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June 15, 2023

Secretary Xavier Becerra
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Re: RIN 0938-AV23; CMS-9894-P
Clarifying Eligibility for a Qualified Health Plan Through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, a Basic Health Program, and for Some Medicaid and Children's Health Insurance Programs

Dear Secretary Becerra and Administrator Brooks-LaSure:

The National Health Law Program (NHeLP) is a public interest law firm that works to advance equitable access to health care and protect the health rights of people with low incomes and underserved populations. For over fifty years, we have litigated, advocated, and educated at the federal and state levels to advance health and civil rights in the United States. Consistent with our mission, we strongly believe that health care is a human right. Every individual should have access to high quality, affordable, and comprehensive health care and be able

to achieve their own highest attainable standard of health. Accordingly, we generally support and appreciate the opportunity to comment on the Department of Health and Human Services' (HHS) proposed rule, *Clarifying Eligibility for a Qualified Health Plan Through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, a Basic Health Program, and for Some Medicaid and Children's Health Insurance Programs* (hereinafter "Proposed Rule").[1]

NHeLP supports the proposed removal of the exception that excludes Deferred Action for Childhood Arrivals (DACA) recipients from the definitions of "lawfully present" used to determine eligibility for the Centers for Medicare & Medicaid Services' (CMS) health insurance affordability programs. Specifically, under the Proposed Rule, DACA recipients would be eligible to enroll in a qualified health plan (QHP) through an Affordable Care Act (ACA) Exchange, with financial assistance such as premium tax credits (PTC), advance payments of the premium tax credits (APTC), and cost-sharing reductions (CSR); a Basic Health Program (BHP); and Medicaid or Children's Health Insurance Program (CHIP) in States that have elected to cover "lawfully residing" pregnant individuals and children under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (hereinafter "CHIPRA 214 option"), if otherwise eligible.[2] This proposed modification would bring DACA recipients in line with other deferred action recipients for purposes of eligibility for insurance affordability programs, greatly benefiting the overall health and well-being of DACA recipients and ameliorating an unjustified oversight that has been in place since 2012.[3] NHeLP strongly

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[1] U.S. Dep't. Health & Human Srvs., *Clarifying Eligibility for a Qualified Health Plan Through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, a Basic Health Program, and for Some Medicaid and Children's Health Insurance Programs, Notice of Proposed Rulemaking*, 88 Fed. Reg. 25313-25335 (proposed Apr. 26, 2023), https://www.federalregister.gov/documents/2023/04/26/2023-08635/clarifying-eligibility-for-a-qualified-health-plan-through-an-exchange-advance-payments-of-the (hereinafter "Proposed Rule").

[2] There are 35 States, the District of Columbia, and 3 territories that have elected the CHIPRA 214 option to provide Medicaid or CHIP coverage to at least one population of lawfully residing children or pregnant individuals. Ctrs. for Medicare & Medicaid Srvs., *Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Individuals*, https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-individuals (last visited Jun. 1, 2023).

[3] U.S. Dep't. Health & Human Srvs., *Pre-Existing Condition Insurance Plan Program, Amendment to Interim Final Rule*, 77 Fed. Reg. 52614-52616 (Aug. 30, 2012), https://www.federalregister.gov/documents/2012/08/30/2012-21519/pre-existing-condition-insurance-plan-program (hereinafter "2012 IFR"); Ctrs. for Medicare & Medicaid Srvs., Dear State Health Official, *SHO #12-002: Individuals with Deferred Action for Childhood Arrivals* (Aug. 28, 2012),

encourages HHS to finalize the Proposed Rule without delay, but no later than the target effective date of November 1, 2023 to align with the individual market Exchange open enrollment period.

