# THE IMPACT OF THE COVID-19 PANDEMIC ON IMMIGRANT ACCESS TO HEALTHCARE

by

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## I. Introduction

In early 2020, SARS-CoV-2 (COVID-19) began to spread through the world, resulting in a worldwide pandemic and unprecedented health and economic impacts upon our global community. As the virus spread, governments across the world began to respond with policy meant to stem the flow of the virus, help their people, and stimulate a struggling economy. In the United States, the federal government initially responded to the virus with a $2 trillion dollar aid package and since then, has introduced measures to expand the social safety net and encourage adherence to public health guidelines. Although the federal government has made these broad efforts, governmental response has diverged significantly on a state and local level, with governors and city governments declaring different protocols of varying intensity. The intersection of this rapidly changing policy at the federal, state, and local levels translates into different levels of access to healthcare in different areas of the US, and it has caused great uncertainty for many Americans about their ability to get treated for COVID-19 or other illnesses. These concerns have been especially exacerbated for populations who are underserved in healthcare; one of these populations is immigrant communities who may face legal, socioeconomic, and cultural barriers in their attempt to access health resources.

In this research, I study the impact of local, state, and federal policy on immigrant populations and their access to healthcare. I investigate a variety of cities (varying in immigration-policy "friendliness" and immigrant population concentration) to determine how differing government responses to COVID-19 have translated into different barriers and opportunities for immigrants at the micro, meso, and macro level. I examine the following questions: What were common individual barriers that immigrants faced when attempting to access health resources during the pandemic? What was the role of non-government actors (such

as community-based organizations and healthcare facilities/providers) in increasing access to healthcare? How did macrostructural factors like government policy, law, and the broad political climate affect immigrant healthcare access? Did some states or cities have better health outcomes for their immigrant populations? If so, what were the characteristics of the city's existing legislation and what were the characteristics of the city's response to the pandemic? Does the leadership of local governments have an impact on health outcomes for immigrants? How might changes in health and government systems due to the COVID-19 pandemic lead to more equitable access in the future?

## II. Background

The COVID-19 pandemic has disproportionately impacted immigrant communities in the United States.[1] The intersection of poverty, limited access to healthcare, medical comorbidities, and fear of legal repercussions has placed vulnerable immigrant communities at a higher risk for contracting COVID-19 and developing more severe symptoms. To understand the intricacies of this impact, we must establish a context of immigrant access to healthcare and healthcare use preceding the pandemic.

In 2018, the US-foreign born population reached a record 44.8 million, with immigrants accounting for around 13.7% of the US population.[2] Of those immigrants, 22 million were noncitizens. The noncitizen population includes both lawfully present and undocumented immigrants, and many individuals live in families with mixed immigration statuses including lawfully present noncitizens, undocumented noncitizens, and foreign and native-born citizens.

Immigrant populations are characterized by certain conditions that might place them in higher need for health services. Socioeconomic disadvantages might place them in working situations and living environments that affect their health and wellbeing. For example, they might live in food deserts where they have limited access to nutritious foods or they might work in agricultural industries where they are not given sick days or work in unsafe conditions.[3] Some immigrants might also suffer from toxic stress related to fear of deportation, a trauma

[1] Clark, E., Fredricks, K., Woc-Colburn, L., Bottazzi, M. E., & Weatherhead, J. (2020). Disproportionate impact of the COVID-19 pandemic on immigrant communities in the United States. PLoS neglected tropical diseases, 14(7), e0008484. https://doi.org/10.1371/journal.pntd.0008484
[2] Budiman, A. (2020, September 22). Key findings about U.S. immigrants. Retrieved from https://www.pewresearch.org/fact-tank/2020/08/20/key-findings-about-u-s-immigrants/
[3] Nebraska DHHS Office of Health Disparities and Health Equity. (2015). Risk Factors for Immigrants in Nebraska. Retrieved from https://dhhs.ne.gov/Reports/Risk Factors for Immigrants.pdf

particularly potent in children.[4] These social determinants of health are only exacerbated by the political climate and institutions in which immigrants attempt to access healthcare.

In the US, lack of insurance coverage is a major barrier to accessing healthcare. Within the US healthcare system, health insurance is important to ensure families and individuals feel comfortable and empowered to access healthcare. Rising healthcare costs and complicated health systems make it difficult to obtain health care without coverage. Noncitizens are more likely to be uninsured compared to foreign-born citizens; in 2018, among the nonelderly population, 23% of lawfully present immigrants and more than 45% of undocumented immigrants were uninsured compared to less than 9% of citizens (both US and foreign born).[5]

Noncitizens are more likely than citizens to be uninsured for a variety of reasons. First, they face gaps in access to private coverage. In 2018, private health insurance coverage was more prevalent than public coverage in the US, covering 67.3% of the population, with employer-sponsored insurance (or ESI) as the most common form.[6] Although most nonelderly noncitizens live in a family with a full-time worker, they are also more likely to work low-wage jobs in industries that are less likely to offer ESI. Their lower incomes also produce a barrier when affording private coverage through the individual health insurance marketplace.

Second, they face barriers to enrollment in public coverage. Lawfully present immigrants may qualify for federal social safety net programs like Medicaid and CHIP, but they are subject to extensive eligibility requirements. Lawfully present immigrants who are not lawful permanent residents (LPRs) must have the "qualified" immigration status of refugee, asylee, or

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[4] Immigration, Health Care and Health. (2019, July 26). Retrieved from https://www.rwjf.org/en/library/research/2017/09/immigration-status-and-health.html

[5] Health Coverage of Immigrants. (2020, March 18). Retrieved from https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/

[6] US Census Bureau. (2019, November 08). Health Insurance Coverage in the United States: 2018. Retrieved from https://www.census.gov/library/publications/2019/demo/p60-267.html#:~:text=The uninsured rate and number,7.9 percent or 25.6 million).&text=The percentage of people with,in 2017 (92.1 percent).

some other forms of humanitarian protection, and meet income-eligibility thresholds. Lawfully present immigrants who are LPRs must wait five years before enrolling, a requirement that has been tightened and loosened across different states. LPRs are, however, eligible to purchase coverage through the ACA marketplace and receive associated subsidies even if they are not eligible for Medicaid or CHIP because of the five-year waiting period. Undocumented immigrants are the most restricted in their access to healthcare because they are neither eligible to enroll in Medicaid or CHIP not able to purchase coverage through the ACA marketplace. Medicaid payments may be used to pay for emergency services given to undocumented immigrants, and some states and cities have expanded their own health programs to cover undocumented immigrants. Nonetheless, the current federal policies in place do result in significant barriers for non -citizen immigrants attempting to access healthcare.

Beyond policies that directly influence healthcare and health insurance coverage, there are also other factors that influence immigrant healthcare access that are exacerbated by government policies and practices. Language, literacy, and cultural beliefs and practices can pose barriers to immigrants accessing healthcare. Immigrants who do not speak English or do not speak it proficiently may be unable to access materials for programs they might otherwise apply to. This barrier is heightened when government websites and services do not provide bilingual resources and staff. Some immigrants may have cultural beliefs and practices that define their interaction with healthcare providers and Western bureaucracies more generally. When government structures do not specifically empower people of these different backgrounds, immigrants tend to underutilize health services.[7]

[7] Barriers to Immigrants' Access to Health and Human Services Programs. (2017, February 21). Retrieved from https://aspe.hhs.gov/basic-report/barriers-immigrants-access-health-and-human-services-programs#language

Immigration policy also plays a large role in deterring immigrants from seeking public assistance, including health services. In August 2019, the Trump administration published a DHS rule to change "public charge" inadmissibility policies. The existing "public charge" policy had allowed immigration officials to deny entry to the US or a change to LPR status to people determined to be a "public charge." The new rule expanded the definition of "public charge" to include individuals who had utilized federal programs including health services like Medicaid. Fear and confusion regarding the "public charge" rule led to a "chilling effect" of lower enrollment rates among noncitizens and individuals who live in households with a noncitizen. This "chilling effect" was also exacerbated by other hardline immigration policy and rhetoric produced during the Trump Administration. Although the "public charge" rule was temporarily suspended in light of the COVID-19 pandemic, the "chilling effect" persists among immigrant communities, leading to fear and unwillingness to access health resources.

All of the barriers to healthcare access mentioned above were present before the COVID-19 pandemic, but the adverse effects suffered by noncitizen immigrants have only been heightened in the midst of this health crisis. Immigrant communities are particularly vulnerable in this pandemic due to their socioeconomic conditions, limited access to healthcare, and fear of legal repercussions of accessing healthcare. Since many vulnerable immigrants are under or uninsured, they are restricted to health services provided through indigent care clinics and community health centers that are already underfunded and may now be overwhelmed due to COVID-19 related healthcare needs. Immigrants may also be at higher medical risk for COVID-19 due to the underlying health conditions and comorbidities that have been linked to more severe COVID-19 cases. Their socioeconomic situation might also put them at greater risk; since many vulnerable immigrants are essential workers, it might be difficult to follow social

distancing or stay-at-home orders. They are also more likely to live in large, multi-generational homes that have similar problems with social distancing and a resultant spread to elderly and immunocompromised individuals.[8] These various factors make immigrant communities particularly vulnerable during the COVID-19 pandemic.

[8] Clark, E., Fredricks, K., Woc-Colburn, L., Bottazzi, M. E., & Weatherhead, J. (2020). Disproportionate impact of the COVID-19 pandemic on immigrant communities in the United States. PLoS neglected tropical diseases, 14(7), e0008484. https://doi.org/10.1371/journal.pntd.0008484

## III. Study Setting

In this paper, I investigate the impact of policy on immigrant health care access by focusing on six cities within a matrix of immigrant-friendliness and immigrant population concentration as demonstrated below:

| | Low (0-20%) | Medium (21-44%) | High (>45%) |
|---|---|---|---|
| Sanctuary City | Burlington, VT | Chicago, IL | Sacramento, CA |
| Non-Sanctuary City | Charlottesville, VA | Austin, TX | Phoenix, AZ |

Status as a sanctuary city is used as a proxy to determine friendliness toward immigrant populations. There is no legal definition for a sanctuary city, but typically it denotes a city that limits its cooperation with federal immigration enforcement in order to protect law-abiding undocumented immigrants from deportation.[9] By asserting sanctuary city status, city officials signal their commitment to the wellbeing of their undocumented immigrant communities which may translate into friendlier policy and actions related to immigrant health at a city level. The immigrant population concentration was proximally calculated using the combined percentage of Hispanic or Latino and Asian populations. Although immigrants exist outside of these communities, and some individuals in these communities may not be immigrants, these numbers provide a proximate understanding of the cities' immigrant population concentration.

| | Charlottesville | Burlington | Austin | Chicago | Phoenix | Sacramento |
|---|---|---|---|---|---|---|
| White alone, percent | 70.70% | 85.30% | 73.50% | 49.40% | 72.90% | 46.30% |
| Black or African American alone, percent(a) | 18.40% | 5.70% | 7.80% | 30.10% | 7.10% | 13.20% |
| American Indian | 0.40% | 0.20% | 0.60% | 0.30% | 2.10% | 0.70% |

[9] Immigration 101: What is a Sanctuary City? (2019, October 09). Retrieved from https://americasvoice.org/blog/what-is-a-sanctuary-city/

| | | | | | | |
|---|---|---|---|---|---|---|
| and Alaska Native alone, percent(a) | | | | | | |
| Asian alone, percent(a) | 7.20% | 5.80% | 7.30% | 6.40% | 3.80% | 18.90% |
| Native Hawaiian and Other Pacific Islander alone, percent(a) | 0.10% | 0.00% | 0.00% | 0.00% | 0.20% | 1.70% |
| Two or More Races, percent | 3.20% | 2.80% | 3.30% | 2.70% | 3.90% | 7.40% |
| Hispanic or Latino, percent(b) | 5.80% | 3.10% | 34.30% | 29.00% | 42.60% | 28.90% |
| White alone, not Hispanic or Latino, percent | 66.20% | 82.90% | 48.30% | 32.80% | 42.50% | 32.40% |
| **Hispanic or Latino + Asian** | **13.00%** | **8.90%** | **41.60%** | **35.40%** | **46.40%** | **47.80%** |

Table 1. Population Breakdown of Race and Hispanic Origin as Gathered from Census QuickFacts Data in 2019[10]

Many of the barriers described in the background section are enshrined in specific policy (ranging from the local to federal level). In the following section, I will detail some of the broader policies, both those in place pre-COVID-19 and those implemented in response to the pandemic, that impact immigrant access to health care.

***Federal Policy***

*Pre-COVID-19 Pandemic*

Federal legislation regarding health care and immigration has developed significantly from 1986 to the present. In 1986, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) which requires anyone coming to an emergency department to be stabilized and treated regardless of their legal status, insurance status, or ability to pay. The law was designed to prevent the practice of hospitals transferring uninsured or Medicaid patients to public hospitals without ensuring they were stable for a transfer. In 1996, the Personal

[10] US Census Bureau. (2019, August 27). QuickFacts. Retrieved from https://www.census.gov/programs-surveys/sis/resources/data-tools/quickfacts.html

Responsibility and Work Opportunity Reconciliation Act (PRWORA) was passed, effectively terminating access to certain benefits (like welfare programs and Medicaid) for undocumented immigrants. This law was a manifestation of the growing "bootstrap" rhetoric about individuals needing to prove work ethic before accessing welfare. In 2013, Congress passed the Border Security, Economic Opportunity, and Immigration Modernization Act of 2013. This law enhanced border security, integrated the undocumented immigrant population at the time, and streamlined the citizenship process for highly skilled and educated people.

