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**Excluded and Frozen Out:
Unauthorized Immigrants’ (Non)Access to Care
after U.S. Healthcare Reform**

Abstract

Though the Affordable Care Act (ACA) of 2010 extends public and private insurance to 32 million individuals in the United States, it expressly excludes unauthorized adult immigrants from participating in the federally-subsidized state health exchanges and the Medicaid expansion. In this article, we show that the ACA has deepened the ‘brightness’ (Alba 2005) of unauthorized immigrants’ symbolic and social exclusion within the U.S. healthcare system via a significant boundary expansion for U.S. citizens and long-term legal immigrants that has no parallel for unauthorized immigrants. As an alternative model, we highlight two subnational jurisdictions – one city/county (San Francisco) and one state (Massachusetts) – to show how they have played more promising roles to reframe and unfreeze this ‘frozen-out’ (Capps and Fix 2013) population. While we demonstrate commonalities in how San Francisco and Massachusetts have successfully ‘blurred’ unauthorized immigrants’ symbolic exclusion and reduced their barriers to health care at the subnational level, we also highlight their mutual limitations, which signal an ongoing need for federal inclusion currently out of sight. Our findings speak to contemporary debates about whether immigrant incorporation is best achieved at the supranational, national, or subnational levels.

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Keywords

immigration; unauthorized; immigration policy; health policy; ACA

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Introduction

The 2010 Patient Protection and Affordable Care Act (ACA and colloquially known as ‘Obamacare’), is ‘arguably the most sweeping overhaul of the nation’s [U.S.] health insurance system ever attempted’ (Rosenbaum 2012, 67). Phased in gradually from 2010 to 2019 with the most significant provisions implemented in 2014, the ACA’s objective is to promote greater healthcare equity by reducing the number of uninsured Americans, making insurance more affordable, and improving access to care (Ku 2010; Hall and Rosenbaum 2012; Kaiser Commission 2013). To meet this objective, the legislation expanded the federal Medicaid program that offers subsidized health insurance and created health insurance exchange marketplaces¹ where moderate-income individuals can purchase private insurance on their own or with federally-subsidized tax credits (Rosenbaum 2012).

However, not all individuals residing in the U.S. will benefit from the ACA, as some immigrants, particularly the unauthorized, are excluded from the policy. In this article, we employ the sociological literature on boundaries to argue that the ACA further institutionalizes the hostile political context toward immigrants that has been developing since the mid-20th century. By expanding health coverage to many previously uninsured U.S. citizens and long-term legal immigrants, the ACA has generated a theoretically important *boundary shift* that produces an even stronger and clearer separation of unauthorized immigrants from the rest of the morally ‘deserving’ U.S. body politic in the healthcare domain (Alba 2005; Willen 2012).

We first provide an overview of the ACA, briefly outlining the policy and how citizenship status influences individuals’ eligibility for insurance. Next, we delve into the

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sociological literature on boundaries to show how the ACA expands and further institutionalizes the symbolic and social boundaries that have been increasingly drawn around unauthorized immigrants. Third, we discuss an alternative strategy for tempering – or ‘blurring’, denoted by sociologist Richard Alba (2005) – unauthorized immigrants’ exclusion via subnational ‘near-universal’ access programs in San Francisco and Massachusetts that *include* unauthorized immigrants. We highlight how both jurisdictions have reduced unauthorized immigrants’ symbolic and social barriers to health care, but remain limited given unauthorized immigrants’ federal exclusion. We conclude by addressing contemporary debates about whether immigrant incorporation is best achieved at the supranational, national, or subnational levels.

Overview of ACA Exclusions for Unauthorized Immigrants

The ACA marks a notable shift in the U.S. paradigm for medical insurance, moving from a model rooted in welfare-based traditions that once excluded many groups deemed unworthy for financial aid (i.e., childless adults) toward a new, broader ‘national paradigm of near-universal coverage’ (Ku 2010, 1176). If fully implemented, approximately 32 million adults and children – many low-income, medically underserved, and previously uninsured – could receive insurance by 2019, increasing the national coverage rate to 83-94 percent (Hall and Rosenbaum 2012). As of May 1, 2014, an estimated 20 million Americans had already gained coverage under ACA provisions, and the national uninsurance rate may have fallen to 13.4 percent, with further gains anticipated (Blumenthal and Collins 2014, 6).

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Nonetheless, the ACA does not provide universal coverage. Individuals newly eligible for the Medicaid expansion will receive fewer services than those already eligible for Medicaid (Ku 2010). Individuals covered via the health exchanges still will not receive services (e.g., vision and dental care) that are not considered ‘essential health benefits.’ More importantly, an estimated 23 million people – about 8 percent of the nonelderly population – could remain uninsured due to being income-ineligible for subsidized coverage, encountering enrollment barriers, or experiencing lapses in eligibility and coverage (Hall and Rosenbaum 2012). Still others will be unauthorized immigrants, who comprise three percent of the total U.S. population and are the only group explicitly excluded from the ACA (Capps and Fix 2013). Unauthorized immigrants cannot participate in the federally-subsidized health exchanges *nor* the Medicaid expansion, even as they remain ineligible for regular Medicaid, to which their access has been denied since the 1970s (Schwartz and Artiga 2007; Buettgens and Hall 2011; Fox 2009, 2013; Capps et al. 2013; Daniels and Ladin forthcoming).² Unlike U.S. citizens and most legal immigrants, they cannot use their own money to purchase private insurance via the exchanges (Patel and McDonough 2010; Blumberg and Clemans-Cope 2012; Long, Stockley, and Dahlen 2012).