We generally support the proposed technical changes to the definitions of "lawfully present" that clarify health coverage for other noncitizens. These proposed modifications would simplify and streamline eligibility verification processes for noncitizens; reduce burden for CMS, States, and individual applicants; and ensure accurate and consistent eligibility determinations processes for these populations that align with the Department of Homeland Security's (DHS) policies. With that said, NHeLP recommends HHS provide a more detailed definition of "qualified noncitizen" at 42 C.F.R. § 435.4 and further clarify the proposed definitions of "lawfully present" at 45 C.F.R. § 155.20 and 42 C.F.R. § 435.4 used to determine eligibility for insurance affordability programs to include:

- individuals eligible to apply for employment authorization, regardless of whether they have been granted an Employment Authorization Document (EAD), and
- applicants for asylum, withholding of removal, or relief under the Convention Against Torture (CAT), regardless of whether they have been granted employment authorization.

Our comments address the benefits of the Proposed Rule for States seeking to expand coverage to the uninsured. The Proposed Rule supports States that currently use State-only funds to cover DACA recipients. NHeLP also recommends HHS release guidance on the usage of Section 1332 waivers by States to allow individuals not considered "lawfully present" to enroll in QHPs through State-based Exchanges (SBEs).[4]

Our comments highlight the importance of maintaining the proposed severability clauses to realize the significant benefits of the Proposed Rule. NHeLP also strongly encourages HHS to develop robust outreach and enrollment strategies for DACA recipients and other noncitizens affected by the Proposed Rule once it is finalized and include messaging directly addressing the persisting fears related to public charge.

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https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-002.pdf (hereinafter "SHO #12-002").

[4] Proposed Rule, *supra* note 1, at 25313 n.2.

I. The Proposed Rule removes eligibility restrictions on DACA recipients for CMS insurance affordability programs, resulting in multiple benefits

Individuals granted deferred action by DHS under the DACA policy are lawfully present and should be treated as such for purposes of eligibility for insurance affordability programs. Therefore, we commend HHS for proposing to modify its interpretation of the statutory phrase "lawfully present" in order to treat DACA recipients the same as other deferred action recipients for these purposes.

A. Existing regulations exclude DACA recipients from insurance affordability programs without sufficient legal or policy justification

The ACA created the "lawfully present" standard of eligibility for the Pre-Existing Condition Insurance Plan (PCIP),[5] which expired in 2014; enrollment in a QHP through an Exchange;[6] eligibility for financial assistance like PTC,[7] APTC,[8] and CSR;[9] and enrollment in a BHP.[10] Because the ACA did not offer a definition of "lawfully present,"[11] HHS issued a PCIP interim final rule[12] in 2010 that adopted the definition of "lawfully residing" established for Medicaid and CHIP eligibility for children and pregnant individuals under the CHIPRA 214 option from a CMS State Health Official (SHO) Letter (SHO #10-006).[13] HHS codified the list of immigration categories considered "lawfully present" for purposes of eligibility for a PCIP at 45 C.F.R. § 152.2.[14] In 2012, HHS adopted the same definition in its Exchange final rule for purposes of

[5] 42 U.S.C. § 18001(d)(1).
[6] 42 U.S.C. § 18032(f)(3).
[7] 26 U.S.C. § 36B(e)(2).
[8] 42 U.S.C. § 18082(d).
[9] 42 U.S.C. § 18071(e).
[10] 42 U.S.C. § 18051(e).
[11] 42 U.S.C. § 18001(d)(1).
[12] U.S. Dep't. Health & Human Srvs., *Pre-Existing Condition Insurance Plan Program, Interim Final Rule*, 75 Fed. Reg. 45013-45033 (Jul. 30, 2010), https://www.federalregister.gov/documents/2010/07/30/2010-18691/pre-existing-condition-insurance-plan-program.
[13] Ctrs. for Medicare & Medicaid Srvs., Dear State Health Official, *SHO #10-006: Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women* (Jul. 1, 2010), https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/sho10006.pdf.
[14] 45 C.F.R § 152.2.

eligibility for a QHP.[15] As a result, under the definitions of "lawfully present" set forth in the 2010 SHO #10-006, 2010 PCIP regulations, and 2012 Exchange regulations, individuals granted deferred action status by DHS were considered "lawfully present" for purposes of eligibility to enroll in a PCIP, a QHP through an Exchange, a BHP, and Medicaid and CHIP under the CHIPRA 214 option. These regulations did not explicitly reference DACA recipients, as the DACA policy had not yet been established.