In 2010, President Obama signed into law the Patient Protection and Affordable Care Act (also known as the ACA and Obamacare). This landmark law intended to transform the American healthcare system in an attempt to achieve national health coverage. However, the law focuses exclusively on legal residents of the USA (including LPRs) and excludes unauthorized immigrants from participation.[11]

In addition to their individual effects on health care and immigration policy, these laws intersect in numerous ways to affect immigrant access to health care. For example, the prerequisite of certain work requirements and a waiting period for noncitizens to access Medicaid is based on the welfare requirements produced by the PRWORA. The 2013 act did not directly address healthcare, but it increased the number of undocumented immigrants who may require access to health care as they became legalized. As mentioned above, even federal policy (as opposed to Congressional legislation) like the "public charge" rule implemented by the DHS

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[11] Health Care for Undocumented Immigrants in Texas Texas Medicine July 2014. (n.d.). Retrieved from https://www.texmed.org/July14Journal/

can also contribute to less health care access because noncitizens fear the repercussions on their long-term ability to remain in the country.[12]

*During COVID-19 Pandemic*

When the novel coronavirus first spread to the United States in early 2020, the federal government's response included some major failures of judgement and inaction that exacerbated the impact of the virus in the months to come.[13] In late January, President Trump doubled down on his rhetoric that the USA had everything under control despite a lack of tangible preventive measures and steps to prepare for the oncoming spread. Accordingly, once cases began to appear in the United States in February, the virus spread in the US mostly undetected and uncontained. There was a lack of comprehensive support or guidance for state governments from the federal government, especially regarding stay-at-home orders, mask mandates, and guidelines for shutdowns.[14]

On March 6, 2020, President Trump signed into law the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, which provided $8.3 billion in emergency funding to support development of vaccines and treatment, grants for state and local governments, preparedness activities for U.S. government facilities, and humanitarian foreign assistance. Once again, discretion on specific use of the funds was left to the states.

The policy response of the federal government had specific impacts on immigrant access to healthcare. The Families First Coronavirus Response (Families First) Act, the Coronavirus

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[12] Changes to "Public Charge" Inadmissibility Rule: Implications for Health and Health Coverage. (2019, August 13). Retrieved from https://www.kff.org/racial-equity-and-health-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/
[13] Wallach, P. A., & Myers, J. (2020, April 01). The federal government's coronavirus actions and failures. Retrieved from https://www.brookings.edu/research/the-federal-governments-coronavirus-actions-and-failures-timeline-and-themes/
[14] Schwellenbach N. (2020, May 6). The First 100 Days of the U.S. Government's COVID-19 Response. Retrieved from https://www.pogo.org/analysis/2020/05/the-first-100-days-of-the-u-s-governments-covid-19-response/

Aid, Relief, and Economic Security (CARES) Act, and the Paycheck Protection Program and Health Care Enhancement (Paycheck Protection) Act provided funds to health care providers that expanded the availability of free testing for COVID-19 through community health centers. Immigrants could continue to access health care services at community health centers, regardless of their immigration status, and at a reduced cost or free of charge depending on their income.

Eligibility for Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA) marketplaces was not changed on the federal level, but states were given the flexibility to cover testing, treatment, and vaccines for COVID-19 under emergency Medicaid. Importantly, the United States Citizenship and Immigration Services Agency posted an update to the infamous public charge rule, saying that they will not consider testing, treatment, or preventative care related to COVID-19 in a public charge inadmissibility determination, even if the services are covered by Medicaid. Under the original rule, use of Medicaid would have negatively impacted some noncitizens' ability to become a legal permanent resident of the USA.[15]

### ***State and Local Policy***

#### *Pre-COVID-19 Pandemic*

Although federal policy broadly dictates access to health care across the country, states do have the ability to restrict or expand health coverage, especially with the Medicaid expansion option included in the ACA. Through the ACA, many states have chosen to expand their health coverage with federal dollars and some have even increased access for noncitizens by loosening work restrictions or waiting period requirements.

[15] Update on Access to Health Care for Immigrants and Their Families. (2021, April 09). Retrieved from https://www.nilc.org/issues/health-care/update-on-access-to-health-care-for-immigrants-and-their-families/

Relative to the state or federal governments, cities do not have much authority in establishing health coverage eligibility. However, local governments play a role in implementing policy and directly delivering health services. Many introduce outreach programs or finance assistance initiatives specifically targeted at under-insured populations. Accordingly, local governments can help restrict or expand access to healthcare for immigrants. Additionally, sanctuary status is typically designated on a city-by-city basis, and this and other initiatives can allow cities some leeway in their "friendliness" to immigrant communities.

In the following section, I highlight notable policies and programs present in the observed cities and states, both: Charlottesville, Virginia; Burlington, Vermont; Austin, Texas; Chicago, Illinois; Phoenix, Arizona; and Sacramento, California.

**Virginia**

Virginia approved Medicaid expansion as part of its FY 2019-2020 budget in May 2018.[16] Virginia allows LPRs who are children and pregnant women to enroll in Medicaid without the five-year waiting period. LPRs who do not fall under those two categories are subject to the 5-year waiting period. Undocumented immigrants and DACA recipients are not eligible for any health coverage programs besides emergency Medicaid.[17]

Until 2020, Virginia was one of only six states that imposed a strict 10 year working period on legal noncitizens before they could be eligible for Medicaid. This "40-quarter" rule was based upon the PRWORA legislation mentioned above, and it was instituted in addition to the federal law requiring five years of residence. This was cited as a major barrier to immigrant

[16] https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[17] A Quick Guide to Immigrant Eligibility for Virginia Medicaid and ACA. (2019, July). Retrieved from https://static1.squarespace.com/static/56e188a6d210b87a6973cf2a/t/5d40776ce783490001d542d3/1564505964562/A Quick Guide to Immigrant Eligibility for Virginia Medicaid and ACA 9.12.2019 (1).pdf

Medicaid enrollment by state and local leaders.[18] In 2020 before the onset of the COVID-19 pandemic, the state legislature voted to eliminate the "40-quarter" restriction which will let more LPRs access health coverage via Medicaid.[19]

Virginia also passed a bill in 2020 which created an "Office of New Americans" in the Department of Social Services. This office is primarily focused on helping immigrants secure housing, employment, and guidance on the citizenship process, but one key health-related provision of the office was to "educate localities and immigration service organizations on health epidemics."[20]

**Charlottesville, VA**

In March of 2017, the then-mayor of Charlottesville formed a new task force dedicated to making the city more welcoming to immigrants and minorities. This task force has launched a number of initiatives in Charlottesville including the "Know Your Neighbor" video project on immigrant stories, various educational programs, political advocacy social media posts, and an annual "Welcoming Week" which celebrates the community's diversity. Another notable program they have launched in 2019 is the ID card program which aims to provide immigrants, the homeless, people returning from prison, and the elderly who can no longer drive with some form of community-based ID so that they can access various services.[21]

Charlottesville was the site of the "Unite the Right" white supremacist rally in August 2017 which drew national attention. Groups of neo-Nazis and white supremacists marched in opposition to the removal of Confederate statues, demonstrating that Charlottesville does harbor

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[18] Virginia Immigrants Have To Work 10 Years To Qualify For Medicaid. (2021, April 27). Retrieved from https://vpm.org/news/articles/6073/virginia-immigrants-have-to-work-10-years-to-qualify-for-medicaid
[19] Figueroa, E. (2020, August 12). Virginia, Other States Advance Immigrant-Inclusive Policies. Retrieved from https://www.cbpp.org/blog/virginia-other-states-advance-immigrant-inclusive-policies
[20] HOUSE BILL NO. 1209. (2020, January 08). Retrieved from https://lis.virginia.gov/cgi-bin/legp604.exe?201+ful+HB1209
[21] Welcoming Greater Charlottesville. (n.d.). Retrieved from https://www.wgcville.org/

individuals and communities opposed to the presence of non-white immigrants. However, there are many local organizations, ranging from faith-based entities to nonprofits, that work with and for the immigrant population in Charlottesville. Especially in the wake of the Trump administration and the associated negative rhetoric around immigration, these community based organizations have taken on efforts like political advocacy, public sanctuaries, legal aid, etc.[22] Despite Charlottesville's membership in Welcoming America, a nonprofit that sets standards and guidelines for what are formally considered to be "welcoming" cities, the city stops short of formally refusing to cooperate with ICE by declaring sanctuary city status.[23]

**Vermont**

Vermont chose to accept Medicaid expansion as soon as it was offered through the passage of the ACA, implementing the expansion on January 1, 2014.[24] Vermont allows both lawfully-residing immigrant children and pregnant women to enroll in Medicaid without the five-year waiting period.[25] LPRs who do not fall under those two categories are subject to the 5-year waiting period. Undocumented immigrants and DACA recipients are not eligible for any health coverage programs besides emergency Medicaid.[26]

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[22] Fighting fear: Local groups step up to help our community of undocumented immigrants. (2018, December 19). Retrieved from https://www.c-ville.com/fighting-fear-local-groups-step-up-to-help-our-community-of-undocumented-immigrants/

[23] Landers, J. (2017, January 19). Although Charlottesville is a Welcoming City, undocumented immigrants still live in fear. Retrieved from https://www.c-ville.com/charlottesville-declared-welcoming-city-undocumented-immigrants-still-live-fear/

[24] Status of State Action on the Medicaid Expansion Decision. (2021, April 13). Retrieved from https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[25] Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women. (2021, January 1). Retrieved from https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[26] Vermont Medicaid Rules. (n.d.). Retrieved from https://dcf.vermont.gov/sites/dcf/files/ESD/Rules/2016/Rules/Annotated.pdf

Even before the ACA, Vermont had taken steps to expand health coverage by creating the programs, Catamount Health and the Vermont Health Access Plan. These programs targeted low-income residents, resulting in one of the lowest uninsured rates in the country.[27] Vermont also created its own state-run virtual health insurance marketplace called Vermont Health Connect which integrated their older programs, Catamount and VHAP. Vermont is also the only state in the nation to make participation in the exchange mandatory.[28] Although these programs have been successful in expanding health coverage broadly, they have not specifically targeted noncitizens deemed ineligible for Medicaid by federal law. Vermont Health Connect does include a significant number of official resources designed to help noncitizens understand their eligibility.[29][30]

In 2018, three Republican senators introduced House Bill 823 which called for a work requirement for the state's Medicaid program. The bill did not pass the house, but the governor has not ruled out the idea of putting forth a Medicaid work requirement in the future.

**Burlington, VT**

Burlington has a thriving immigrant community and is generally viewed as an immigrant-friendly city. In 2019, Burlington mayor Miro Weinberger publicly announced that the city would welcome asylum-seeking immigrants if the Trump administration moved forward with its idea to relocate them to "sanctuary cities," reaffirming the city's acceptance and celebration of immigrants.[31] Since 1989, at least six thousand men, women, and children have come to

[27] Norris, L. (2021, March 24). Vermont and the ACA's Medicaid expansion. Retrieved from https://www.healthinsurance.org/vermont-medicaid/

[28] VTD Staff Nov 18 2013January 7, 2. (2016, January 07). What the heck is Vermont Health Connect? Retrieved from https://vtdigger.org/2013/11/18/heck-vermont-health-connect/

[29] Vermont Health Connect. (n.d.). Migrant FAQ. Retrieved from https://info.healthconnect.vermont.gov/sites/hcexchange/files/VTAHS 7254-02_MigrantFAQ_Final_0617.pdf

[30] Public Charge Rule. (n.d.). Retrieved from https://info.healthconnect.vermont.gov/public_charge

[31] Quigley, A. (2019, April 15). Burlington mayor opens arms to asylum-seeking immigrants. Retrieved from https://vtdigger.org/2019/04/15/burlington-mayor-opens-arms-asylum-seeking-immigrants/

Vermont through a federal refugee resettlement program. The Burlington area is seen as one of the most hospitable destinations for immigrants due to the opportunities and assistance offered by Chittenden county institutions and service providers. For example, Chittenden County schools include dozens of languages in addition to English. Vermont resettlement specialists have observed the process of refugee assimilation to be largely free of xenophobia or racism but warn that the relationship between immigrants and the city could be strained as the proportion of immigrants in the Burlington area continues to grow.

**Texas**

Texas did not adopt Medicaid expansion.[32] Texas allows LPRs who are children to enroll in Medicaid without the five-year waiting period, but it does require the five-year waiting period for pregnant women along with all other non-children LPRs. Undocumented immigrants and DACA recipients are not eligible for any health coverage programs besides emergency Medicaid.[33]

Because Texas did not expand Medicaid, there are many individuals who fall into a "coverage gap." Adults who fall into the coverage gap have incomes above their state's eligibility for Medicaid but below the minimum income eligibility for ACA tax credits. This is because the ACA was designed with the assumption that low-income people would receive

[32] Status of State Action on the Medicaid Expansion Decision. (2021, April 13). Retrieved from https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[33] Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women. (2021, January 1). Retrieved from https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

coverage through Medicaid, not the federal marketplace. As a result, in Texas, certain LPRs are trapped in the coverage gap although they are otherwise eligible for health coverage.[34]

**Austin, TX**

In September 2013, the Austin city council issued a proclamation declaring Austin "a welcoming city for international newcomers." Soon afterwards, it launched the International Welcome Program, declaring membership with Welcoming America, a nonprofit that sets standards and guidelines for what are formally considered to be "welcoming" cities. Through the Welcoming City initiative, the city of Austin sought to understand the issues faced by immigrants in the city, producing a comprehensive report, and host information events like the *Austin: Welcoming City Summit* to educate the general public and service providers on issues affecting immigrants.[35] In addition to these initiatives, Austin has also taken steps to combat anti-immigrant legislation passed by the state. Senate Bill 4, signed by Governor Abbott into law in 2017, required all Texas law enforcement agencies to comply with US Customs and Enforcement detainers and would punish local government entities for not enforcing federal immigration laws.[36] Elected officials in Austin, joined by advocacy groups and elected officials from Dallas, Houston, San Antonio, and El Paso challenged SB 4, citing a need to protect their communities.[37] Despite these efforts, the law still remains in effect.