The situation is similarly harsh for nonimmigrants – the official terminology for students, visitors, and temporary guest workers – who are legally present but not legal permanent residents (LPRs). They too are ineligible for ACA benefits.³ Similarly, recently-arrived LPRs are ineligible for most federal benefit programs, including public health insurance, due to a 5-year residency requirement enacted under 1996 national welfare and immigration reforms (Fox 2009,

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2013; Viladrich 2012; Capps and Fix 2013). Thus, most immigrants face greater barriers to insurance coverage and health care than U.S. citizens and long-term LPRs (Ortega et al. 2007; Vargas-Bustamante et al. 2012). If they do not have coverage through a spouse, parent, or employer, their only options are to pay for services out-of-pocket or self-medicate (Menjívar 2002; Lee, Kearns, and Friesen 2010; Chavez 2012; Joseph 2013). The option of last resort is to rely on limited and ‘categorically unequal’ services at the nation’s stressed safety-net hospitals and clinics, which immigrants are more likely than U.S. citizens to use (Light 2012; Portes, Fernández-Kelly, and Light 2012).

Many immigrants ineligible for ACA provisions are and likely will remain uninsured (Zuckerman, Waidman, and Lawton 2011; Capps and Fix 2013). Since approximately 71 percent of unauthorized adults lacked health insurance in 2011, representing 16 percent of total uninsured adults nationwide (Capps et al. 2013), the significance of the ACA’s institutionalized exclusions cannot be underestimated. Some estimate that this population could constitute a full one third of the remaining 23 million uninsured by 2019 (Hall and Rosenbaum 2012; Mickey 2012),⁴ although their proportion may be lower if new unauthorized migration continues to decline (Zuckerman, Waidman, and Lawton 2011).

Symbolic and Social Boundaries: Excluding the Unauthorized from U.S. Society and Health Care

Academic interest in the concept of boundaries has increased in recent decades, with scholars examining how boundaries are (re)created, institutionalized, crossed, maintained, and

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dismantled at various levels (e.g., social, structural) and in various domains (e.g., class inequality, professions). Lamont and Molnár (2002) argue that the concept of boundaries is theoretically powerful because it ‘captures a fundamental social process, that of *relationality*’ between two or more groups, usually conceived of as ‘us’ versus ‘them’ (169, emphasis added).

Critical in this scholarship is the distinction between *symbolic boundaries* – distinctions social actors use to categorize objects, people, and practices – and *social boundaries* – ‘objectified forms of social differences manifested in unequal access to and unequal distribution of resources (material and nonmaterial) and social opportunities’ (Lamont and Molnár 2002, 168). According to Lamont and Molnár, symbolic boundaries are an essential medium through which people acquire status and monopolize resources over groups they perceive and classify as separate and dissimilar. If and when symbolic boundaries become widely agreed upon, they can be institutionalized as social boundaries, demarcating identifiable patterns of social exclusion. Often, symbolic boundaries enforce, maintain, or rationalize social boundaries, becoming so salient that they sometimes replace social boundaries.

Lamont and Molnár advocate three potential avenues in the research on boundaries, which are relevant to our analysis of unauthorized immigrants in the American healthcare system. First, they argue more attention could be paid to the interplay between symbolic and social boundaries by examining variation in the *properties* of boundaries such as their permeability, salience, durability, and visibility. Second, they argue more attention could be focused on the *mechanisms* associated with boundary activation, maintenance, transposition, bridging, crossing, and dissolution. Finally, they argue more attention could be paid to *cultural*

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membership, or, how social actors construct and classify groups as similar or different, by what metrics they do so, and how this shapes their relative understanding of their responsibilities toward their own versus other groups.

Sociologist Andreas Wimmer (2008, 2013) has filled some of these gaps through his study of ethnic boundary making. He argues that institutional structures, the distribution of power, and political dynamics may yield varying degrees of social closure, hierarchies, and inequality that influence the construction of boundaries between different ethnic groups in diverse societies. Wimmer (2008) suggests there are five strategies through which ethnic boundary making occurs: (1) *boundary expansion* – new people are included in a group from which they were previously excluded; (2) *boundary contraction* – some of those previously included in a group are ejected; (3) *boundary hierarchy transformation* – the hierarchy of ethnic categories is rearranged; (4) *boundary crossing* – an individual changes his/her categorical membership; and (5) *boundary blurring* – an individual emphasizes other social characteristics less important to the social boundary in question.⁵

We argue that although the symbolic and social boundaries excluding unauthorized immigrants in the U.S. healthcare system have been salient and visible for the past half century, they have become ‘brighter’ since passage of the ACA. Applying Wimmer’s typologies, this ‘brightening’ has happened because an important *boundary expansion* has occurred for many citizens and long-term legal immigrants – including many non-elderly, racial minority, and poor Americans – who previously did not have access to affordable insurance. Through this expansion, what Alba (2005) defines as a *boundary shift* is occurring such that a boundary has

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been ‘relocated’ (23), as former outsiders are becoming insiders. The unauthorized will actually lose some of their historical access to coverage and care under the ACA. We briefly overview both trends before discussing our two subnational case studies.