On June 15, 2012, DHS announced that it would grant deferred action under its administrative authority to childhood arrivals residing in the United States who meet specific requirements.[16] The DACA program was officially launched on August 15, 2012. At this point, once an individual was granted deferred action under DACA, the above regulations would have classified them as "lawfully present" for purposes of eligibility for insurance affordability programs.

However, on August 28, 2012, CMS issued SHO #12-002, excluding DACA recipients from the definition of "lawfully residing" for purposes of Medicaid or CHIP eligibility under the CHIPRA 214 option.[17] Then, on August 30, 2012, HHS issued an amendment to the PCIP interim final rule (hereinafter "2012 IFR"), modifying the regulatory definition of "lawfully present" to exclude DACA recipients by carving out an exception for these individuals at 45 C.F.R. § 152.2(8).[18]

In NHeLP's public comments in response to the 2012 IFR, we strongly opposed the exclusion of DACA recipients from the list of immigration categories that HHS considered "lawfully present" for purposes of eligibility for insurance affordability programs.[19] We believed the rule

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[15] U.S. Dep't. Health & Human Srvs., *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule*, 77 Fed. Reg. 18309-18475 (Mar. 27, 2012), https://www.federalregister.gov/documents/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans.

[16] U.S. Dep't. Homeland Sec., Memorandum, *Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children* (Jun. 15, 2012), https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf.

[17] SHO #12-002, *supra* note 3.

[18] 2012 IFR, *supra* note 3, at 52615; 45 C.F.R. § 152.2(8).

[19] Nat'l Health Law Prog., *NHeLP Comments on Changes to Definition of Lawfully Present in the Pre-Existing Condition Insurance Plan Program of the Affordable Care Act of 2010* (Oct. 29, 2012),

change was unnecessary, arbitrary, and lacked sufficient legal or policy justification. Furthermore, not only did the rule change undermine the primary goal of the ACA to expand access to affordable health coverage to the uninsured, it also contradicted the purposes of DACA to integrate childhood arrivals into the fabric of their communities, despite their previously undocumented status. Overall, the rule change denied DACA recipients access to affordable health coverage, negatively affecting their health outcomes, increasing health care costs, and exacerbating health inequities.

B. The Proposed Rule leads to increased health coverage and improved health outcomes for DACA recipients

The Proposed Rule would no longer exclude DACA recipients from the definitions of "lawfully present" applicable to eligibility for enrollment in a QHP through an Exchange, a BHP, and Medicaid and CHIP in States that have elected the CHIPRA 214 option. As of December 31, 2022, approximately 580,000 individuals are active DACA recipients.[20] HHS estimates that 129,000 previously uninsured DACA recipients would benefit from the Proposed Rule.[21]

i. Increased health coverage

With DACA recipients nearly three times as likely to be uninsured than the general population in the United States, the Proposed Rule would greatly benefit DACA recipients' health and well-being.[22] According to a 2022 survey, 27 percent of DACA recipient respondents reported that they were not covered by any health insurance.[23] Of those with health insurance, 80 percent of respondents received coverage through an employer or union.[24] In contrast, almost 50 percent of the general population has employer-sponsored insurance, while less than 10 percent are uninsured.[25] While this demonstrates that DACA has enabled some recipients to

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https://healthlaw.org/resource/nhelp-comments-on-changes-to-definition-of-lawfully-present-in-the-pre-existi/.

[20] U.S. Citizenship & Immigr. Srvs., *Active DACA Recipients – December 31, 2022* (Apr. 5, 2023), https://www.uscis.gov/sites/default/files/document/data/Active_DACA_Recipients_Dec_FY23_qtr1.pdf.