**Illinois**

[34] Dunkelberg, A. (n.d.). Immigrants' Access to Health Care in Texas: An Updated Landscape. Retrieved from https://everytexan.org/images/HW_2016_ImmigrantsAccess_FullReport.pdf
[35] https://www.austintexas.gov/sites/default/files/files/EGRSO/WelcomingCityInitiativeFinalReport9_4_2015__1_.pdf
[36] Five Things to Know About Texas's SB 4 Bill. (n.d.). Retrieved from http://immigrationforum.org/wp-content/uploads/2017/05/SB-4-five-questions.pdf
[37] Tuma, M. (2017, May 06). Austin, Texas Cities Promise Legal Fight Against SB 4. Retrieved from https://www.austinchronicle.com/daily/news/2017-05-16/austin-texas-cities-promise-legal-fight-against-sb-4/

Illinois chose to accept Medicaid expansion as soon as it was offered through the passage of the ACA, implementing the expansion on January 1, 2014.[38] Illinois allows LPRs who are children to enroll in Medicaid without the five-year waiting period, but it does require the five-year waiting period for pregnant women along with all other non-children LPRs. Undocumented immigrants and DACA recipients are not eligible for any health coverage programs besides emergency Medicaid.[39]

Under the ACA, more than 200,000 immigrants in Illinois became newly eligible to buy health insurance, but many of them experienced barriers in accessing healthcare due to limited English proficiency, a complicated application and eligibility process, work obligations, and a climate of fear and mistrust. The Immigrant Family Resource Program (IFRP) was designed to address many of these barriers. IFRP is a partnership between immigrant-serving agencies throughout Illinois, the Illinois Coalition for Immigrant and Refugee Rights (ICIRR) and the Illinois Department of Human Services (IDHS) to support immigrant access to health and human services. The program partners with a number of community based organizations with capacity in 59 languages.[40]

The Illinois Department of Healthcare and Family Services also administers a program called All Kids that provides free or affordable healthcare coverage to children 18 years and younger of low-income, uninsured families in Illinois, regardless of immigration status or

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[38] Status of State Action on the Medicaid Expansion Decision. (2021, April 13). Retrieved from https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[39] Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women. (2021, January 1). Retrieved from https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[40] Quiñones, L., & Rashid, A. (n.d.). Affordable Care Act Implementation in Illinois: Overcoming Barriers to Immigrant Health Care Access. Retrieved from https://www.hfnlc.org/wp-content/uploads/2015/09/Overcoming-Barriers-to-Immigrant-Health-Care-Access.pdf

medical condition. Payment for All Kids is determined on a sliding scale depending on household income, and the child must be uninsured for at least 12 months before they can be eligible for All Kids (unless household income is less than a certain amount). There is also an associated program called Family Care for citizen and LPR parents and caretaker relatives who have resided in the United States for longer than five years and are living and caring for children 18 years old and younger.[41] Receiving benefits through All Kids or Family Care does not hurt immigration status of beneficiaries.

**Chicago, IL**

Former Mayor Rahm Emanuel declared Chicago's status as a sanctuary city, a position he strongly reiterated in response to the Trump administration's hardline positions on immigration.[42] This position has been strengthened by current mayor Lori Lightfoot when she removed exceptions where local policy can cooperate with federal immigration authorities.[43] The mayor's office has put out an official guide for immigrant populations which includes resources for legal help, know-your-rights, a municipal ID program, mental health care, and public safety.[44] There is also an established Office of New Americans which implements numerous initiatives to enhance immigrant integration and receptivity in the city. These include assistance with citizenship acquisition, legal aid, and higher education scholarships.[45] Chicago is

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[41] Healthcare Resources for Immigrants. (n.d.). Retrieved from https://www.icirr.org/healthcareresources-for-immigrants

[42] Gonzales, R. (2016, November 15). Mayor Rahm Emanuel: 'Chicago Always Will Be A Sanctuary City'. Retrieved from https://www.npr.org/sections/thetwo-way/2016/11/14/502066703/mayor-rahm-emanuel-chicago-always-will-be-a-sanctuary-city

[43] Press, A. (2021, February 24). Chicago Mayor Lori Lightfoot signs plan boosting sanctuary protections. Retrieved from https://www.fox32chicago.com/news/chicago-mayor-lori-lightfoot-signs-plan-boosting-sanctuary-protections

[44] https://www.chicago.gov/content/dam/city/depts/mayor/Office%20of%20New%20Americans/PDFs/Resources_Flyers/Resources_Flyer_English_Color.pdf

[45] Welcoming America. (2021, April 22). Retrieved from https://welcomingamerica.org/

also part of the Welcoming America initiative, a nonprofit network that sets standards and guidelines for what are formally considered to be "welcoming" cities.[46]

**Arizona**

Arizona chose to accept Medicaid expansion as soon as it was offered through the passage of the ACA, implementing the expansion on January 1, 2014.[47] However, Arizona does not allow children or pregnant women to bypass the five-year waiting period for Medicaid eligibility.[48] Undocumented immigrants and DACA recipients are not eligible for any health coverage programs besides emergency Medicaid.

Before the expansion of Medicaid, Arizona contended with the passing of SB 1070, a law which required police to investigate, detain, and arrest people if they sense immigration violations. It was the most severe immigration enforcement law enacted by any state since 1994 and many law enforcement groups in Arizona opposed the bill because of the major impacts it would have on community policing efforts which rely on residents cooperating with the police rather than hiding from them.[49] A 2014 study found that immigration policies such as SB 1070 may contribute to decreases in use of preventive health care and public assistance among high-risk populations, specifically Mexican-origin individuals who may have a fear of deportation or

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[46] Welcoming America. (2021, April 22). Retrieved from https://welcomingamerica.org/
[47] Status of State Action on the Medicaid Expansion Decision. (2021, April 13). Retrieved from https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[48] Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women. (2021, January 1). Retrieved from https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[49] Martinez, G. (2010, May 14). Beyond Arizona: Without Comprehensive Immigration Reform, Intolerance Will Rise Across Our Country. Retrieved from https://www.americanprogress.org/issues/immigration/reports/2010/05/14/7779/beyond-arizona/

perceived lack of safety when in contact with public providers such as medical or governmental professionals.[50]

**Phoenix, AZ**

In 2017, Mayor Greg Stanton responded to calls by local activists asking for the city to defy state law on immigration issues with the decision that he would not declare Phoenix a sanctuary city.[51] Although local activists have petitioned city government on this issue for a long time especially in response to SB 1070, a particularly harsh immigration law, the mayor refused to break with state policy. The Phoenix area and associated local authorities are known to be unfriendly for immigrants, with a history of some of the harshest anti-undocumented-immigrant laws in the United States. Maricopa County Sheriff Joe Arpaio played a notable role in establishing this hostile environment. The self-described toughest sheriff in America was well-known for his "crime suppression sweeps," racial profiling and illegal detention of Latinos, and keeping of inmates in brutal jail conditions.[52]

**California**

California chose to accept Medicaid expansion as soon as it was offered through the passage of the ACA, implementing the expansion on January 1, 2014.[53] California allows LPRs who are children and pregnant women to enroll in Medicaid without the five-year waiting period.

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[50] Toomey, R. B., Umaña-Taylor, A. J., Williams, D. R., Harvey-Mendoza, E., Jahromi, L. B., & Updegraff, K. A. (2014). Impact of Arizona's SB 1070 immigration law on utilization of health care and public assistance among Mexican-origin adolescent mothers and their mother figures. American journal of public health, 104 Suppl 1(Suppl 1), S28–S34. https://doi.org/10.2105/AJPH.2013.301655

[51] Goth, B. (2017, February 03). Mayor Greg Stanton: Phoenix can't be a 'sanctuary city'. Retrieved from https://www.azcentral.com/story/news/local/phoenix/2017/02/02/mayor-greg-stanton-phoenix-cannot-sanctuary-city/97417082/

[52] Illegal: Life and Death in Arizona's Immigration War Zone. (2004). Retrieved from https://www.goucher.edu/learn/graduate-programs/mfa-in-nonfiction/student-alumni-work/illegal

[53] Status of State Action on the Medicaid Expansion Decision. (2021, April 13). Retrieved from https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

In 2019, California became the first state in the country to offer government-subsidized health benefits to adult undocumented immigrants. Governor Gavin Newsom signed SB-104 which extended health care benefits to individuals 19 to 25 years of age, regardless of immigration status through the state's Medicaid program, MediCal.[54] Since 2016, California has allowed children under 18 to receive taxpayer-backed healthcare regardless of immigration status.[55] Some lawmakers are currently pushing for universal health coverage in California which would entail expanding MediCal to cover every income-eligible resident regardless of immigration status.[56]

**Sacramento, CA**

The city of Sacramento is recognized as an immigrant-friendly city nationwide, ranked at no. 18 on the New American Economy cities index which analyzed 100 of the largest US cities and assigned them a score based on criteria of how well they integrate immigrants.[57] In 2016, the Sacramento mayor-elect Darrell Steinberg reaffirmed Sacramento's status as a sanctuary city, responding to the Trump administration's crackdown on Central American immigrants.[58] Elected officials who are immigrants themselves have played a major role in advocating for

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[54] Cole, D., & Moon, S. (2019, July 10). California gov signs health care bill extending coverage to some undocumented residents - CNN Politics. Retrieved from https://www.cnn.com/2019/07/10/politics/california-gavin-newsom-medicaid-coverage-undocumented-immigrants

[55] Health Coverage and Care for Undocumented Immigrants. (2019, May 15). Retrieved from https://www.ppic.org/publication/health-coverage-and-care-for-undocumented-immigrants/

[56] Hart, A. (2020, December 09). California lawmakers to Gov, Newsom: Give all immigrants health coverage. Retrieved from https://medcitynews.com/2020/12/california-lawmakers-to-gov-newsom-give-all-immigrants-health-coverage/

[57] The City of Sacramento is Recognized as an Immigrant-Friendly City Nationwide. (2018, September 17). Retrieved from https://www.cityofsacramento.org/Mayor-Council/Districts/District6/Media-Releases/Immigrant-Friendly-City

[58] Chabria, A. (2016, November 17). Sacramento Mayor-elect Darrell Steinberg vows to fight Trump on immigration. Retrieved from https://www.sacbee.com/news/local/article115282793.html

immigrant communities in the city, a notable example being Councilman Eric Guerra who had been brought into the country illegally as a child.[59]

As part of a statewide patchwork effort to bring care to undocumented immigrants, Sacramento County offers a Healthy Partners program which offer services to the uninsured, regardless of immigration status. Although the program has made some steps in increasing access to healthcare for immigrant populations, especially through advocates pushing for removal of the age-limit and increasing the 3,000-patient cap, it now has a cap of 4,000 patients and falls short of fulfilling all requests for medical care.[60]

*During the COVID-19 Pandemic*

States had some leeway as to how they addressed the pandemic. I will be including actions taken by the state government between March 2020 and July 2020 and other actions pertinent to this research taken outside that time period.

Cities also had some ability to enforce mask mandates and stay-at-home orders. However, they answered to the authority of the states and in some situations, state leaders superseded extra precautions undertaken by city mayors and compelled them to be more lenient in their public health safety measures.

**Virginia**

Governor Northam declared a state of emergency on March 12, 2020 when the state had 17 reported cases of COVID-19. A gathering ban was instituted on March 17th. A stay-at-home executive order was issued on March 30th until June 10th when the state had reached 1.2k

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[59] Breton, M. (2019, November 24). That immigrant we shun could be our next councilman. Ask Eric Guerra, ‘a proud American.’. Retrieved from https://www.sacbee.com/opinion/article237602199.html

[60] Caiola, S. (2019, October 20). California’s patchwork of care for the undocumented: Where you live matters. Retrieved from https://www.sacbee.com/latest-news/article228303499.html

cases.[61] On April 27, Governor Northam announced his reopening plan for the state. Despite this plan, he chose to extend the executive order on business restriction on May 4th. The state government also allowed Northern VA to delay reopening on May 12, demonstrating cooperation between state and local governments. On May 15, Virginia launched its first phase of reopening at 28.7k cases and on May 26, the governor announced a face covering mandate.[62]

On July 15, 2020, Governor Northam announced the adoption of statewide emergency workplace safety standards in response to COVID-19 that would protect Virginia workers from the spread of COVID-19.[63] In response to calls for action from community organizations, Governor Northam prioritized farm and migrant workers during the vaccine rollout.[64] In February 2021, he signed legislation allowing undocumented immigrants to receive driver privilege cards from the VA Department of Motor Vehicles, providing undocumented immigrants with a method of providing valid identification for various social services.[65]

**Charlottesville, VA**

The city of Charlottesville did rework its budget and undergo a number of changes in response to the coronavirus pandemic. Mayor Walker shared with journalists that she did not think discussions about equity were as robust as they should be. The city did attempt to make some individual changes that broke with state ordinances including an extension of deadlines for

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[61] Boyer, J. (2020, March 24). TIMELINE: A look at how coronavirus news developed and quickly escalated in Virginia. Retrieved from https://richmond.com/special-report/coronavirus/timeline-a-look-at-how-coronavirus-news-developed-and-quickly-escalated-in-virginia/article_bcdd6def-41d7-56d5-a936-316709704d17.html
[62] Documenting Virginia's path to recovery from the coronavirus (COVID-19) pandemic, 2020-2021. (n.d.). Retrieved from https://ballotpedia.org/Documenting_Virginia's_path_to_recovery_from_the_coronavirus_(COVID-19)_pandemic,_2020-2021
[63] Office of the Governor. (2020, July 15). Virginia Adopts First-in-the-Nation Workplace Safety Standards for COVID-19 Pandemic. Retrieved from https://www.governor.virginia.gov/newsroom/all-releases/2020/july/headline-859234-en.html
[64] Jones, J. (2020, December 21). Letter to Gov. Northam re: Vaccine Distribution. Retrieved from https://www.justice4all.org/2020/12/21/letter-to-gov-northam-re-vaccine-distribution/
[65] Tyree, E. (2020, July 20). Northam signs law allowing undocumented immigrants to get driver's licenses in Virginia. Retrieved from https://wset.com/news/at-the-capitol/drivers-licenses

FOIA requests (which was later repealed by the state attorney general).[66] The city also chose to adopt ordinances that walked back some of the loosened restrictions from the governor at the time.[67] Mayor Walker has continued to advise caution to Charlottesville residents even as the pandemic seems to be nearing its end.