Intensifying Undeservingness in U.S. Society and Health Care

The unauthorized population was first created in 1882 with passage of the Chinese Exclusion Act, and grew after 1924 when the U.S. enacted numerical restrictions on immigration, established a land Border Patrol, and made ‘entry without inspection’ sufficient grounds for deportation (Ngai 2004). The social construction of an ‘illegal’ category was further consolidated in 1965-68 and 1976 when the U.S. terminated the *Bracero* agricultural guest worker program with Mexico while also imposing legal immigration limits on sending countries from the Western hemisphere. Consequently, new arrivals, particularly from Mexico, have increasingly had to enter as unauthorized immigrants (Massey, Durand, and Malone 2002; Ngai 2004). Current levels of unauthorized immigration have decreased amid a slackening American economy, increased immigration law enforcement, and expansion of new temporary guest worker visa programs since the mid-2000s. For the 11 million unauthorized immigrants already in the U.S., lack of legal status has become an important axis of social stratification, institutionalized both socially in restrictive immigration policy and rising levels of enforcement (Massey and Sánchez 2010) as well as symbolically in public opinion. Recent studies show that Americans’ views of unauthorized immigrants are consistently more negative and punitive than those of legal immigrants (Kohut et al. 2006; Lee and Fiske 2006).

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The dominant vision of unauthorized immigrants as illegal, immoral, and undeserving of membership in the national body politic often ‘brightly’ divides them from more deserving legal immigrants (Yukich 2013). Sociologist Hana Brown has identified a prominent ‘legality’ collective action frame through which anti-Hispanic stereotypes rely solely on legal status categories as cultural markers of worth, ‘demonizing illegal immigrants but espousing the virtues of legal immigrants’ (2013, 293). When mobilized, this frame has significant discursive, organizational, and electoral consequences for policy outcomes – namely through claims-making possibilities and cross-racial organizing by *authorized* noncitizens – coupled with responsiveness among politicians to ‘the emerging consensus in favor of legal immigrants’ but the simultaneous scapegoating of illegal immigrants (309-10).

This growing symbolic and social exclusion is mirrored within the ‘decidedly hostile’ federal institutional arena of health care (Newton and Adams 2009), where documentation status yields unequal access to resources. Formal restrictions by documentation status were placed on federal benefits programs beginning in the mid-1970s (Fox 2009), yielding a *boundary contraction* that excluded unauthorized immigrants from social programs to which they were previously entitled. These restrictions have since intensified. The 1996 welfare and immigration reforms codified mid-1970s policymakers’ hard line stance toward unauthorized immigrants while introducing a 5-year residency bar on recently-arrived legal immigrants, enacting a boundary contraction for them, too. Since those reforms, states can only extend public benefits to ineligible unauthorized and recent legal immigrants if they use state funds and enact specific legislation providing it (Newton and Adams 2009; Viladrich 2012; Warner 2012).

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Thus, unauthorized immigrants are ‘brightly’ excluded from all three realms that Willen (2012) identifies as important to the study of American health care: (1) the *moral* realm –strong conceptions of their undeservingness for treatment; (2) the *juridical* realm – stringently curbed rights, policies, and other formal entitlements to health care; and (3) the *empirical* realm – radically stunted access to care largely produced by moral and juridical exclusion (Schwartz and Artiga 2007; Siddiqi, Zuberi, and Nguyen 2009; Viladrich 2012). These three realms correspond fittingly with the model used by sociologists of boundaries. Symbolic boundaries have grown stronger and more negative over time (moral realm) and have become increasingly institutionalized as disempowering social boundaries (juridical realm). Together, such changes have generated exclusion in outcomes (empirical realm). Unauthorized immigrants have so little legitimacy in prevailing American political discourse today (Brown 2013) that policymakers working to craft and pass the ACA likely had to make strategic decisions to exclude them from its most visible provisions.⁶ In the controversial context of healthcare reform, any attempt to include them may have been accurately perceived as a danger to its supporters’ legitimacy and ultimate chances for success.

Boundary Blurring and Brightening under the ACA

Although the ACA further excludes unauthorized immigrants, the unauthorized have never been entirely excluded from access to insurance and care in the U.S. They can acquire private insurance through their own or a spouse or parent’s employer or purchase private individual insurance (which is expensive, so few do). Competing ethical and political

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perspectives toward serving unauthorized immigrants have been incorporated into policy debates (Viladrich 2012; Daniels and Ladin forthcoming), resulting in allocation of federal funds to select healthcare institutions for treating ‘deserving’ populations like pregnant mothers, the elderly, and children, with unauthorized immigrants included (Marrow 2012a, 2012b; Mickey 2012; Warner 2012).

This system includes three avenues through which unauthorized immigrants have historically found access to care. First, the Emergency Medical Treatment and Labor Act (EMTALA), passed in 1986, requires hospitals receiving federal funds to stabilize emergency conditions regardless of any patient’s ability to pay (Matthew 2012; Warner 2012). Second, the Disproportionate Share Hospital (DSH) Program, also established in 1986, increased Medicaid payments to hospitals serving many Medicaid and uninsured patients, allowing them to subsidize care to Medicaid and indigent patients, including unauthorized ones (Warner 2012).⁷ Third, the national system of federally-qualified healthcare centers (FQHCs), the principal source of primary health care for the nation’s officially designated ‘medically underserved populations’ (including uninsured and unauthorized ones) since the 1960s, has reduced ethno-racial disparities in health outcomes (Mickey 2012; Portes, Fernández-Kelly, and Light 2012; Searles 2012).⁸

Though the ACA excludes unauthorized immigrants from its insurance provisions, it increases federal funding by \$22 billion over five fiscal years to FQHCs. This represents the *only* way unauthorized immigrants are included within and may potentially benefit from the ACA (Mickey 2012; Warner 2012). This will benefit unauthorized immigrants who live near such centers if they can navigate the bureaucratic forms, eligibility requirements, and waiting lines.