[21] Proposed Rule, *supra* note 1, at 25317. https://app.asana.com/0/goal/1203681999473258

[22] Nat'l Immigr. Law Ctr., *DACA Recipients' Access to Health Care: 2023 Report* (May 2023), https://www.nilc.org/news/special-reports/daca-recipients-access-to-health-care-2023-report/.

[23] *Id*.

[24] *Id.*

[25] Kaiser Fam. Found., *Health Insurance Coverage of the Total Population*, https://www.kff.org/other/state-indicator/total-population/ (last visited Jun. 1, 2023).

access health coverage through employer-sponsored insurance, it also illustrates how DACA recipients' health outcomes and coverage options are directly tied to their employment status. Consequently, for a DACA recipient, the stark reality is that losing their job likely means losing their health coverage. The majority of DACA recipients are employed, with the 2022 survey finding an 83.1 percent employment rate among respondents.[26] Despite such high rates of employment, individuals likely eligible for DACA are also more likely to have low incomes, which is plausibly attributable to disproportionate employment in low-wage jobs and industries that are less likely to offer employer-sponsored insurance.[27]

During the COVID-19 pandemic, DACA recipients experienced exacerbated health inequities due to their ineligibility for some relief programs and overrepresentation among essential workers. At the height of the pandemic, 343,000 DACA recipients were employed in jobs deemed "essential" by DHS, working to protect our health, safety, and well-being on the frontlines.[28] This included:

- 34,000 health care workers providing patient care;
- 11,000 individuals working in health care settings to keep facilities functioning;
- 20,000 educators; and
- 100,000 individuals working in the food supply chain.[29]

Like many in the United States, DACA recipients were not immune to the pandemic-related economic downturn. In a 2020 survey, 25.8 percent of employed DACA recipient respondents reported having either their work hours or pay reduced due to the pandemic, while 45.1

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[26] Tom K. Wong et al., Ctr. for Am. Progress, *DACA Boosts Recipients' Well-Being and Economic Contributions: 2022 Survey Results* (Apr. 7, 2023), https://www.americanprogress.org/article/daca-boosts-recipients-well-being-and-economic-contributions-2022-survey-results/; Tom K. Wong et al., U.C. San Diego U.S. Immigr. Pol'y Ctr., *Results from Tom K. Wong et al., 2022 National DACA Study* (Apr. 7, 2023), https://www.americanprogress.org/wp-content/uploads/sites/2/2023/04/DACA-Survey-2022-Toplines.pdf.

[27] Kaiser Fam. Found., *Key Facts on Deferred Action for Childhood Arrivals (DACA)* (Apr. 13, 2023), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.

[28] Nicole Prchal Svajlenka & Trinh Q. Truong, Ctr. for Am. Progress, *The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition* (Nov. 24, 2021), https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/.

[29] *Id.*

percent of unemployed respondents reported that they lost their job due to the pandemic.[30] Additionally, almost 18 percent of DACA recipient respondents in a 2021 survey reported that they lost their employer-sponsored insurance during the pandemic.[31] However, unlike many of their peers, DACA recipients lacked other coverage options once they lost their employer-sponsored insurance—they did not have access to public health insurance programs, like Medicaid, CHIP, and BHPs, or the ACA Exchanges to purchase QHPs possibly with financial assistance.[32] Clearly, it is time for DACA recipients to have access to the health coverage options they deserve.

DACA recipients face major barriers to accessing health care coverage and services. In the 2022 survey, DACA recipient respondents identified their immigration status, the lack of available affordable care or coverage options, and their concern that using health care services could negatively affect their own or their family's immigration status as significant barriers to accessing coverage.[33] Furthermore, 71 percent of DACA recipient respondents reported being unable to pay medical bills or expenses in the past, while 48 percent reported that they have previously delayed or forgone getting medical care altogether because of their immigration status.[34] For uninsured DACA recipients, concerns over the cost of health care services aligns with those of the general uninsured population, but DACA recipients additionally harbor fears that seeking care may harm their immigration status.[35] Because DACA recipients face such compounded barriers to accessing health coverage and care, the Proposed Rule would greatly benefit this population.