**Vermont**

Governor Scott declared a state of emergency on March 13, 2020 when the state had 2 reported cases of COVID-19. A stay-at-home executive order was issued on March 24th when the state had reached 52 cases.[68] On April 17, Governor Scott outlined his reopening plan for the state. On April 20, Virginia launched its first phase of reopening at 816 cases.[69]

Vermont was recognized for its efficient and effective handling of the coronavirus. By flattening the curve early through early lockdowns and a gradual reopening based on local needs. The state was also strict about visitors, and closely followed scientific expertise.[70]

Despite this above-average response, immigrant communities were still hit harder by the coronavirus. Governor Scott's stay-at-home order exempted farms from shutting down in-person operations, an industry where undocumented immigrants are overrepresented. Additionally, undocumented workers did not benefit much from the federal stimulus package because of their lack of a social security number to prove eligibility.[71]

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[66] Woods, C. R. (2021, March 11). COVID-19 forces changes to local government. Retrieved from https://www.cvilletomorrow.org/articles/covid-19-forces-changes-to-local-government/

[67] Woods, C. R. (2020, July 27). City and county ordinances that restrict gatherings don't apply to schools. Retrieved from https://www.cvilletomorrow.org/articles/city-and-county-ordinances-that-restrict-gatherings-dont-apply-to-schools/

[68] JHU Coronavirus Tracker. (n.d.). Retrieved from https://coronavirus.jhu.edu/us-map

[69] https://www.huschblackwell.com/vermont-state-by-state-covid-19-guidance

[70] Doherty, T., Guida, V., Quilantan, B., & Wanneh, G. (2020, October 15). Which states had the best pandemic response? Retrieved from https://www.politico.com/news/2020/10/14/best-state-responses-to-pandemic-429376

[71] Trombly, J. (2020, April 06). Undocumented farmworkers essential, but excluded, in coronavirus response. Retrieved from https://vtdigger.org/2020/04/06/undocumented-farmworkers-essential-but-excluded-in-coronavirus-response/

**Burlington, VT**

Mayor Weinberger has encouraged Burlington residents to follow public health measures like wearing masks and social distancing throughout the pandemic.[72] The city also put forth a number of initiatives to help residents including a Green Energy Stimulus Plan, a small business grant program, and a COVID-19 dashboard that will ensure steady and accurate information to Burlington residents.[73]

The state government of Vermont allowed local governments the authority to set stricter rules if desired, and Burlington, the state's most populous city, took advantage of this leeway to reduce its outdoor gathering limit to 25 in late August when college students began returning to nearby campuses, keeping COVID-19 rates relatively low.[74]

**Texas**

Governor Abbott declared a state of emergency on March 13, 2020 when the state had 50 reported cases of COVID-19. At this point, some city mayors had already declared a public health emergency at the beginning of March. On March 19, Governor Abbott issued an executive order that limited social gatherings to 10 people and closed bars, restaurants and schools. On March 31 at 3.2k cases, the governor told Texans to stay home but declined to call it a stay-at-home or shelter-in-place order. On April 17, Governor Scott outlined his reopening plan for the state. On April 20, Virginia launched its first phase of reopening at 816 cases. On April 17, Governor Abbott announced initial steps for Texas reopening which began on May 1 at

[72] Staff, V. (2020, November 6). Burlington Mayor Calls For Extra Caution As Local Case Counts Rise. Retrieved from https://www.vpr.org/post/burlington-mayor-calls-extra-caution-local-case-counts-rise#stream/0
[73] Bradley, P. (2020, April 22). Burlington Mayor Provides Update On City's COVID-19 Response. Retrieved from https://www.wamc.org/post/burlington-mayor-provides-update-city-s-covid-19-response
[74] Doherty, T., Guida, V., Quilantan, B., & Wanneh, G. (2020, October 14). Which states had the best pandemic response? Retrieved from https://www.politico.com/news/2020/10/14/best-state-responses-to-pandemic-429376

29k cases. On July 2 at 175.9k cases, Governor Abbott issued a statewide mask mandate after a surge in cases.[75]

Texas started out doing well in the pandemic, with state and local officials providing clear messaging about the severity of the virus and taking steps to limit movement within, into, and out of the state. However, after the initial stay-at-home order lapsed on April 30, the governor began reopening the economy and cases and hospitalizations spiked.[76] Since then, there has been a mismatch in messaging between local and state leaders and an emphasis on reopening and lifting restrictions which has resulted in Texas having one of the highest number of cases by the end of 2020.[77]

**Austin, TX**

On March 17, 2020, Mayor Adler signed an order to limit restaurants to drive-thru, pick-up, and delivery service; close bars; prohibit gatherings of more than 10 people. Just before this, Mayor Adler had made the decision to cancel SXSW, a major annual event held in Austin.[78] In July 2020, Austin was doing better than other large Texas cities at controlling the spread of COVID-19 thanks to local restrictions and adherence to public health measures.[79]

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[75] Limon, E. (2020, July 31). Here's how the COVID-19 pandemic has unfolded in Texas since March. Retrieved from https://www.texastribune.org/2020/07/31/coronavirus-timeline-texas/

[76] Côté, M. J., & Radcliff, T. A. (2021, April 22). COVID-19 messes with Texas: What went wrong, and what other states can learn as younger people get sick. Retrieved from https://theconversation.com/covid-19-messes-with-texas-what-went-wrong-and-what-other-states-can-learn-as-younger-people-get-sick-141563

[77] Smith, M., Harmon, A., Tompkins, L., & Fuller, T. (2020, November 12). What Places Are Hardest Hit by the Coronavirus? It Depends on the Measure. Retrieved from https://www.nytimes.com/2020/11/12/us/coronavirus-crisis-united-states.html

[78] Charpentier, M. (2020, March 18). Austin Closes Bars, Prohibits Dining In At Restaurants And Limits Gatherings In Response To COVID-19. Retrieved from https://www.kut.org/austin/2020-03-17/austin-closes-bars-prohibits-dining-in-at-restaurants-and-limits-gatherings-in-response-to-covid-19

[79] Wilson, W. (2020, August 04). Austin now has better control of COVID-19 than any other large Texas city. Retrieved from https://www.kxan.com/news/austin-now-has-better-control-of-covid-19-than-any-other-large-texas-city/

Mayor Adler has also been transparent throughout the pandemic, detailing the data informing reopening plans[80] and sharing his own personal experiences and best practices for actions like testing and avoiding crowded venues.[81]

In December 2020, Austin placed new restrictions on restaurant operations which was met with threats of legal action from the Texas attorney general. Governor Abbott had tweeted: "This shutdown order by Austin isn't allowed. Period. My executive order stops cities like Austin from arbitrarily shutting down businesses. The city has a responsibility to enforce existing orders, not make new ones." Adler said he had no plans to rescind the order.[82] In March 2021, when Governor Abbott announced that he would be lifting Texas's mask mandate, Mayor Adler issued a letter to the governor urging him to keep the statewide mask mandate in place, pointing to best practices recommended by experts and the importance of preventative measures.[83]

**Illinois**

Governor Pritzker declared a state of emergency on March 9, 2020 when the state had 11 reported cases of COVID-19. The first confirmed case of COVID-19 in Illinois was announced on January 24, the second confirmed case in the entire country. On March 13, Governor Pritzker closed all public and private schools, overriding some mayors in the process. A stay-at-home executive order was issued on March 21 when the state had reached 753 cases, making Illinois

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[80] Eubank, B. (2020, April 27). Mayor Adler 'not ready' to go to restaurants when they re-open on May 1. Retrieved from https://www.kvue.com/article/news/health/coronavirus/coronavirus-adler-responds-abbott-reopen-texas-plan/269-0402136b-6201-48c6-9919-9e327f1dd406

[81] Livengood, P. (2020, June 12). Austin Mayor Steve Adler talks COVID-19 hospitalization spike, phase 3 of reopening Texas and police reform vote on KVUE. Retrieved from https://www.kvue.com/article/news/local/texas/austin-texas-covid19-hospitalizations-police-reform-mayor-adler-interview-kvue/269-c7e39ff8-7bc3-4fb8-bd8f-87e10cb43d1a

[82] Falcon, R., & Clark, K. (2021, January 04). 'Contempt': Texas AG Ken Paxton sues City of Austin, Mayor Adler and others over COVID-19 restriction order. Retrieved from https://www.kxan.com/news/texas-politics/texas-ag-to-austin-mayor-i-will-take-legal-action-against-you-if-covid-19-restriction-order-not-pulled-back/

[83] Bell, J., & Knight, D. (2021, February 25). Austin Mayor, Travis County judge issue letter urging Abbott to continue mask mandate. Retrieved from https://www.kvue.com/article/news/health/coronavirus/austin-mayor-urges-governor-not-to-lift-texas-face-mask-mandate/269-edfa2bc8-6d0c-46b5-8f57-6a28c8fd0aa3

among the first states to take such action.[84] On May 5 at 65.9k cases, Governor Scott unveiled a five-phase plan for reopening the state which set specific thresholds for reopening as opposed to certain dates.[85] Illinois state officials were at the leading edge of enacting social distancing measures, and their early and decisive action likely contributed to successful mitigation efforts.

Notably, Illinois recently became the first state to provide public health insurance to all low-income noncitizen seniors, even if they're in the country illegally, a major step forward in increasing access to healthcare for immigrants.[86]

**Chicago, IL**

On March 15, Mayor Lightfoot took the step of limiting bar and restaurant capacity during St. Patrick's Day weekend, also cancelling a holiday parade a few days prior. However, she did restrict a district-wide closure which she was overruled on by Governor Pritzker.[87]

Mayor Lightfoot's response to the pandemic did include a drastic emergency power grab, avoiding calls for more transparency and democracy in government, and she also refused to work on redistributive policies such as a corporate head tax or a financial transaction tax that were being propagated by left-wing council members.[88]

**Arizona**

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[84] Gantz, J. (2020, April 19). Illinois' Response to the COVID-19 Outbreak: A Brief Look Back - Center for Illinois Politics. Retrieved from https://www.centerforilpolitics.org/articles/looking-back-at-illinois-pandemic-response
[85] Comptroller, I. S. (2020, August 03). TIMELINE: HOW COVID-19 UNFOLDED IN ILLINOIS. Retrieved from https://medium.com/gdgf/timeline-how-covid-19-unfolded-in-illinois-fc8d124ae033
[86] Bruce, G. (2021, February 17). Illinois Is First in the Nation to Extend Health Coverage to Undocumented Seniors. Retrieved from https://khn.org/news/article/illinois-is-first-in-the-nation-to-extend-health-coverage-to-undocumented-seniors/
[87] Gantz, J. (2020, April 19). Illinois' Response to the COVID-19 Outbreak: A Brief Look Back - Center for Illinois Politics. Retrieved from https://www.centerforilpolitics.org/articles/looking-back-at-illinois-pandemic-response
[88] Kampf-Lassin, M. (2020, May 28). Lori Lightfoot's Coronavirus Response in Chicago Has Been Anything But "Progressive". Retrieved from https://www.jacobinmag.com/2020/05/lori-lightfoot-chicago-mayor-coronavirus-progressive

Governor Ducey declared a state of emergency on March 11, 2020 when the state had 9 reported cases of COVID-19. On March 17, a stay-at-home order and gathering ban were instituted alongside guidelines that shut down many businesses, bars, and restaurants. On May 15 at 13.2k cases, Governor Ducey allowed the stay-at-home order to expire and allowed for limited reopening of businesses with guidelines. On June 17 at 40.9k cases, Governor Ducey announced that he would leave it up to individual cities and counties to implement and enforce a mask mandate, forgoing a statewide mask mandate among statewide business reopenings.[89]

Arizona was found to be one of the worst states for its COVID response, due in part to significant racial and ethnic disparities in rates of infection, hospitalization, and death. The study identified strong and early public health measures as key in effective pandemic response - measures which were not taken by state officials in Arizona.[90] Community health leaders pointed to blunders by top officials as undermining faith in the data. They also criticized state leader decisions to reopen despite continued community transition without transparent benchmarks or latitude for localities with more severe transmission rates.[91]

**Phoenix, AZ**

The city of Phoenix took steps to help residents in light of the COVID-19 pandemic, including halting water shut-offs for non-payment, allocating funds for COVID-19 testing and

[89] Block, A. (2020, September 28). Looking back at the timeline of coronavirus in Arizona. Retrieved from https://www.12news.com/article/news/local/arizona/timeline-of-coronavirus-in-arizona/75-69c216df-6773-4b25-a34d-5a397d049196
[90] Arizona ranks No. 47 out of 50 states for COVID response. (2021, April 03). Retrieved from https://azbigmedia.com/business/arizona-ranks-no-47-out-of-50-states-for-covid-response/
[91] Duda, J., Stanley-Becker, I., & Janes, C. (2020, June 26). How Arizona 'lost control of the epidemic'. Retrieved from https://www.washingtonpost.com/health/how-arizona-lost-control-of-the-epidemic/2020/06/25/f692a5a8-b658-11ea-aca5-ebb63d27e1ff_story.html

enhanced cleaning measures, redistributing remaining federal COVID relief funds, and planning ahead to determine the city's role in vaccine delivery once they became available.[92]

Phoenix Mayor Gallego has expressed her discontent with the leadership of Governor Ducey, referring to the statewide executive order which requires Arizona cities and counties to abide by state-level guidelines and do nothing that "conflicts with or is in addition to" those restrictions.[93] Gallego shared that "if [she] had the opportunity to do so, [she] would closely follow the Centers for Disease Control guidelines, which would have [them] opening in stages and would not have allowed [them] to go straight to packed nightclubs with no masks."[94]

In mid-June 2020, Governor Ducey relented, allowing cities to impose their own facemask requirements if they desired. Phoenix quickly did so, in line with other public health measures it had attempted to put in place.[95] The mayor also shared that communication from the governor had been limited and nontransparent.[96]

**California**

The state of California had perhaps one of the most robust, swift, and strict responses to the coronavirus pandemic. In late February, the state secured COVID-19 test kits from the CDC and in early March, the state made available its emergency planning reserves to address shortages in PPE. Governor Newsom declared a state of emergency on March 4 when the state

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[92] Stone, K. (2020, December 07). Phoenix mayor: Arizona governor's order restricts city COVID response. Retrieved from https://ktar.com/story/3734730/phoenix-mayor-arizona-governors-order-restricts-city-covid-response/

[93] Doubek, J., & Chang, A. (2020, July 06). Phoenix Mayor Says The City Is In A 'Crisis Situation,' Needs Help. Retrieved from https://www.npr.org/sections/coronavirus-live-updates/2020/07/06/887925764/phoenix-mayor-on-citys-efforts-to-manage-coronavirus-outbreak

[94] O'Dowd, P. (2020, June 12). Phoenix Mayor On Arizona's Alarming Rise In COVID-19 Cases Since Reopening, Protests. Retrieved from https://www.wbur.org/hereandnow/2020/06/12/arizona-covid-19-rise-reopening