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Currently FQHCs are only located in one-quarter of the areas designated as medically underserved and provide primary, preventive, and some specialty services. Patients must go elsewhere for specialty care unavailable in FQHCs (Mickey 2012). The requirements for proving income and residency eligibility, combined with low fee-for-service costs, are *de facto* barriers that keep many unauthorized immigrants away (Portes, Fernández-Kelly, and Light 2012; Marrow 2012a, 2012b; Konczal and Varga 2012). For those unauthorized immigrants who do make it inside, Deeb-Sossa (2013) and López-Sanders (2013) show that gatekeeping and brokerage processes generate inequality and churning across the system, limiting progress in outcomes. Finally, some scholars worry that expanded FQHC funding may highlight unauthorized immigrants’ use of services, leading to greater public scrutiny and political backlash (Mickey 2012). Others worry that FQHCs’ rationalization of healthcare delivery and new demands generated by the Medicaid expansion will weaken FQHCs’ ability to treat the unauthorized alongside newly-eligible Americans (López-Sanders 2013).

In contrast, ACA policymakers assumed that DSH payments would be unnecessary as more Americans became insured. Consequently, decreases in DSH funding to safety-net hospitals are occurring as health reform is being implemented. So despite increases in funding toward preventive care in FQHCs, some scholars worry that most safety-net hospitals will have fewer resources to serve the uninsured, particularly in specialty and emergency situations (Zuckerman, Waidman, and Lawton 2011; Gusmano and Thompson 2012; Capps and Fix 2013).

Inclusive Devolution: Envisioning the Unauthorized within State and Local Body Politics

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Linking these trends to the boundaries literature, we argue that the American state has sharpened the distinctions, both legal and social, between unauthorized immigrants and others, ‘brightening’ the symbolic and social exclusion of the former. The ACA is a formal juridical mechanism that further institutionalizes their national-level exclusion by turning previously uninsured U.S. citizens and long-term legal immigrants into healthcare ‘insiders.’ This process makes unauthorized immigrants more visible among the remaining uninsured.

However, with comprehensive federal immigration reform stalled in Congress, U.S. scholars have documented an intensification of local and state efforts at immigration policymaking (Newton and Adams 2009; Hopkins 2010; Varsanyi 2010). Even if future federal reform passes, state and local jurisdictions will play a crucial role in implementation. As Crul and Schneider (2010) argue, ‘institutional contexts’ vary widely across countries and cities, exhibiting pragmatic ways of responding to their immigrant populations and tangible influences on immigrants’ participation and belonging. In Crul and Schneider’s view, examining ‘comparative contexts of integration’ – particularly how various institutions like labor markets and legal policies are arranged – is key to identifying the underlying processes, degrees, and consequences of incorporation for immigrants into a nation-state or locality. Because health care qualifies as an institution within their ‘context of integration’ model, we heed their call to ‘look at the national and local “institutional arrangements” facilitating or hampering [immigrants’] participation and access, reproducing inequality’ (1259). Specifically, we draw on data from healthcare providers and immigrants in two subnational jurisdictions – one city/county (San Francisco) and one state (Massachusetts) – to show how both have developed institutional

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arrangements that have ‘blurred’ unauthorized immigrants’ symbolic exclusion and reduced their healthcare barriers. We also highlight their mutual limitations, demonstrating that both jurisdictions’ institutional arrangements remain imperfect substitutes for a more inclusive national-level one.

Data and Methods

Data come from two qualitative case studies that the authors individually conducted in San Francisco, California and Boston, Massachusetts. From May to September 2009, Marrow interviewed 36 safety-net healthcare providers and staff working in a large, residency-training, outpatient clinic associated with the integrated city and county of San Francisco’s public safety-net hospital, hereafter called Hospital Outpatient Clinic (HOC) (a pseudonym). HOC provides comprehensive primary care services and select specialty services and serves a diverse patient population of low income, uninsured, and racial/ethnic minority individuals. Respondents were recruited using purposive and snowball sampling, and included a range of providers (i.e., professional physicians, non-physician staff) who provide care to unauthorized immigrants. Marrow also interviewed 18 safety-net providers and staff from other hospital clinics and departments, a Latino-oriented FQHC, and a Latino day labourer-oriented free clinic to explore their perceptions of how unauthorized immigrants interact with HOC providers and staff.

From September 2012 to June 2013 in Boston, Joseph interviewed 31 adult Brazilian and Dominican immigrants; a range of 19 healthcare professionals (i.e., physicians, social workers, medical interpreters) at a multisite hospital system with a reputation for providing quality health

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care to minority and uninsured populations, referred to by the pseudonym Boston Health Coalition (BHC) (a pseudonym); and 20 immigrant and health organization employees. Purposive and snowball sampling were used to obtain diversity in gender and legal status among the immigrant sample and to interview healthcare professionals and employees at organizations serving (primarily Latino) immigrant and minority populations.

