finding culturally competent and linguistically compatible care (i.e., interpreters) (Long, Goin, and Lynch 2013; PICUM 2011). While access to coverage is essential for producing health equity, simplifying enrollment procedures, making related correspondence and assistance available in multiple languages, and having multilingual and ethnically diverse health care professionals also make the health care system more accessible. But, given that immigrants tend to

arrive in the United States with better health and then face prolonged periods of non-access to care, which leads to more expensive emergency room and treatment costs as they age, policies that provide accessible care now will save money in the future. They also will generate health equity for a significant global demographic.

Immigrants' current underinsurance (in Massachusetts) and exclusion from the ACA on the basis of documentation status illustrates how this sociopolitical construction (alongside race, ethnicity, and income) facilitates de jure as well as de facto discrimination for this group. This article has illustrated how the intersection of multiple policy domains increases social inequality in health care access in Boston and reflects a similar citizen-noncitizen divide in American society. The Boston case offers insights for other locales that aim to incorporate inclusive reforms despite the ACA's exclusions for most immigrants. The inclusive Boston case also allows researchers, policy makers, and the general population to imagine the starkly greater vulnerability that immigrants, particularly those of color, around the nation may experience when they are overtly excluded from state- and federal-level reforms.

Consequently, President Donald Trump and conservative federal lawmakers' promises to repeal the ACA have generated concerns about how such action will affect ACA beneficiaries and the larger health care system. Repealing the ACA will likely undo any health equity gains made in expansion and non-expansion states, as some aspects of the law (e.g., preexisting conditions, young adult coverage through age 26) benefited people around the country. Furthermore, 20 million people who currently receive coverage through the Medicaid expansion or health exchanges may lose their insurance, especially if conservative federal lawmakers do not develop a replacement plan before repealing (Blumenthal and Collins 2016).

Even without the ACA, President Trump's overtly anti-immigrant policies will likely result in fewer federally eligible immigrants using health or other social services, particularly as immigration enforcement and deportations are anticipated to increase under his administration (Chozick 2017). Amid such policy changes, the social and symbolic boundaries around immigrants will be brightened, increasing their vulnerability and exclusion. As for Massachusetts, repealing the ACA may mean reverting to the state's 2006 reform. However, the state would have to generate additional revenue to compensate for the budget shortfall from federal Medicaid expansion funds. State lawmakers will likely remain committed to maintaining "universal" coverage, but will make difficult budget decisions

regarding who to provide coverage for and how much to provide. If history is any indicator, federally ineligible (and perhaps some eligible) immigrants and low-income residents may be expendable to maintain coverage for (middle-income) citizen residents. Thus, the health equity implications for Massachusetts may be less severe than for the nation, but disparities in coverage and care will likely increase among the state and country's most vulnerable populations if a suitable ACA replacement policy is not passed and implemented.

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