[95] O'Dowd, P. (2020, June 12). Phoenix Mayor On Arizona's Alarming Rise In COVID-19 Cases Since Reopening, Protests. Retrieved from https://www.wbur.org/hereandnow/2020/06/12/arizona-covid-19-rise-reopening

[96] Grigg, N. (2020, November 11). Phoenix mayor has not heard from Arizona Gov. Doug Ducey on COVID-19 in months. Retrieved from https://www.abc15.com/news/coronavirus/phoenix-mayor-has-not-heard-from-az-gov-doug-ducey-on-covid-19-in-months

was at 35 cases. He implemented a gathering ban on March 11 at 200 cases. Governor Newsom issued multiple executive orders throughout the month of March which removed administrative waiting periods for unemployment and disability insurance, retained state funding for schools, halted evictions and disenrollment from MediCal, and protected the wellbeing of Californians most vulnerable to COVID-19 because of their residence in healthcare facilities. Restaurants, bars, and clubs were directed to close on March 17 at 700 cases. The governor also chose to allocate a significant portion of emergency funding to helping the homeless population. A stay-at-home order was issued on March 19 at 1k cases. In early April, the governor created a COVID-19 Testing Task Force, a public-private collaboration that will work with stakeholders to rapidly boost testing capacity. On May 7 at 62k cases, the state released updated industry guidance to begin reopening with modifications that reduce risk and establish a safer environment for workers and customers.[97]

Governor Newsom was the first governor to take actions like business closures and stay-at-home orders. These myriad restrictions were very effective in controlling the virus and helping struggling populations such as the homeless, unemployed, undocumented, or uninsured. However, these restrictions did hurt the economy, and public health experts, while confident that mask wearing and staying home reduced the spread of the coronavirus, acknowledged that California's strict rules became less effective as exhaustion set in by late 2020.[98]

**Sacramento, CA**

[97] Office of Governor Newsom. (n.d.). California Takes Action to Combat COVID-19. Retrieved from https://www.gov.ca.gov/california-takes-action-to-combat-covid-19/

[98] Karlamangla, S., & Lin, R., II. (2021, March 09). California vs. Florida: Who handled COVID-19 better? Retrieved from https://www.latimes.com/california/story/2021-03-09/florida-vs-california-who-had-better-covid-response

Sacramento has largely accorded with the public health orders implemented by the state of California. Following a directive from the CA Department of Public Health and Governor Newsom, Sacramento amended its public health order on July 14 to prohibit the operation of certain industries, including fitness centers, hair salons, nail salons, barbershops and indoor malls, unless they can be modified to operate outside or by pick-up. The order also prohibited gatherings in homes of individuals who don't shelter together and required people to wear face coverings in public indoor spaces and outdoors when they cannot maintain six feet from one another (with some exemptions).[99]

From March, Mayor Steinberg promoted adherence to the strict guidelines being put in place by the state, stating that "this is what we need to do to flatten this (growth) curve and prevent our health care system from being overwhelmed."[100] The city of Sacramento also worked on a statewide initiative called Project Roomkey which sought to purchase and refurbish hotels, motels, apartment buildings and other structures for long-term shelter. Mayor Steinberg also signaled his support for these statewide initiatives to help homeless populations, stating that he was "hopeful in the post-COVID era knowing what works."[101]

With this policy background in mind, we can identify where potential gaps in support may exist.

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[99] Coronavirus in Sacramento. (2020, September 17). Retrieved from https://www.cityofsacramento.org/Emergency-Management/COVID19
[100] McGough, M. (2021, March 12). A year gone: How the COVID-19 pandemic upended life in the Sacramento region. Retrieved from https://www.sacbee.com/news/coronavirus/article249862593.html
[101] Wiley, H. (2021, April 3). California took 35,000 homeless people off the street for 1 year. Did the program work? Retrieved from https://www.sacbee.com/news/politics-government/capitol-alert/article250213025.html

## IV. Literature Review

In this literature review, I address two major themes in the literature – factors that affect immigration health service utilization and the role of policy at various levels of government in the US.

### *I. Factors Affecting Immigrant Health Service Utilization*

In "Barriers to health care for undocumented immigrants: a literature review," Hacker et. al conduct a literature review of published articles from the last 10 years which focused on three main concepts: immigrants, undocumented, and access to health care.[102] This research was prompted by unprecedented rates of migration coupled with the decisions made by many countries to dissuade immigration through heightened immigration restrictions and through domestic policies like healthcare. Throughout the literature, undocumented immigrants are seen to be underutilizing the health care system because of a variety of barriers to health care access. In the review, these barriers were separated into three major categories - policy arena, health system, and individual level. The policy arena category focused on issues of law and policy which included access to insurance and limitations to types of health care that undocumented populations could utilize. The healthcare system category focused on factors within healthcare institutions such as bureaucratic obstacles, availability (or lack) of safety net alternative care, and discriminatory practices. The individual level category focused on individual immigrants' fears of the government and law enforcement, stigma around health care access, and lack of both social and financial capital. The chart included below summarizes the categorization of the various barriers into these three categories.

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[102] Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: a literature review. Risk management and healthcare policy, 8, 175–183. https://doi.org/10.2147/RMHP.S70173

Barriers to health care experienced by undocumented immigrants

| Category | Subcategory | Description |
|---|---|---|
| Policy arena | Law/insurance | Legal barriers including barred access to insurance by law |
| | Need for documentation to get services/unauthorized parents | Requirements that individuals show documentation to get health care services, often leading unauthorized parents to avoid care for authorized children |
| Health system | External resource constraints | Constraints beyond individual's ability to pay for services including work conflicts, lack of transportation, and limited health care capacity (such as lack of translation services, cultural competency, and funding cuts) |
| | Discrimination | Discrimination on the basis of documentation status resulting in stigma experienced by undocumented immigrants |
| | Bureaucracy | Complex paperwork or systems required to gain access to health care |
| Individual level | Fear of deportation | Concerns about being reported to authorities if they utilized services or provided their documentation |
| | Communication ability | Not speaking or understanding the dominant language to communicate with health care providers. Also cultural challenges to understanding the nuances of another culture and expressing one's problems so that they are understood and not ignored |
| | Financial resources | Lack of personal financial resources to pay for services |

Table 2. Barriers to Health Care Experienced by Undocumented Immigrants[103]

[103] Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: a literature review. Risk management and healthcare policy, 8, 175–183. https://doi.org/10.2147/RMHP.S70173

This literature review consolidates a large body of research about barriers to healthcare access for immigrant populations, in a way taking on a top-down approach. Government policies on immigration and healthcare are the most "powerful" but they have effects that seep into "lower" levels such as the healthcare system and individual concerns. Since this is a literature review rather than a stand-alone study, it reveals where research on the topic of immigrant health care use has been extensive and where it has been limited. For example, the focus of the middle level on the healthcare system suggests that not as much as research has been devoted to the role of community-based organizations, the specific role of the workplace, and other institutions that fall between the individual and the government. Additionally, for the purposes of my research, this literature review provides barriers to healthcare access but does not address factors that may help immigrants access healthcare. Since this paper also seeks to understand factors that may improve healthcare access and outcomes, further research beyond this literature review is necessary.

In "Explaining Immigrant Health Service Utilization: A Theoretical Framework," Yang and Hwang survey and build on influential theories and models for understanding general health service utilization (HSU) to propose a theoretical framework for explaining disparities in immigrant HSU.[104]

Andersen's Health Behavior is the most common framework used in the study of health service access and utilization. This model, first proposed in 1968, explained people's HSU "by three clusters of factors: (a) predisposition to use health service, including demographics, social structure, and health beliefs; (b) enabling factors, including personal or family resources (e.g., income, health insurance, and regular source of care) and community resources (e.g., availability

[104] Yang, P. Q., & Hwang, S. H. (2016). Explaining immigrant health service utilization: a theoretical framework. Sage Open, 6(2), 2158244016648137.

of health personnel and facilities); and (c) need for care, including perceived needs and clinically evaluated needs."[105] Later models included new categories called "health care system" and "external environment." Yang and Hwang identify Anderson's initial model with the addition of predictors such as health care system and environmental factors as the most effective model in predicting HSU.

They propose a modified theoretical framework (displayed in image below) based on Andersen's model which takes into account factors especially pertinent to immigrants.

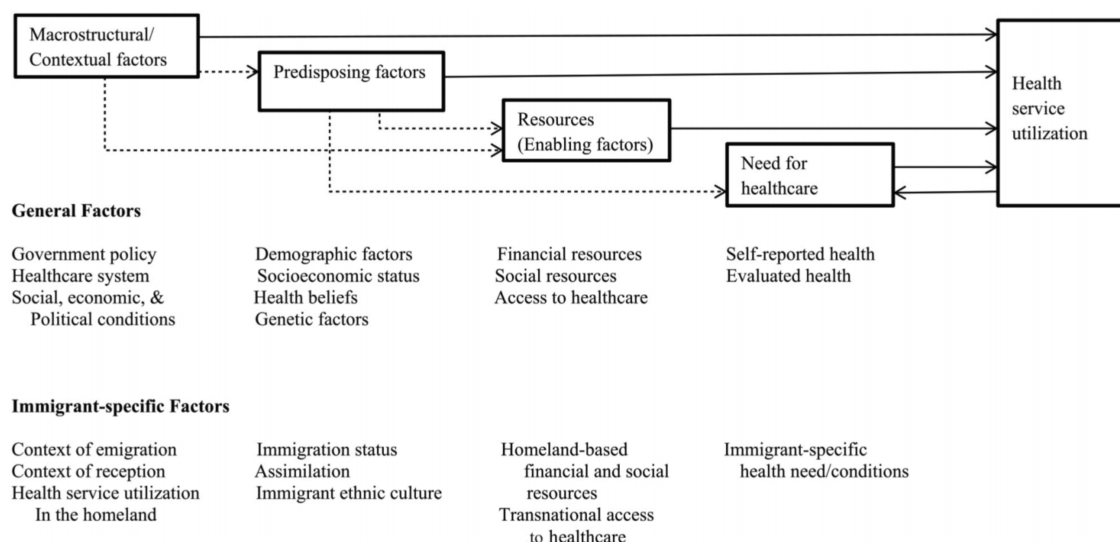


Figure 1. An analytical framework for immigrant health service utilization[106]

Certain changes are made to Andersen's model to emphasize the unique situation of immigrants. The first is the specification of ideas like need, enabling, and predisposing factors for immigrants. They also believe macrostructural or contextual factors need to be emphasized and singled out.

[105] Yang, P. Q., & Hwang, S. H. (2016). Explaining immigrant health service utilization: a theoretical framework. Sage Open, 6(2), 2158244016648137.
[106] Yang, P. Q., & Hwang, S. H. (2016). Explaining immigrant health service utilization: a theoretical framework. Sage Open, 6(2), 2158244016648137.

The first category of factors is "need for healthcare." They divide this into general needs and immigrant-specific health needs and conditions. Although healthcare need is universal, general need in either of those forms (self-rated or professionally evaluated) may be expressed or perceived differently across gender or ethnic lines. Immigrant-specific needs include differences due to the health environment in their country of origin (ex. The tuberculosis rate is higher in immigrants than native-born population). Immunization access might be limited for immigrants, so their immunization record is less likely to be up to date. Finally, immigrants typically exhibit a "health migrant effect" (immigrants being healthier than the native born population at time of immigration) but their health comes to resemble native-born health the longer they are in the host country.

The second category is resources which is split into general and immigrant-specific resources. General resources include financial and social resources and access to health services and language access. Immigrant-specific resources include certain advantages that could be present in immigrant communities because of their status as an immigrant. Their access to health services might also be more transnational and flexible because of potential access to their home country.

The third category is predisposing factors. The general predisposing factors include demographics, socioeconomic status, health beliefs, and genetics. Immigrant-specific predisposing factors include immigration status - this one is very significant as it can affect access to insurance and produce a fear of deportation. Assimilation or acculturation to host culture is seen as a factor that may increase HSU. Finally, immigrant ethnic culture such as norms, values, beliefs, traditions, and behaviors regarding healthcare can be major predisposing factors in immigrant HSU.

The final category is macrostructural/contextual factors. General factors include federal, state and local policy, the health care system, and general contextual factors like economic recession, civil war, and domestic unrest. The immigrant-specific factors include the context of emigration such as quality of care in the home country and context of reception to the host country.

As shown in the diagram above (dotted lines), some factors within the category can have an indirect effect on HSU via one or more mediating variables.

The framework proposed by Yang and Hwang is comprehensive, drawing on the widely used Andersen HSU frameworks and approaching immigrant health service use through the lens of the individual immigrant. This bottom-up approach to understanding how an immigrant decides to use health services is a helpful framework in understanding the barriers put forth in the literature review above and also factors that may positively impact immigrant health service use. While the proposed framework is quite extensive, it could be more nuanced in its understanding of macrostructural factors. It groups together the institutions of government and the healthcare system with broad contextual factors. However, each of these institutions plays such different roles in immigrant health service access and may even have mediating effects on each other. The intricacies of these institutions' effects might not be fully explored through this grouping, and for this reason, my research will seek to delineate the macrostructural context into smaller groups.

*II. Specific Role of Policy on Immigrant Health Access*

In "Policy Recommendations to Address High Risk of COVID-19 Among Immigrants," Langellier recommends three policy changes to address the high health and economic risks

posted to noncitizens by the COVID-19 pandemic.[107] The first recommendation is to collect citizenship data (either through the federal government or local agencies) to determine high immigrant density neighborhoods where tests and vaccines should be overallocated. The second is to eliminate public assistance restrictions in order to increase access to public-assistance programs, facilitate more efficient testing and treatment, and help prevent safety-net providers from becoming overwhelmed. The final recommendation is to permanently amend the public charge rule implemented by the USCIS in February 2020 which made immigrants who receive public assistance programs ineligible to apply for citizenship and residency.

Langellier's policy recommendations would be major steps forward in expanding access to healthcare for immigrant populations. It is important to note that these recommendations focus largely on federal level policy. If these changes were to be made on a national level, they would likely denote a significant but unlikely shift in attitude towards immigration in the US. Another thing to consider is while it is true that federal level policy (such as immigration and the ACA) are the most consequential and most wide-ranging, this paper does not account for regional differences in policy implementation. In addition to federal policy, recommendations for expanding healthcare access must also take into account state autonomy in policy-making and also the role of local authorities in implementation.