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[30] United We Dream, *Amid Changes to the DACA Program and COVID-19, DACA Recipients are Fired Up and Civically Engaged* (Oct. 20, 2020), https://unitedwedream.org/resources/amid-changes-to-the-daca-program-and-covid-19-daca-recipients-are-fired-up-and-civically-engaged/; Tom K. Wong, et al., U.C. San Diego U.S. Immigr. Pol'y Ctr., *Results from Tom K. Wong et al., 2020 National DACA Study* (Oct. 5, 2020), https://americanprogress.org/wp-content/uploads/sites/2/2020/10/DACA-Survey-20201.pdf?_ga=2.83589141.2095145263.1685633617-1894156241.1685321087.

[31] Nat'l Immigr. Law Ctr., *Tracking DACA Recipients' Access to Health Care* (Jun. 2022), https://www.nilc.org/news/special-reports/daca-access-to-health-care/.

[32] DACA recipients also did not have access to the new optional COVID-19 Medicaid eligibility group that was created during the COVID-19 public health emergency; *see* Families First Coronavirus Response Act § 6004(a)(3).

[33] Nat'l Immigr. Law Ctr., *supra* note 22.

[34] *Id*.

[35] Jennifer Tolbert et al., Kaiser Fam. Found., *Key Facts about the Uninsured Population* (Dec. 19, 2022), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

ii. Access to care and improved health outcomes

Having health coverage increases access to preventive care and improves health outcomes. Studies repeatedly demonstrate that uninsured individuals are less likely than insured individuals to access preventive care for major health conditions and chronic diseases.[36] While DACA recipients can currently access care at community health centers at no cost or on a sliding-fee scale, research shows that uninsured individuals are less likely than those with Medicaid coverage to access medical and dental care, receive recommended follow-up care, complete referrals for outside specialty care, and obtain prescription medications.[37] Moreover, community health centers and other safety net providers have limited resources and capacity, and not all uninsured individuals have the necessary geographic access.[38] With uninsured individuals less likely to access preventive care, they are also more likely to be admitted to hospitals through the emergency department after their health conditions have worsened from delaying care.[39] And when hospitalized, uninsured individuals receive fewer treatments and procedures and experience higher mortality rates compared to the insured.[40]

The Proposed Rule would particularly expand access to sexual and reproductive health care services for DACA recipients. With women making up 53 percent of active DACA recipients

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[36] *Id*; Laura Hawks et al., *Trends in Unmet Need for Physician and Preventive Services in the United States, 1998-2017*, 180 JAMA INTERNAL MED. 439 (2020), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2759743; Hailun Liang et al., *Health Needs, Utilization of Services and Access to Care Among Medicaid and Uninsured Patients with Chronic Disease in Health Centres*, 24 J. HEALTH SERVS. RSCH. & POL'Y 172 (2019), https://journals.sagepub.com/doi/10.1177/1355819619836130.

[37] Nat'l Immigr. Law Ctr., *Frequently Asked Questions: Exclusion of Youth Granted "Deferred Action for Childhood Arrivals" from Affordable Health Care* (Dec. 2022), https://www.nilc.org/issues/health-care/acadacafaq/; Veri Sero et al., *Access to Care Among Medicaid and Uninsured Patients in Community Health Centers After the Affordable Care Act*, 19 BMC HEALTH SERVS. RSCH. (2019), https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4124-z; Megan B. Cole et al., *Health Insurance Coverage and Access to Care for Community Health Center Patients: Evidence Following the Affordable Care Act*, 33 J. GEN. INTERNAL MED. 1444 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6108997/.

[38] Tolbert et al., *supra* note 35.