Interviews in both case studies queried how legal status influences immigrants’ health coverage options, and how institutional and contextual factors pertaining to San Francisco’s (2007) and Massachusetts’ (2006) near-universal healthcare policies shape immigrants’ experiences with their respective healthcare systems. Interviews also explored providers and organizations’ beliefs and actions toward immigrant patients and constituencies. In both projects, interviews lasted on average 60 minutes and were conducted in English, Spanish, or Brazilian Portuguese. All interviews were audio-recorded, transcribed, cleaned, coded, and analysed using ATLAS.ti (SF study) and NVivo (Boston study), two qualitative analysis software programs. To ensure anonymity, all names and identifying characteristics of individual respondents have been changed. Human subjects’ approvals were obtained from each author’s respective institution, and both authors also analysed publicly available data on federal/local immigration and health policy.

Recategorization in San Francisco

In San Francisco, local officials have allocated substantial funds to the city’s public safety-net infrastructure and enacted measures that separate lack of legal status from the provision of public benefits, including an official ‘sanctuary’ policy and a Municipal ID

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ordinance.⁹ The city enacted Healthy San Francisco (HSF) in 2007 to provide ‘universal access’ to primary medical care at certain hospitals (only one in 2009) and FQHCs for *all* local resident adults ages 18-65 with incomes under 500 percent of the federal poverty level (FPL) who were ineligible for other forms of public coverage. Income and local residency, rather than documentation status, were the main criteria for HSF eligibility and inclusion. Participation was free for city residents with incomes under the federal poverty line. Otherwise, it was based on designated quarterly participation and point of service-fees (Katz 2008; Dow, Dube, and Colla 2009).¹⁰ By 2011, almost two thirds of the city’s uninsured were covered through HSF, the total uninsurance rate dropped to three percent, and patient satisfaction was high (Grady 2011).

This inclusive local policy effectively ‘re-categorized’ unauthorized immigrants as people located *within* the city’s conception of ‘we’ (Matthew 2012). Unlike the national ACA, HSF represents a boundary expansion that gives uninsured city residents, *including* unauthorized immigrants, greater access to care. Marrow (2012a, 2012b) found that HSF has had profoundly positive symbolic and social effects. Symbolically, it legitimates local safety-net providers’ views of unauthorized immigrants as morally deserving patients. According to clerical worker Shana, the city’s political and HOC’s institutional emphasis on ‘treating everyone, of all groups’ tempers providers’ expressions of fiscal resentment toward unauthorized immigrants through re-categorizing unauthorized immigrants as ‘insiders, and part of my community’ instead of as ‘those people.’ In medical resident Eduardo’s words:

Voicing a view of unauthorized immigrants as ‘undeserving’ within the San Francisco safety-net is taboo. Thanks to a strong and inclusive institutional culture, while you hear those things at the margins, the general reaction would be for people to say, ‘We don’t

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say that kind of thing here.’ I think you would be reprimanded for it and seen as someone negative.

Socially, HSF reinforces a documentation-status-blind environment, reduces the fears that unauthorized immigrants exhibit about accessing care, and increases patient-provider trust. HSF’s funding structure also allows providers to effectively marshal primary-care resources for their patients without having to ask about documentation status. For nurse practitioner Sarah:

There’s just once in a while something you can’t do. And I feel lucky that I don’t really care [about documentation status]. It doesn’t, you know, for the most part it doesn’t really affect what we can do for people.

Physician Mary also agreed that providers:

Often don’t know [legal status] because we are very lucky in San Francisco in having no [legal or financial constraints placed on us] for anything we can provide on-site [at the public safety net hospital] to anyone who lacks health insurance.

These same providers noted that without inclusive HSF policy and funding that currently allows them to ‘look past’ their patients’ legal statuses, they would probably inquire about patients’ documentation status to determine what benefits they have access to. HOC providers were adamant that local policy and funding were critical for creating a safe hospital context, reassuring applicants that documentation status was only required to determine plans and payers (never for disqualification purposes), and connecting eligible patients to services in the system.

However, this recategorization has limits. Formally, as only a ‘universal access’ model, HSF remains categorically unequal (Light 2012) to other forms of public and private health insurance in California. It also only includes primary care provided by participating healthcare institutions and does not cover certain specialty care services (i.e., dental, vision) or other

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ancillary ‘social support’ services (i.e., disability, hospice). Unauthorized immigrants’ access to these services lies outside the domain of San Francisco policy and continues to be delimited by restrictive federal and state policies. When moving across junctures between primary, specialty, and ancillary care, HOC providers reported that the resources they can offer to unauthorized patients gets restricted. Subsequently, their ability to ‘ignore’ patients’ illegal status in their caregiving disappears. Physician Elena is:

Able to provide [a] standard of care for the majority of my patients who are chronically ill. For the small group of patients who do become sicker than that level, severely enough ill, or have the wrong thing, lack of legal status suddenly matters because they [doctors] just can’t get care and it becomes really hard [to get them care], depending on what the service is.

Providers like Elena see clear patterns of blocked access swiftly emerge for unauthorized patients as they move in to the realms of specialty care and ancillary services not covered by federal, state, or local monies. In these situations, HOC providers report going into advocacy mode to link their unauthorized patients to care. But as medical resident Laura explained, their success is ‘voluntary and discretionary’ rather than systemic. Many times their hands are simply tied.