In "US State Polarization, Policymaking Power, and Population Health," Montez explores the historical, political, and ideological roots behind the growing gap in life expectancy across American states, focusing on the power of state autonomy in influencing health policy for its residents.[108] She discusses the five competing hypotheses for US health trends - policies and

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[107] Langellier B. A. (2020). Policy Recommendations to Address High Risk of COVID-19 Among Immigrants. American journal of public health, 110(8), 1137–1139. https://doi.org/10.2105/AJPH.2020.305792

[108] Montez JK. US state polarization, policymaking power, and population health. Milbank Q. 2020;98(4):1033-1052. https://doi.org/10.1111/1468-0009.12482

social values, physical and social environments, public health and medical care systems, social and economic factors, and individual behaviors. The frameworks used to formulate these hypotheses describe health behaviors as the result of multiple layers of causes, as seen in other research papers referenced in this review. Montez divides these layers into *macro layers* which include overarching institutions, policies, and systems such as political and economic systems, *micro layers* which refer to individuals and their immediate environment, and *meso layers* such as workplaces and health care providers that fall in between. She then points out how much of the research thus far focuses on micro and meso hypotheses to understand the disparities between different states. Even the public narrative in the US hyper-focuses on micro level explanations, implying that the reason for poor health outcomes is an individual's "bad habits."

Montez examines structural causes through the observation of US states and their policy making power. State policies and politics play a major role in many domains of life including birth, death, marriage, divorce, crime, punishment, and other domains "that affect population health, such as medical care (e.g., Medicaid, abortion), economic circumstances (e.g., minimum wage), and behaviors like smoking, alcohol consumption, and marijuana and seat belt use." Since the 1970s, state governments have been increasingly strengthened through two major movements to consolidate power at the state level. The first movement - the "devolution movement" transferred certain federal oversights and fiscal responsibilities to the states as an attempt to shrink government and reduce federal spending on social services. To do so, Congress chose to allocate money to states through block grants that could be spent at their discretion, allowing states to create vastly different social safety nets. This change also transferred the burden of paying for social services from high-income to middle-income individuals because state tax systems tend to be less progressive than the federal tax system. The

second movement was the introduction of state preemption laws which allow state governments to prohibit or restrict local governments from legislating on certain issues. These laws were initially intended to produce consistency among state and local policies, but state governments began to use them as a way to specifically target policy domains where local governments might ideologically diverge from the state government (ex. policies on minimum wage and paid leave). Because of this consolidation of state power, state governments have hyperpolarized state policy along partisan lines. One of the consequences of this hyperpolarization is that Democratic states tend to create overarching policy that promotes well-being among the population while Republican states do the opposite. This has been especially true during the COVID-19 pandemic when the federal government left much responsibility for handling the crisis to the states.

Montez's research focuses largely on the effects that this consolidation of state power has on health policy. She suggests further and focused research on the legal, political, and commercial determinants of health, specifically to better understand how the intersection of federal and state level policy have shaped population health. This paper puts forth the micro, meso, and macro level structure of understanding factors affecting healthcare access, which I use in this study to structure the results of my research. Montez also provides a key argument about the importance of state level policy which I explore further in this research by looking at the role of all three levels of government in various cities during the COVID-19 pandemic.

## V. Methods

*Methodological Approach*

As demonstrated above, there are a wide range of actors in the web of resources and institutions that impact immigrant access to and use of health care. Community organizations tend to be a key linking organization between immigrant communities and the resources and help that they may need. Since immigrants might fear going directly to government institutions (a fear that extends from law enforcement to even hospitals), trusted community organizations such as non-profits focused on legal, economic, and health justice act as an essential go-between.

Thus, in my research, I chose to use a qualitative approach and conduct informant interviews with representatives from non-profit organizations that work closely with immigrant populations. Through these interviews, I hoped to better understand the policy landscape in which these organizations worked, how they helped their clients navigate the system, and gain a proximate understanding of the lived experiences of immigrant communities during the COVID-19 pandemic.

`To understand the major barriers or limiting factors in immigrants accessing healthcare, I will draw from the frameworks presented within the literature review. The first framework focuses on three categories of barriers to health care - policy arena, health system, and individual level. The second framework, which was based upon the widely-used Andersen's model of health service utilization, approached the issue from a needs-based perspective. This need for healthcare was then tempered by resources available to the immigrant, predisposing factors, and macrostructural/contextual factors. I focus on these two frameworks because they provide two different perspectives on what influences immigrant use of health services. The first takes a top-down approach, assuming need for healthcare, and evaluating the factors that limit access to it.

The second takes a bottom-up approach, first seeking to understand why an immigrant would need or want to access healthcare and then what factors would influence their ultimate use of health services.

*Data Collection*

Semi-structured interviews were conducted with 5 representatives from non-profit organizations working in the specific cities. These representatives were staff members from the organization who could speak to the policy landscape of their city or state and the role of their organization in working with policy and providing support to immigrants in accessing health care and related resources. I identified potential informants by contacting non-profit organizations in the cities of interest and asking for a staff member who was willing and able to be interviewed for the purpose of this research. Interviews were conducted via Zoom, and lasted approximately 1 hour each. Each interview was recorded with consent.

I was unable to obtain an interview with a representative from Austin, TX, so in place of an interview, I compiled information about the policy landscape and environment for immigrant populations through the blogs and websites of local non-profit organizations.

*Analysis*

The interviews were transcribed and read through multiple times to identify major themes. I identified eight key themes: Micro Level, Meso Level, Macro Level, Federal Policy, State Policy, Local Policy, Community-Based Organizations, and Looking Forward. Sections of the interview were color-coded to identify iterations of those eight themes. Instances of each theme were then summarized and examined for trends.

*Evaluation of Methods*

The strengths of the interview and thematic analysis method was the ability to gain a more personal and nuanced understanding of how these communities have been affected by the pandemic. Informants could illustrate concepts through anecdotes and share their feelings and thoughts on the policies they have worked with. Some informants were immigrants themselves or children of immigrants which provided further insight into the experience of immigrant communities during the pandemic.

Some of the weaknesses in these methods were the relatively small set of data and the variance in policy expertise among informants. It is also important to note that looking at individual barriers through the lens of community-based organizations does leave out information about immigrants who do not interact with these organizations. Accordingly, there is a limitation in fully identifying and understanding the individual-level barriers that all immigrants may face.

Although my findings are not generalizable because of the small sample size, they do provide descriptive information and insight via individual experience and perspective into larger trends around health and immigration policy at the various levels of government during the COVID-19 pandemic.

# VI. Results

In the analysis of the interviews, I organize the findings around barriers to healthcare access during the pandemic at the micro, meso, and macro level. Micro level included individual concerns such as demographic factors, cultural differences, resources, fear of authorities, and need for healthcare. Meso level included the health care system and other institutions and organizations that fell "between" the individual and the government. Macro level focused on larger, contextual factors such as government policy, law, and broad social, economic, and political conditions. With respect to policy factors, I investigate the federal, state and local level policies. I end with respondents' suggestions for future change.

## *Micro Level*

The micro level focused on individual factors that influenced access to and the need for healthcare among immigrant populations. There were common factors reported as barriers across the interviews and seemed to be shared by immigrant populations across the country. Informants described how these individual factors were typical barriers to health care use even before the pandemic, but they became exacerbated during the tense socioeconomic and political environment of the pandemic. Three major categories emerged within the microlevel - knowledge gaps, negative feelings, and unique cultural backgrounds.

Knowledge gaps included language, technological, and educational barriers. Alicia Lopez, a senior Programs Manager at a Sacramento community-based organization (CBO), described how "navigating the healthcare system [was] a really huge issue" even before the pandemic due to "language barriers, technological barriers." A child of immigrants herself, Lopez could speak both professionally and personally to the difficulties of navigating a system that is both hostile and unknown. She also described how "folks are finding themselves applying

for public assistance programs for the first time in their life." Many of them had been "pretty self-sufficient up until the pandemic, and then the pandemic hit, and all of a sudden they have to navigate unemployment and switch over to medical [insurance] because they've fallen out of coverage from their employer." Lopez's descriptions demonstrate how these barriers are present and worsened by the pandemic. However, they also subvert some of the negative characterizations of immigrants that have been perpetuated especially over the past few years about immigrants being a burden on the social safety net and health care system. Contrary to this rhetoric, many immigrants have actively supported themselves without government intervention or support for most of their lives and the shock of the pandemic is, for the first time, creating a need for public assistance and support.

The negative feelings category included fear, stigma, and shame experienced by immigrant populations when accessing or considering access of healthcare services. Taylor Johnson, a health justice attorney at a CBO in Charlottesville, VA describes how stigma affected the willingness of immigrant populations to engage with public health protocol. She described how it is "emotionally hard to engage with the contract tracing process because there's such a stigma around being sick and weak or sick and unclean." Further, when "rumors get out that the Hispanic population in Charlottesville is infected with COVID, it creates a backlash [and] they experience the actual effects of discrimination [such as] people getting fired because they're Spanish speakers."

Johnson also shared that it was difficult for immigrant communities to trust contract tracers because of a fear that they were cooperating with immigration enforcement authorities. This was a sentiment echoed in other interviews. Joseph Fuller, the founder and former director of a health clinic in Phoenix, Arizona, spoke about the lack of trust immigrant communities had

in the county government because of the prominence of a famously racist sheriff in the county leadership for many years. Victoria Ngoy, the racial equity director at a CBO in Burlington, VT, pointed out that the police body of Vermont does not include any people of color and explained how that lack of diversity furthered the discomfort and lack of trust between the immigrant community and local authorities.

Lastly, unique backgrounds spanned the range of differential experiences and expectations held by immigrants when interacting with health care systems. Ngoy (Burlington), a physician from the Republic of Congo, could speak firsthand to these differences. She shared how the majority of immigrants that she works with "come from countries where there are no insurance systems." In their home countries, they "used to go to the hospital to get medical care when they were sick - maybe once or twice a year," but the healthcare system in the United States is based on preventive medicine. This difference manifests itself as a barrier when immigrants do make visits to the doctor. Many medical facilities in the United States "function on the basis of a 15 minute visit" which does not allow immigrants to bring "a huge list of concerns that they want to be resolved" and does not allow for "a nice interaction with the provider, especially when there was an interpreter involved."

Johnson (Charlottesville) described how traditions within certain immigrant populations could lead to different healthcare needs. She provided the example of the Nepalese community in Virginia who gathered at a funeral to mourn an important religious leader, leading to a major spread within the community. She added a disclaimer that the instinct to gather is not "endemic to any one immigrant population," pointing out that American families gathered in large numbers during the pandemic for the Thanksgiving holiday. With that understanding, she suggested that

these cultural idiosyncrasies need to be better identified and addressed in a culturally competent manner.

Fuller (Phoenix) also echoed these sentiments, speaking to some differential experiences he has seen between different immigrant populations. He explained that Guatemalan immigrants in Phoenix "have had less access to formal education prior to leaving [their home] country," especially compared to immigrants from Mexico. Although poor migrants from Mexico are still undereducated compared to the average education level in the US, Mexico has "tried to invest in education opportunities for its people." Although Guatemalan immigrants typically suffer greater language and education barriers to the health care system, this distinction may be lost when all Latino immigrants are grouped into one category. As Johnson said, cultural factors in immigrant populations should be accounted for, and they should address different strate within populations to ensure truly culturally competent support.

The information shared by informants showed how the individual-level barriers experienced by immigrants during COVID-19 were relatively similar to the barriers experienced pre-pandemic but exacerbated by the tense political climate and strains placed on resources within the healthcare system. Despite their categorization as micro-level individual factors, many of these barriers are not entirely under individual control. Only the third category about unique backgrounds were a result of cultural differences present within the immigrant community. The other two categories of language or education barriers and impulses like fear or shame are results of broader systems and policies. This leads into the next two categories of the meso and macro level.

***Meso Level***

The meso level included the health care system and other bureaucratic institutions like social services departments that fell "between" the individual and government policies. For the purposes of analysis, I also included the workplace within the meso level. Essentially, these are the places where immigrant communities interact with the policies and laws set forth by the government. There were four major categories that emerged within the meso level: the health care system, the bureaucracy and administrative systems, the workplace, and community-based organizations.

*Healthcare System*

The healthcare system within the various cities played the pivotal role of providing indigent care and partaking in outreach programs to the immigrant population. Since many noncitizen immigrants do not have access to health insurance, their primary means of accessing health care is through indigent care programs provided at local hospitals and clinics. Jae Hwa Kim, the Director of Community Resources and Education at a CBO in Chicago, Illinois shared how "low-income families without insurance … can go to Cooke County hospitals" but also expressed her concerns about the quality of service which she identified as another concern for immigrant families. Johnson (Charlottesville) also described how, in the wake of the pandemic, there has been "way more targeted outreach by the health system that works in collaboration with communities, organizers, who are from those communities." She further explains that some hospitals that are notorious for collecting on low-income patients have also taken "internal steps to pause collections that helped both non-citizens and citizens, but particularly non-citizens because that's the largest pocket of uninsured folks." Entities within the healthcare system did take steps during the pandemic to expand their capabilities to provide care to immigrants;

however, most of these initiatives were underfunded and depended on the decisions of individual clinics and hospitals, leading to many gaps in service.

*Bureaucracy and Administrative Systems*

The bureaucracy and administrative systems within healthcare were identified as a major barrier in immigrant health access across interviews. Johnson (Charlottesville) described how there are universal bureaucratic issues that affect the general population and not just immigrants such as “people getting their Medicaid services taken away for no reason [because of] private health insurance companies having incentives to save money.” However, these bureaucratic barriers are particularly harmful to immigrant communities. Johnson shared a story about how a lack of comprehensive knowledge in the bureaucracy about immigration and healthcare policies can have deadly consequences for immigrant patients. Virginia offers Medicaid eligibility to immigrants who have a pending application for asylum refugee status, but workers within the Department of Social Services and hospital finance offices tend to not know this. They have made assumptions about the Medicaid eligibility of certain individuals “by virtue of their last name and their monolingual Spanish speaking capacity.” Johnson’s work involves educating these administrative workers on this intersection of immigration policy and Medicaid eligibility. She also works with health care providers to identify sources of funding for immigrant patients who might be eligible for Medicaid. In this role, she encountered a chronically-ill patient who “needed to be discharged with home health care,” who was actually eligible for Medicaid because of her pending refugee application. Unfortunately, “the local DSS had processed her application incorrectly because she was a monolingual Spanish speaker and was denied meaningful language access.” Because her eligibility status had been discovered so late, the patient passed away at the hospital in the process of appealing the case without receiving the

services she needed. Johnson shared that it was a sobering instance of "how misinformation or lack of information at the intersection of Medicaid policy and immigration policy results in people falling through the cracks with dire consequences."