[39] *Id*; Marco A. Castaneda & Meryem Saygili, *The Health Conditions and the Health Care Consumption of the Uninsured*, 6 HEALTH ECON. REV. (2016), https://healtheconomicsreview.biomedcentral.com/articles/10.1186/s13561-016-0137-z.

[40] Tolbert et al., *supra* note 35; Castaneda & Saygili, supra note 39; Steffie Woolhandler & David U. Himmelstein, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 ANNALS INTERNAL MED. 424 (2017), https://www.acpjournals.org/doi/full/10.7326/M17-1403.

and the majority of DACA recipients between the ages of 16 and 40, there is great need for comprehensive sexual and reproductive health care services among this demographic.[41] For example, immigrant women experience higher breast and cervical cancer incidence and mortality rates and lower screening rates compared to U.S.-born women.[42] Studies also demonstrate that the lack of health coverage is associated with more advanced-stage breast and cervical cancer diagnoses and suggest that coverage may even help mitigate existing racial and ethnic inequities.[43] Expanding access to ACA Exchanges would allow DACA recipients to purchase QHPs that provide a range of sexual and reproductive health care services without any cost-sharing.[44] Some of these services include well-woman visits, contraceptive services and counseling, breastfeeding support and supplies, prenatal visits and screenings, breast and cervical cancer screenings, and STI and HIV testing and counseling.[45] Additionally, Medicaid and CHIP are important sources of preventive sexual and reproductive health care, providing family planning services and supplies, screenings for STIs and breast and cervical cancer, and pregnancy-related services, including prenatal and postpartum care.[46]

The Proposed Rule would expand access to preventive health care services and coverage for children. While only 6,700 DACA recipients are under age 21, these individuals are most likely still in school and uninsured if they cannot access employer-sponsored insurance through

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[41] U.S. Citizenship & Immigr. Srvs., *supra* note 20.
[42] Ctrs. for Disease Control & Prevention, *Breast Cancer Screening Among Women by Nativity, Birthplace, and Length of Time in the United States*, 129 NAT'L HEALTH STAT. REPS. (2019), https://www.cdc.gov/nchs/data/nhsr/nhsr129-508.pdf; Meheret Endeshaw et al., *Cervical Cancer Screening Among Women by Birthplace and Percent of Lifetime Living in the United States*, 22 J. LOWER GENITAL TRACT DISEASE 280 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6664302/.
[43] Naomi Y. Ko et al., *Association of Insurance Status and Racial Disparities With the Detection of Early-Stage Breast Cancer*, 6 JAMA ONCOLOGY 385 (2020), https://jamanetwork.com/journals/jamaoncology/fullarticle/2758266; Hunter K. Holt et al., *Mediation of Racial and Ethnic Inequities in the Diagnosis of Advanced-Stage Cervical Cancer by Insurance Status*, 6 JAMA NETWORK OPEN (2023), https://jamanetwork.com/journals/jamaoncology/fullarticle/2758266.
[44] 42 U.S.C. § 300 gg-13.
[45] Kaiser Fam. Found., *Preventive Services Covered by Private Health Plans under the Affordable Care Act* (May 15, 2023), https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/.
[46] 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R § 441.20; 42 U.S.C. §§ 1396a(a)(10)(A), (C), 1396a(l), 1396d(n); 42 C.F.R. § 440.210(a)(2); *see* Nat'l Health Law Prog., *An Advocate's Guide to Reproductive and Sexual Health in the Medicaid Program* (Sept. 17, 2019), https://healthlaw.org/resource/an-advocates-guide-to-reproductive-and-sexual-health-in-the-medicaid-program/.

their parents' employment.[47] Therefore, this demographic would particularly benefit from the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in Medicaid and some CHIP programs.[48] EPSDT services must include any medically necessary health care, diagnostic services, and treatments, regardless of whether the services are covered for adults in the State's Medicaid program.[49] Additionally, 300,000 U.S.-born children have at least one parent who is a DACA recipient.[50] Studies repeatedly have shown that children are more likely to be insured when their parents have health insurance, meaning parents' access to health care services often affects their children's access.[51] Accordingly, expanding health coverage options for DACA recipient parents would likely open the doors to coverage for their children.