Informally, providers also recounted seeing complex documentation steps exclude some unauthorized immigrants from accessing the care to which they are theoretically entitled. HSF requires proof of local San Francisco residency, proof of low income, *and* denial from Medi-Cal, the state’s Medicaid program. The first two are often difficult for the unauthorized to provide and understand if they speak a different language (Portes, Fernández-Kelly, and Light 2012); the latter creates fear and confusion. In registered nurse Catarina’s words:

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Even if Healthy San Francisco and [this hospital] may not do anything with that information, if you’re undocumented and you know that there's a possibility you could get deported, there is wariness to submit all this documentation or have to come up with it. So, it may not be meant as a barrier but it definitely is serving as one.

Recategorization in Massachusetts

While Healthy San Francisco is a city/county-level program, Massachusetts provides a state-level example of inclusive health reform. In 2006, Massachusetts became the first U.S. state to enact near-universal health reform by requiring all eligible state residents to have insurance coverage, expanding Medicaid coverage for eligible low-income residents, and establishing a statewide health exchange for moderate-income residents (Long, Stockley, and Dahlen 2012; Long, Stockley, and Nordahl 2013). The reform was lauded, becoming the model for the 2010 national ACA (Patel and McDonough 2010; Long, Stockley, and Dahlen 2012).

Though the Massachusetts reform primarily targeted U.S. citizens, it extended some benefits to immigrants. Unlike the ACA, it allowed income-eligible legal immigrants with less than five years residency to qualify for the state-funded Commonwealth Care program, which provided subsidized private insurance to moderate-income citizens and legal immigrants via the state health exchange (Joseph forthcoming).¹¹ Furthermore, although unauthorized immigrants were ineligible for *federally-subsidized* coverage under Massachusetts health reform (Wilson 2008), the state made an explicit decision to maintain its *state-funded* safety net program – now known as the Health Safety Net (HSN). Under HSN, remaining uninsured residents of any documentation status with incomes below 400 percent FPL could access health coverage and care at certain hospitals and FQHCs (Wilson 2008; Patel and McDonough 2010).¹²

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Like Healthy San Francisco, the Massachusetts reform includes unauthorized immigrants within the state community through programs like HSN, recategorizing them as eligible for coverage due to their state residency despite their documentation status. As a result, healthcare professionals can provide care for immigrant patients without concerns about documentation status. A BHC physician named Amanda discussed how this increases immigrants’ comfort levels:

I think it's [the reform] definitely a contribution. I think that we do serve patients that don't have citizenship or legal residency here and I feel that they are connected to us and they know that they have us to care for them. And they trust us.

This is one of the reasons respondents across all stakeholder groups in the Massachusetts study felt health care was more accessible for immigrants there compared to the rest of country.

Amanda also commented on how immigrants’ inclusion improves their healthcare access:

I feel great that we are able to provide them with so much, the preventive things that they need so that they don't present in a much tougher situation.... I feel that having, everybody having the need to cover everybody is a good thing. Especially when we talk about populations that are at risk and might not have it. If it wasn't for something like this [reform], so I think that's good. Obviously there is room for improvement. But I think that overall it's a good thing.

While the Health Safety Net is an inclusive program for income-eligible unauthorized immigrants, like Healthy San Francisco, it is not insurance and is only offered at select healthcare facilities. HSN only ‘universalizes access’ to primary care for state residents who remained uninsured due to their ineligibility to receive public health insurance under the state-level reform. So despite minimizing unauthorized and newly-arrived legal immigrants’ social and symbolic marginalization within the realm of preventive care, Massachusetts has done so in delimited and unequal ways. Access to and quality of preventive care is still shaped

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hierarchically by one’s insurance type and other socioeconomic factors. Relative to state residents with private coverage, those with ‘public’ coverage (i.e. HSN, MassHealth – the state’s Medicaid program) experience greater barriers to care due to limitations on services provided through their plans, or lower levels of reimbursement paid to their providers (Wilson 2008; Clark et al. 2011; Joseph 2013).

Informally, Massachusetts shares with San Francisco the tendency toward bureaucratic disenfranchisement. Proving local/state residency and income eligibility using income tax forms, bank accounts, or apartment leases is difficult in both locales. Moreover, the Massachusetts counterpart to Healthy San Francisco’s requirement of proof of denial from Medi-Cal is the fact that the unauthorized are automatically rejected from MassHealth prior to HSN enrollment.

Elise, the supervisor of financial assistance at BHC explained how this confuses applicants:

[MassHealth applicants receive] a 4-page letter [whose first side] starts off saying you have been denied. So every time a patient comes to us with that denial letter, we say, did you turn [it over]? Did you see your name there? [MassHealth] only sends out letters in English and Spanish and there are other populations that get it.

While the back of the form states that individuals denied MassHealth coverage are *eligible* for HSN, program applicants, especially those who are non-English speaking, receive this letter and assume they are ineligible. As in San Francisco, such complex documentation, language barriers, and lack of knowledge about eligibility have the *de facto* effect of excluding some unauthorized immigrants from accessing care through this program to which they are theoretically entitled.