Another instance of bureaucratic failure occurs when state governments work with private entities without proper due diligence. Fuller (Phoenix) describes how the state government of Arizona used the federal funds for testing to subcontract to for-profit contractors. The state intended for this testing to be accessible to all, regardless of immigration status. To ensure that these contractors were being honest about their testing numbers, they asked for a "valid Arizona ID photocopy for everybody they tested." This resulted in immigrant populations being largely unable to access testing because of the lack of a valid Arizona ID (usually a driver's license). Fuller's anecdote demonstrates how outsourcing of responsibility to private entities without proper oversight can also result in barriers to immigrant health access.

*Workplace*

The workplace is a key contributor to immigrant access and use of healthcare. Across the interviews, informants spoke to the overrepresentation of immigrant communities in the service and agricultural industries. Both industries do not translate to remote work, either resulting in the lay off of immigrant workers or their continued work in unsafe conditions during a pandemic. At one point during the pandemic, Johnson (Charlottesville) received a phone call from a doctor in the UVA ICU informing her that they had "30 patients on ventilators right now, all of them Hispanic, all of them from one area, in a town not far away from Charlottesville." The reason for that was "an outbreak at a nursery where all the workers were of Central American and Mexican descent" and they "had no agency to stop going to work because they weren't guaranteed paid sick leave." She continued on to explain that "workers who staff big agricultural

employers, big chicken farms, those kinds of work settings, tend to be predominantly Hispanic, predominantly Central American and North American" which results in them being "overrepresented in [the state's] COVID statistics." Johnson also discussed some potential methods of increasing agency in the workplace and the impacts such changes can have. She described how her organization among other CBOs "pushed the governor to create emergency COVID workplace safety standards." Prior to the pandemic, there "were no enforceable workplace safety regulations in Virginia," so this change represented a major change within the workplace that could empower immigrants and their health decisions.

*Community-Based Organizations (CBOs)*

Since these interviews were with leaders who worked at non-profit community organizations, a major theme throughout the interviews was the role of community based organizations in assisting immigrant communities as they access health care. As stated by Kim (Chicago), CBOs are the "go-between organizations" that "represent [immigrant] communities." They took on the role of language translation, education efforts, assistance with services like unemployment benefits and insurance, legal aid, vaccine distribution and testing, and so much more. Fundamentally, they have built trust with the immigrant communities they serve through consistent care and meaningful, effective work, and now they are able to play a crucial connecting role between health care providers and immigrants and government services and immigrants.

The meso level represents the spaces where individuals interact with larger systems and policies. From the information presented in these interviews, the overarching sentiment seems to be that not enough time, energy, and resources are devoted to making these systems accessible for immigrant populations. Some of these barriers may not be implemented with malicious

intent (for example, the oversight about IDs in Arizona testing rollout or the lack of translators at an indigent care clinic). However, these oversights result in major barriers to healthcare for immigrant communities. While efforts to expand access by health care institutions and community-based organizations are laudable, these individual efforts are not nearly enough to ensure consistent and well-supported access to healthcare for immigrant populations. There needs to be structural change to the system - factors that are covered in the next section on the macro level.

***Macro Level***

The macro level included larger, contextual factors such as government policy, law, and broad social, economic, and political conditions.

One issue that came up frequently was the effects of the harsh anti-immigrant rhetoric espoused by the Trump administration for the past four years. Multiple informants spoke to the fear and shame created by the consistent attacks on immigrant populations, and expressed relief at the fact that there was a new president coming into office. However, many of them stressed the fact that these macro level issues extend beyond just the Trump administration. Lopez (Sacramento) cited the fact that "there was a huge rhetoric of hope" under the Obama administration, but the administration "ended up deporting more folks than ever, historically." This demonstrates how these issues are not specific to any one president, even if Trump did employ particularly harmful rhetoric. These are systemic problems that are built into the institutions and structures of the United States, a fact demonstrated through the rest of the data encoded as macro level.

The informants pointed out a number of current structures enshrined in policy and law that have major effects on immigrant health access. Fuller (Phoenix) described how testing in

Arizona initially required an Arizona ID even though testing was marketed as universally available regardless of immigration status. The health insurance-based system of health service access in the US is also a major barrier for immigrants seeking health access. Since many noncitizen immigrants are simply ineligible for health insurance, they must turn to community health centers and indigent care clinics despite underfunding and an overburdened system. Finally, the imposition of rules like the 5-year waiting period on legal permanent residents (LPRs) who are eligible for Medicaid provides another barrier to health access for immigrants. Johnson (Charlottesville) describes how the five-year waiting period comes from a federal law called the Personal Work and Responsibility Act of 1992, a welfare reform that transformed the nation's welfare system into one that requires work in exchange for time limited government assistance. These anecdotes depict how the system is fundamentally structured in a way that is inaccessible to noncitizen immigrants, and demonstrates the need for comprehensive restructuring, a sentiment that came up consistently in the interviews.

Johnson (Charlottesville) spoke to the need for greater social support, giving examples such as "guaranteed housing, workplace safety regulations, enforceable paid sick leave, universal basic income, and caregiving provisions." A legislative and policy director for a Texas CBO explains that "the pandemic exposed fundamental flaws in our systems, including lack of access to food, unemployment insurance, interrupted health care coverage and more." He continues that although "the governor and state agencies addressed some of these through emergency stop gaps, the legislature should end the red tape and access barriers permanently." Fuller (Phoenix) called for a complete overhaul of the American healthcare system, sharing a friend's way of explaining it - "the American healthcare system spends 95% of its healthcare dollars on acute care and 5% on primary care. And another way to save that is that we spend 5% on primary care, and 95% on

primary care of failures. And when you're budgeting ahead of time to spend 95% of your resources on failing … that's a really interesting investment strategy." Every informant spoke to a need for universal health care.

In order to better understand the intricacies of the macro level, the next section will focus specifically on policy at the different levels of government - federal, state, and local.

*Federal Policy*

Observations and sentiments about federal policy were relatively uniform across the informant interviews. The two major types of policy that were discussed were immigration policy and healthcare policy. Since immigration policy is under federal jurisdiction, concerns about the effects of immigration policy fell under this theme. The public charge rule was mentioned in every interview as it contributed heavily to the "chilling effect" or fear within immigrant communities that reduced their willingness to access health services. Johnson (Charlottesville) described how the public charge rule, although it has no legal effect currently, "discouraged noncitizens from accessing things like Medicaid even when they may be entitled to it." Fuller (Phoenix) spoke about his disappointment that federal entities like the CDC and FDA were being politicized during the pandemic instead of sticking to scientifically-sound expertise, and Ngoy (Burlington) brought up President Trump's executive order prohibiting diversity training in the workplace. Many of these rules and laws are no longer in place, but they continue to have a tangible impact on immigrant health access because of the widespread climate of fear and distrust they create.

Healthcare policy at a federal level was not discussed in great depth during the interviews due to their focus on state and local policy, but the broader structures of health insurance created through the ACA were mentioned as a basic reason why some immigrants cannot access

healthcare. Because the United States federal government continues to impose a multi-payer system of healthcare system that is predicated on having insurance, individuals who are not eligible to participate in the healthcare marketplace are systematically left out of the system.

*State Policy*

The state level of government and policy revealed a great deal of variety across the informant interviews. The cities in this study were not chosen based on state-related characteristics, yet there happened to be differences across the states represented with respect to the political affiliation of their leadership, the overall concentration of immigrants in the state, and their health and immigration policy environment. One of the major areas where states differed was their implementation of Medicaid. Johnson (Charlottesville) described the "40 work quarters" policy that the state of Virginia had recently repealed. On top of the federally required 5-year waiting period to access Medicaid as a legal permanent resident (LPR), the state of Virginia had instituted a rule that the individual must have 40 work quarters in order to get Medicaid. She further explained - "Imagine you're somebody who has come over to the United States, maybe you're an elderly parent, and you've gone through all of the proper and arduous legal channels to wind up in the United States. And because you're elderly, and maybe you're monolingual, maybe you even have like a long-term health condition, like dementia, or Alzheimer's or a physical limitation that prevents you from working, if you don't have those 40 work quarters, and your spouse doesn't have those 40 work quarters, you don't get Medicaid." She identifies this rule as one concrete way in which Virginia had "made certain decisions about who in the noncitizen community is entitled to various essential health supports."

On the other hand, Lopez (Sacramento) described how California had taken concrete steps to expand Medicaid access within the state. She explains that "California is probably the

most progressive state in the nation when it comes to offering healthcare to immigrants." They started off with "offering MediCal to all children, regardless of their status … and then, not so long ago, [they] expanded that to health care coverage for young adults."

Ngoy (Burlington) discussed a pandemic-related change made by the state of Vermont - the decision to place a moratorium on the termination of Medicaid coverage across the state. This decision was not specifically targeted at immigrants and did not affect people who were wholly ineligible for health insurance, but the moratorium did help those who might have been kicked off and left without health insurance mid-pandemic. Similar moratoriums were instituted in other states as well.

Beyond Medicaid, there are many other ways states can take unilateral initiative, including weakening or strengthening immigration policy. In California, the state government passed the VALUES Act which "limited how local authorities can interact or engage with federal law enforcement agencies." Lopez (Sacramento) recounts how before the act, "this was a bigger issue in some parts of the state than others. When [she] was living in San Diego, [she] distinctly remembers this was a huge issue and a big win, particularly for cities like Escondido." Escondido "used to have their police department house ICE agents inside the police department building, and that was a huge issue and red flag for advocates." This is because "folks were often scared to reach out to [local] police departments because they knew that they had such close proximity to immigration enforcement." Accordingly, the California VALUES Act "played a big role in just limiting those kinds of interactions and, and making the role of each agency more clear." On the other hand, states can also strengthen immigration enforcement. Fuller (Phoenix) describes the "famously racist immigration bill called SB 1070" which required

police to investigate, detain, and arrest people if they sense immigration violations. Through this state policy, immigration enforcement (a federal issue) was actually strengthened.

The unilateral power of states was especially visible amidst the COVID-19 pandemic. Kim (Chicago) shared that “the state of Illinois was providing some special grants for those families without any documents - special COVID-19 emergency relief funding and special rent and utility grants for undocumented families.” The state also has a welcoming center, “a state agency that provides lots of basic services for those people without documents.” Lopez (Sacramento) also shared a California state program for disaster relief assistance which “was rolled out by the governor to specifically help those that didn't qualify for the federal assistance through cash aid.”

Johnson (Charlottesville) explains how Governor Northam, in response to pressure from community organizations, created “emergency COVID workplace safety standards” which were especially helpful to migrant workers in the service and agricultural industries. He also explicitly prioritized agricultural workers in the vaccine rollout, placing them in the 1B category. Texas similarly ensured that vaccine access was not limited based on immigration status, specifically providing instruction to not require documentation.

State actions could also negatively impact the immigrant community. Fuller (Phoenix) described the governor of Phoenix as “very much beholden to the former president” and “hesitant to provide a clarity of messaging that might have conflicted some of the stuff coming out of [President Trump’s] mouth.” Texas faces similar issues with Governor Abbott recently declaring that the “Biden Administration is recklessly releasing hundreds of illegal immigrants who have COVID into Texas communities.” This line of attack is largely believed to be

unfounded and a political move to blame immigrants for coronavirus rates that will likely be caused by the recently lifted mask mandate.

The data presented within the state policy theme demonstrated how powerful and influential state governments can be in healthcare and immigration policy, and particularly how they can alleviate or exacerbate barriers created at the intersection of these two areas of policy. This fits in to the framing described in the Montez paper which focuses on the disproportionately powerful influence that state governments and policy have over health outcomes.

*Local Policy*

The cities in this study were selected along a continuum of immigrant friendliness and immigrant population concentration which lent itself to observation of how these factors influenced immigrant access to healthcare. There was an assumption that cities that self-identified as "sanctuary cities" would have fewer barriers to healthcare than those that did not. I also hoped to better understand how immigrant population concentration could impact these policies – i.e., would more immigrants in a city result in positive or negative policy actions by the local authorities.

The data provided on local policy describe two major ideas. The first is that "immigrant friendliness" within a city is a vague term that requires greater precision and perhaps would benefit from legal delineation. The second is that local authorities are perhaps the most well-equipped (of the levels of government) to work with community-based organizations.

The idea of "immigrant friendliness" came up throughout the interviews. Some referred to it when discussing initiatives taken by local governments. For example, Kim (Chicago) looked upon the Chicago mayor's enforcement of public health protocol favorably. Lopez

(Sacramento) discussed the importance of positive rhetoric, visibility, and support in the local community through elected officials who were also immigrants.

"Immigrant friendliness" was also referred to when discussing local law enforcement authorities and their role in perpetuating climates of fear. Fuller (Phoenix) described the long-lasting effects of the "famously racist Sheriff Joe Arpaio" on immigrant distrust of local authorities, a distrust that extended into health care systems and the county health department. Johnson (Charlottesville) described how immigrants were "loath to participate in contact tracing [because] some counties in and around Charlottesville were using local police force to do contact tracing." It was difficult for the community to trust these authorities because of past experiences with cooperation between local law enforcement and ICE.

These anecdotes suggest that there are two levels of demonstrating "immigrant friendliness" on a local level, one being positive, helpful initiatives focused on immigrant communities and the second being a purposeful denouncement of cooperation with federal immigration officials. Thus, declaration as a "sanctuary city" does not necessarily ensure increased support of immigrant communities for their health needs. However, self-proclaimed "sanctuary city" status can still be meaningful to immigrant communities. Across the six cities, those that did not identify as sanctuary cities, regardless of their immigrant population concentration, had greater barriers related to political climate and fear. This may be because the lack of "sanctuary city" status was caused by overarching state policies which banned sanctuary cities across the state (like in Texas), signaling a state-level hostility towards immigrants that also manifested at the local level. This also seemed to be exacerbated in Phoenix, a city with a high immigrant population concentration but without a "sanctuary city" status. As opposed to Sacramento, whose local authorities had taken major steps to help a large portion of its

population, Phoenix had put forth specific hostile policy in response to the large influx of immigrants to the state. This suggests that immigrant population concentration might necessitate greater policy attention but that attention could be positive or negative for immigrants dependent on local authority immigrant friendliness.