Once they get HSN coverage, many unauthorized immigrants, especially if they look ‘Latino’, fear using healthcare services due to possible surveillance by immigration and local law

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enforcement. Reports of unauthorized immigrants being detained by law enforcement in transit to medical appointments have been reported in Boston and shown to decrease healthcare access among unauthorized immigrants *and* their authorized family members (Hacker et al. 2011; Joseph 2013). Adam, a Boston immigrant organization coordinator recounted a story about an immigrant patient whose healthcare providers called regarding his blood work, urging him to come to the doctor’s office immediately:

He [patient] drives 45 minutes, pulls on to Somerville Avenue which was being totally torn up and repaired, filled with Somerville cops, hanging around having coffee on their detail. They [police] could care less who’s driving by, but he sees all those police, he turns around and goes home which is the rational thing to do but it just mitigates against doing anything.

In San Francisco, several providers also reported high-profile immigration raids in 2007 and 2008, stoking unauthorized immigrants’ wariness about interacting with them as members of the ‘safe’ public safety net.

Conclusion: Whither the Great ‘Unfreeze’

Due to the actions of the American state over the last half century, distinctions have sharpened between unauthorized immigrants and others, such that in 2010 the symbolic and social boundaries around unauthorized immigrants in U.S. health care were already ‘bright.’ Still, they were somewhat ‘blurred’ as 32 million other Americans also lacked insurance and access to care. Since passage of the ACA in 2010, however, a critical boundary shift is underway as many U.S. citizens and long-term legal immigrants are being ‘recategorized’ (Matthew 2012)

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into insurance ‘insiders’, while unauthorized immigrants remain ‘frozen out’ (Capps and Fix 2013).

In both San Francisco and Massachusetts, our research demonstrates more inclusive recategorization of the unauthorized in health care compared to the national level. Symbolic boundaries have shifted toward recognizing unauthorized immigrants’ *de facto* legitimacy to be part of both locales’ civic communities (de Graauw 2012; Ridgley 2008). These symbolic boundaries have also been institutionalized into social boundaries, whereby unauthorized immigrants are afforded some coverage and access to care. Interestingly, in both places symbolic and social boundaries by income and local/state residency – that is, against people from Oakland or outside Massachusetts – have hardened even as those by documentation status have softened.

Nonetheless, between the two cases we see mutual limitations worthy of theoretical discussion. First, even though HSF and HSN are ostensibly ‘universal’ for all low-income residents, unauthorized immigrants have only been partially recategorized as morally worthy of care and given access to the bottom of a ‘categorically unequal’ system of coverage and access. Due to budget cuts, financial resources are limited and healthcare providers most stretched in this bottom stratum (Joseph 2013, forthcoming). In both systems, unauthorized immigrants remain disentitled because of financial and language barriers and bureaucratic requirements for accessing the safety net. Theoretically, both Healthy San Francisco and (Massachusetts’) Health Safety Net exist only as lower-bound floors through which (some) unauthorized immigrants can access their respective jurisdiction’s healthcare system. Policymakers and healthcare providers laud these policies, but also worry they compound other barriers to care for the unauthorized.

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Roger, a BHC physician, expressed concerns about how comprehensive health reform may eject some unauthorized immigrants from the local and national systems:

I suspect that a whole bunch of [the unauthorized] have left [the national system]. And the major leaving in our [MA] situation was the [2006] health care reform because what happened was that the Free Care pool [...] the state funds to pay for people who didn’t have insurance [...] before 2006] healthcare reform, that included *everyone* – small business owners, whole mass of students, or people just out of college who didn’t have jobs, as well as [the] undocumented. So everyone was bunched. The undocumented group was bunched together with other people. With [2006 MA] health care reform and [2010 ACA] Obamacare, now naturally what it’s going to do is it pulls those people out so it makes the Free Care pool [the remaining funding to the uninsured] much smaller and more likely [to be] the undocumented, and it’s much easier to cut them off.

More importantly, both subnational jurisdictions remain ‘subservient’ to the nation within the U.S. federalist system (de Graauw 2012, 147). The blurrier symbolic and social boundaries and the expanded access to health care for unauthorized immigrants we find in both locales remain embedded within a restrictive national climate, and therefore ‘place-bound and limited’ (de Graauw 2012, 147; Marrow 2012a, 2012b). Neither San Francisco nor Massachusetts can change boundaries or provide access to rights, benefits, and protections that the federal government can restrict. Without comprehensive immigration reform at the national level, we agree that San Francisco and Massachusetts remain inclusive ‘alternatives’ that ‘cannot live up to their full potential’ (de Graauw 2012, 147).

We conclude that both jurisdictions’ institutional arrangements remain imperfect substitutes for a more inclusive national-level one. Contrary to the post-national membership model advanced by Soysal (1994), where discourses of universalistic personhood are hypothesized to eventually supplant national citizenship in granting legitimacy and social, civil, and political rights, we still see national citizenship as critical for the incorporation of

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immigrants in the U.S. healthcare system. Also contrary to the emerging subnational membership model being investigated by scholars who are (rightly) curious about the causes and consequences of variation in responses to immigrants at the local and institutional levels (Crul and Schneider 2010; Varsanyi 2010), we also feel that ‘citizenship practice’ retains an ‘externally exclusive dimension’ as it becomes more internally inclusive (Joppke 1999, 6). In other countries with strong national welfare states, which offer more extensive insurance coverage or health care services to a fuller range of their citizen publics, the exclusion of the unauthorized in health care has typically been even ‘brighter’ than in the U.S.

Amid troubles plaguing ACA implementation – such as various states’ refusal to expand Medicaid and conservatives’ threats to repeal the law – many other U.S. citizens and long-term legal immigrants may not fully benefit from the policy either. This is most concerning in states where large numbers of low-income and racial minority citizens could ultimately be prevented from qualifying for Medicaid. Early optimism about increased enrollment rates in the ACA’s Medicaid expansion program is tempered by a wariness that Medicaid enrollment will diverge regionally between expansion and expansion-resistant states. Thus, the line separating citizens and legal immigrants from unauthorized immigrants may stay more ‘blurred’ in expansion-resistant states. But we stress that there remains a fundamental difference in how that exclusion is being produced. In non-expansion states, this exclusion is generated through political resistance and other implementation problems, which could be overcome within the bounds of the ACA. In contrast, the original ACA policy design separates the unauthorized from ‘deserving’ citizens and long-term immigrants nationwide.

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There are two possible solutions to uniformly blur unauthorized immigrants’ exclusion at the national level. First, revising the 1996 immigration and welfare reform policies that make them ineligible for the ACA could grant them greater access. Second, comprehensive federal immigration reform could adjust their documentation status, which would also make them ACA-eligible (Capps and Fix 2013). However, increasing anti-immigrant sentiment in national discourse and political gridlock along party lines in the federal government makes such changes unlikely. The 2013 reform bills presented in Congress would have at best made the path toward citizenship and equal healthcare coverage long and winding (Fox 2013). And more recent, piecemeal executive action policies only provide temporary relief from deportation and limited privileges for certain unauthorized immigrants, excluding access to federal public health insurance programs.¹³ The more likely scenario at this point is political stasis, with at best only a few small categories of unauthorized immigrants (e.g., high-achieving youth, pregnant women) deemed symbolically deserving enough to warrant inclusion within official policies. Thus, in the absence of federal immigration reform and in such a hostile context, imperfect subnational strategies such as those in San Francisco, Massachusetts, and elsewhere¹⁴ may be the most practical and promising recourse.

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Endnotes

¹ Thirty-four states use the federal exchange and 16 states created their own (Rosenbaum 2014).

² Unauthorized immigrants qualify for select public health and nutrition measures, such as immunizations and testing and treatment for communicable diseases. They only qualify for a limited form of ‘Emergency Medicaid’, which covers labour and delivery and other designated emergencies. They only qualify for non-emergency care in a few states or localities that use state or local funds.

³ Income-eligible immigrants with ‘Temporary Protected Status’ (TPS) and asylees and refugees are eligible for all ACA provisions their first seven years in the U.S. (Joseph forthcoming; NILC 2013).

⁴ Uneven ACA implementation may prevent some U.S. citizens from gaining coverage because they still deem purchasing coverage unaffordable, experience lapses in eligibility for subsidies, or live in non-ACA-compliant states (Buettgens and Hall 2011; Hall and Rosenbaum 2012; Tavernise and Gereloff 2013).

⁵ We have consolidated them in this manner; see Wimmer (2008) for more.

⁶ An opinion poll of likely voters conducted in December 2007 uncovered ‘overwhelming opposition’ to giving unauthorized immigrants access to Medicaid (Dionne 2008, 80).

⁷ While EMTALA does not prevent hospitals from billing patients for these services, federal DSH funds (which reached \$10 billion in 2009) or state funds can be used to reimburse uncollected emergency care costs. Otherwise, hospitals take the loss of treating such patients (Konczal and Varga 2012).

⁸ In 2008, more than 1,200 FQHCs operated in more than 8,000 urban and rural locations and served 20 million patients (Mickey 2012; Rosenbaum 2012; López-Sanders 2013).

⁹ See Marrow (2012a, 2012b) for more detail.

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¹⁰ HSF was funded through direct city-county public investment (about \$100 million in 2010 from the City’s General Fund), fees from patients (\$5.9 million), taxes on city employers (\$12.9 million), and a combination of expired and federal grants (Grady 2011).

¹¹ The structure of all publicly-subsidized Massachusetts programs has changed to comply with ACA requirements (Joseph forthcoming). However, they remain available to all immigrants.

¹² The HSN is funded with revenue collected from healthcare facilities and insurers across the state, which is redistributed to acute hospitals and FQHCs that serve uninsured populations (Wilson 2008). A small portion comes from the state government (Joseph forthcoming). The HSN fund is smaller than it was before the reform passed since the state’s uninsured population has decreased (Wilson 2008; Patel and McDonough 2010; Hall and Rosenbaum 2012).

¹³ President Obama announced the Deferred Action for Childhood Arrivals (DACA) program in 2012, which allowed undocumented young adults brought to the U.S. as children to receive temporary relief from deportation. DACA recipients can receive work authorization but do not have LPR status and cannot obtain citizenship. They are ineligible for ACA provisions unless under age 18 and low-income, which makes them eligible for the Children’s Health Insurance Program (CHIP) (Wong et al. 2013).

¹⁴ Vermont passed health reform in 2011, using state funds to insure unauthorized immigrants (Gram 2011). California has used state funds to extend Medicaid coverage to DACA-eligible youth, who are ineligible for such coverage at the federal level (Brindis et al. 2014). One California state senator has even called for the state to allow unauthorized immigrants’ access not only to its state Medicaid program, but also its state health exchange (May 2014).