The second major theme was how local authorities are well-equipped to work with CBOs. Lopez (Sacramento) described the FUEL network, a partnership between local government and community organizations, and the "lifeline" it has been for immigrant communities as they access healthcare and other social services amidst the pandemic. In cities where local authorities have not been willing or able to work with community partners, there have been much greater barriers to health services for immigrant populations. Fuller (Phoenix) describes how "the responsible people running the county health department … have to be quiet about how they support [CBOs]" because they fear political consequences from the "very racist County Board of Supervisors." He gives a specific example of how his organization has set up a vaccine program and went through the substantial administrative jumps to be a distributor of COVID-19 vaccines. However, an unwillingness to communicate by the county health department has resulted in no vaccines being delivered to this organization that would serve a very vulnerable immigrant population.

This willingness and unwillingness by local governments to work with CBOs demonstrated in Sacramento and Phoenix, respectively, shows again how "sanctuary city" status and the immigrant friendliness it signals can be meaningful in increasing access to healthcare for immigrants. When local governments are hesitant or unable to work with CBOs, immigrant populations are negatively impacted, but when they are willing, there can be major positive changes for immigrant populations, even with restrictive federal policy and other macro level

barriers. The local policies discussed across the interviews also suggested that immigrant population concentration might necessitate greater policy attention but that attention could be positive or negative for immigrants dependent on local authority immigrant friendliness. Compared to the other cities, the cities of Phoenix and Sacramento seemed to dedicate more time and policy to immigrant-related policy and action because of their high immigrant population concentration.

***Looking Forward***

Through their work assisting immigrant populations and petitioning authorities for change, these community based organizations have a great deal of accumulated knowledge on changes that could be made as we move forward through and beyond the pandemic. These suggestions fell into the broad categories of small-scale and large-scale changes.

Small-scale changes included strategies and unexpected synergies observed during the pandemic. Telehealth was observed as an area for potential expansion even past the pandemic. Fuller (Phoenix) described how the pandemic-induced use of telehealth is going to "leave [them] reexamining whether follow up visits should just be telehealth in the long term." He stressed that there are times "when you've got to see someone in person… but there's an argument to be made that we should consider keeping this as a bigger part of our repertoire than it's been in the past."

Lopez (Sacramento) described the role of *promotores* - lay Hispanic/Latino community members who receive specialized training to provide basic health education in the community without being a professional health care worker. She suggested that *promotores* should have a more involved role in formulating policy since they work so closely with the vulnerable populations and ultimately help with policy implementation.

This was similar to a sentiment expressed by Ngoy (Burlington) who has concerns that there is still a fundamental disconnect between how immigrants and the standard American healthcare system understands health. She suggested a rethinking of cultural responsiveness in healthcare, especially in the way health care providers are taught to communicate with and explain concepts to patients from a diversity of backgrounds.

Large-scale changes included hopes about the potential for change with the new presidential administration. Although organizations and individuals are still skeptical about the capacity and willingness of the Biden administration to make large-scale change, there is belief that change might be possible now that there is political momentum for concepts like universal health care. Fuller (Phoenix) acknowledges that universal health care might "not sound like a politically realistic or pragmatic solution," but he points to the recently passed stimulus bill as something that "could not have been considered in the US three years ago [because] it would have been like written off … as radical European style socialism."

They are also aware of the need for strategic marketing and branding of certain initiatives. Johnson (Charlottesville) described the process of Medicaid expansion in Virginia and recounted how it had to be "whitewashed." The cover of the pamphlet presented to other legislators included "a white farmer and his family, a self-employed white individual and their family, not an immigrant, not somebody who was black or brown," and the expansion was purposefully *not* passed "as a program that would reduce health disparities along racial lines, even though [they] all knew that that was part of the urgency." Similar strategic branding might pave the way for meaningful large-scale changes in health and immigration policy in the near future.

## VII. Discussion

By analyzing the data with both of the frameworks mentioned in the methods section, I hoped to determine whether there was a "most" limiting factor that could be identified in either framework. The data demonstrate that the macro level is the most critical in limiting health access for immigrant populations. This is true from both a barrier-focused framework and the needs-focused framework. In the barrier-focused framework, the categories are simply listed without indication of interactions between the different levels of barriers. Through this simple evaluation, the subcategories in the policy arena category (law/insurance, need for documentation to get services/unauthorized parents) have greater effects than the subcategories listed in the health system and individual level categories. For example, the legal lack of access to health insurance and federal immigration policy play a wide-reaching and critical role in preventing immigrants accessing healthcare whereas issues like language access, while still consequential, can be partially remedied through the intervention of CBOs. In the needs-focused framework, the various variables are indicated as having mediating relationships with one another. Through this analysis, the macro level factors not only provide a direct effect on health-service utilization, but they also affect meso and micro level factors. For example, the individual fears around deportation and law enforcement stem from national level immigration policies like the public charge rule and anti-immigrant rhetoric from President Trump. Government policies dictate how much money is allocated to social safety net spending and whether that money can be used to help immigrant communities. Even factors like language barriers and lack of education about the system could be combatted through targeted, positive policy that seeks to make the health care system more accessible.

By analyzing the various levels of factors in immigrant health access, macro level factors play the largest role in immigrant health access, not only because of their direct and individually limiting effects on immigrant health access, but also because of the trickle down effects they have on meso and micro level factors as well.

This leads into the next major discussion which focuses on these macro level factors in greater depth by understanding how various levels of government policy interact and influence immigrant health access. The second group of themes in the thematic analysis included federal, state, and local policies. The data provided evidence in support of the argument made in Montez's paper on state policy. Montez argued that state level government and policy hold a disproportionate influence (as opposed to federal or local policy) over health outcomes for its residents through its jurisdiction over matters like Medicaid expansion, willingness to cooperate with federal immigration authorities, and most recently public health measures to respond to the COVID-19 pandemic. While both federal and local policy and actions were cited as important in the interviews, state policy did emerge as the most pivotal policy actor in immigrant health outcomes.

Federal policy is likely where the most consequential changes could be made since immigration is a federal issue and major health insurance policy (like the Affordable Care Act) is passed at the federal level. However, it seems unlikely that such sweeping changes will occur. Although the change in administration has brought some tentative hope to immigrant communities and their advocates, there is still an expectation that President Biden will stick to the status quo, perhaps making some incremental changes but not addressing the key issues in immigration and health policy. The biggest goal for advocates seems to be getting progressive voices at the table at all to make those incremental changes.

As explained in Montez's paper, the state holds a significant amount of power over policies that can affect immigrant health access. Pre-pandemic this power was displayed through the state's decision about ACA Medicaid expansion and the choice to strengthen or loosen the base-level federal barriers (like the 5-year rule) and extend optional extra coverage (like the coverage of children and women). Montez's research did not focus specifically on immigration, but states also have some power over the handling of immigration within the state. States can pass laws prohibiting cooperation of local authorities with federal immigration law enforcement (like in California) or pass laws mandating that cooperation (like in Arizona). Although the states are not substantively changing the law, they hold power over how it is implemented which can have severe consequences for the immigrant population within the state.

The COVID-19 pandemic further demonstrated the individual power of state government. At the onset of the pandemic, the federal government extended a great deal of leeway to individual states on how they would handle pandemic response, and there was a clear difference in policy between states with Democratic and Republican leadership. The timeline and implementation of stay-at-home orders, mask mandates and reopening procedures varied wildly across states. The power of the state government during the pandemic also extended into the local government.

The local government does not have much power when compared to the federal and state governments. As Montez points out in her research, only does the state have power over federal issues like Medicaid, but it also holds significant power over the local governments because of preemption laws. Before the pandemic, this manifested itself as states prohibiting cities from claiming sanctuary status or imposing strict immigration compliance on all cities within the state. During the pandemic, governors lifted mayor-imposed stay-at-home orders, curfews, or mask

mandates on cities. In some situations, the state went to the lengths of suing mayors for such actions. These occurrences demonstrate that the biggest role of local government and authorities when it comes to immigrant health seems to be rhetoric and non-policy-based collaboration with the community. Many of the informants spoke about their organization's work with local authorities and how the willingness or lack thereof could help or hurt their efforts in increasing health access. For example, in cities like Sacramento where the FUEL Network united the efforts of local government and CBOs, many barriers to immigrant health access could be addressed and immigrant health service use was expanded as a result. In other cities like Phoenix where the local authorities were either unwilling or politically unable to cooperate, CBOs ran into many barriers with their work, having to spend much of their time simply negotiating with local authorities.

The observations made above through the use of frameworks and arguments made in past research yields some next steps and recommendations for the future. There are two ways to approach expansion of immigrant health access, especially in light of the COVID-19 pandemic - top-down and bottom-up change.

Top-down change would entail major changes being made at the federal level. Although the immigrant community and their advocates tentatively hoped for changes with the Biden administration, there has not been much substantive policy change in issues around immigration or the healthcare system. This is not wholly unexpected since similar lack of change occurred under President Obama as well. In a way, the end of the Trump administration has resulted in less attention given to immigration issues generally because people think the worst has passed. For example, the FUEL network in Sacramento, which provided essential services to immigrant

populations as they accessed healthcare, is now being defunded by the city government because Trump is no longer in office.

The key issue here seems to be that increasing access for noncitizens is not a popular policy platform among the general public, so the work will consistently fall on progressive advocates to push for change from the status quo. However, the COVID-19 pandemic has provided a perhaps unique window of opportunity for change because it has exposed the importance of community health and the need for a more holistic understanding of health. Advocates have been strategic about their approaches with this opportunity window, and during the interviews, informants provided a variety of potential strategies for pursuing change.

Bottom-up change begins at the community level and works its way up through grassroots movements. This approach might be less effective for widespread change, but there is potential for community-led, truly inclusive changes by beginning at the grassroots. One of the biggest takeaways from this research was the pivotal role of community-based organizations in connecting immigrant communities to health services. There are so many passionate people dedicated to this work across the country, present in various communities, doing work to fill in the gaps created by structural issues and a broken social safety net. Changes on a local level may seem inconsequential because they cannot substantively change overarching policies, but even that willingness to collaborate between local authorities and CBOs can make drastic changes for the immigrant populations in that community.

Much of the work being done by CBOs is dispelling fears and addressing concerns that help connect immigrants to the resources they need, but their work showed that trust can indeed be built. Despite the anti-immigrant rhetoric and hostile structural system within the country, these CBOs have built trust within the immigrant communities they serve so that they feel

comfortable accessing healthcare through them or getting the resources they need through them. This demonstrates that, with the right attention, trust, and care, many of the immigrant-specific factors like language barriers, resource barriers, lack of education about the system, and fears can be overcome. Accordingly, working from the bottom-up, building trust among communities, and leading progressive change through such a movement can be a potent step forward in ensuring health access for some of our most vulnerable and marginalized populations.

## VIII. Conclusion

In this research, I aimed to understand how the COVID-19 pandemic affected immigrant access to and use of healthcare services. Immigrant communities were disproportionately affected by the pandemic due to socioeconomic factors, medical risk factors, legal restrictions, and a hostile political environment. I hoped to specifically study the impact of local, state, and federal policy on immigrant populations by studying a variety of cities (varying on a continuum of immigration-policy "friendliness" and immigrant population concentration). Through interviews, I was able to determine how differing government responses to COVID-19 translated into different barriers and opportunities for immigrants at the micro, meso, and macro level.

The micro level revealed common trends across the country in individual barriers to accessing healthcare. The meso level also revealed common trends. The healthcare system, bureaucracy and administrative institutions, and workplace demonstrated a number of barriers that occur "between" individual immigrants and the government. However, community-based organizations and certain community healthcare institutions played a major role in expanding access to healthcare by working with immigrants to navigate hostile policy and legal barriers.

Through the data, I observed that the most variable and far-reaching barriers occurred at the macro level. This included government institutions, law, and policy. To better understand the macro level, I delved further into policy at different levels of government. From here, I observed that federal policy seemed to be where the most wide-ranging change could be made since immigration is a federal issue and major health insurance policy (like the Affordable Care Act) is passed at the federal level.

The cities in this study were not chosen based on state-related characteristics, yet there happened to be differences across the states represented with respect to the political affiliation of

their leadership, the overall concentration of immigrants in the state, and their health and immigration policy environment. Across these differing states, I observed that the state government has a significant amount of power over healthcare policy because of its jurisdiction over Medicaid expansion and spending, and it also had a great deal of authority over the coronavirus pandemic response measures.

Lastly, the study was structured around the local level of government by selecting cities on a continuum of immigrant friendliness of the city vs. immigrant population concentration of the city. The data suggests that declaration as a "sanctuary city" does not necessarily ensure increased support of immigrant communities for their health needs because "sanctuary" status only relates to immigration enforcement. However, self-proclaimed "sanctuary city" status can still be meaningful to immigrant communities because it signals a commitment of local authorities to the wellbeing of immigrant communities. Additionally, the data suggests that immigrant population concentration might necessitate greater policy attention but that attention could be positive or negative for immigrants dependent on local authority immigrant friendliness.

Although the local level of government is the least powerful because of the authority of the federal and state governments, it does have great potential to work with or hinder efforts by local CBOs and other service providers to increase access to healthcare for immigrants.

The coronavirus pandemic has provided a wholly unique opportunity for change. Each of the informants expressed a hope that the pandemic has exposed deep structural issues with our healthcare and safety net systems, and provided suggestions moving forward to increase equity for all people, regardless of their race, ethnicity, nationality, or legal status. From their recommendations, I suggest that change should be approached in two ways. First, through top-

down change that focuses on federal and state policy, advocates can work towards broad, structural changes like Medicare for All or immigration policy reform. Second, through bottom-up change, local governments and community organizations can work towards increasing access for individual immigrants. Together, these approaches can work to close the gaps that immigrants face in their attempts to access healthcare services.

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