The Proposed Rule would also expand access to mental health care services for DACA recipients. Feelings of depression, anxiety, and fear related to the future of their immigration status run high among DACA recipients, especially in response to immigration policy threats, such as the Trump Administration's attempted rescission of the DACA program in 2017.[52] In the 2022 survey, 48 percent of DACA recipient respondents who indicated they experience

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[47] U.S. Citizenship & Immigr. Srvs., *supra* note 20.
[48] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); *see* Medicaid & CHIP Payment & Access Comm'n, *EPSDT in Medicaid*, https://www.macpac.gov/subtopic/epsdt-in-medicaid/ (last visited Jun. 1, 2023).
[49] 42 U.S.C. §§ 1396a(a)(43)(C), 1396d(r)(5); 42 C.F.R. §§ 441.50-441.62.
[50] Svajlenka & Truong, *supra* note 28.
[51] Samantha Artiga & Petry Ubri, Kaiser Fam. Found., *Key Issues in Children's Health Coverage* (Feb. 15, 2017), https://www.kff.org/medicaid/issue-brief/key-issues-in-childrens-health-coverage/; Jessica Schubel, Ctr. on Budget & Pol'y Priorities, *Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children* (Jun. 14, 2021), https://www.cbpp.org/research/health/expanding-medicaid-for-parents-improves-coverage-and-health-for-both-parents-and; Karina Wagnerman, Geo. Univ. Ctr. for Child. & Fams., *Research Update: How Medicaid Coverage for Parents Benefits Children* (Jan. 12, 2018), https://ccf.georgetown.edu/2018/01/12/research-update-how-medicaid-coverage-for-parents-benefits-children/; Maya Venkataramani et al., *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services*, 140 PEDIATRICS (2017), https://publications.aap.org/pediatrics/article-abstract/140/6/e20170953/38165/Spillover-Effects-of-Adult-Medicaid-Expansions-on.
[52] Nat'l Immigr. Law Ctr., *supra* note 22; Elizabeth Aranda et al., *Undocumented Again? DACA Rescission, Emotions, and Incorporation Outcomes Among Young Adults*, 101 SOCIAL FORCES 1321 (2022), https://academic.oup.com/sf/article-abstract/101/3/1321/6613397; Caitlin Patler et al., *Uncertainty About DACA May Undermine Its Positive Impact on Health for Recipients and Their Children*, 38 HEALTH AFFS. 738 (2019), https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05495; *see* Dep't. Homeland Sec., Memorandum, *Rescission of the June 15, 2012 Memorandum Entitled "Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States As Children"* (Sept. 5, 2017), https://www.dhs.gov/news/2017/09/05/memorandum-rescission-daca.

mental or behavioral health issues reported that they were not receiving any counseling, therapy, or psychiatric services from a mental health professional.[53] For DACA recipients, barriers to accessing mental health care include high costs of care, lack of time to access care, and lack of mental health providers who meet their cultural or language needs.[54] Furthermore, uninsured individuals are less likely to receive mental health care services compared to their insured counterparts.[55] Expanding access to ACA Exchanges would allow DACA recipients to purchase QHPs that must cover mental health services as part of their essential health benefits package.[56] Medicaid also covers a range of behavioral health services, including psychiatric services, substance use disorder treatment, integrated care services, and institutional care and intensive services.[57] Behavioral health services are particularly comprehensive for children through Medicaid's EPSDT benefit.[58]

C. The Proposed Rule leads to improved financial well-being and reduced health care costs and strain on the health care safety net

Providing DACA recipients with access to affordable health coverage options should improve their financial well-being, largely through reduced medical debt. Individuals with medical debt often have to make difficult sacrifices, such as cutting back spending on basic necessities, skipping or missing payments on other bills, delaying or avoiding medically necessary care, and using up emergency savings.[59] By rendering individuals unable to pay for utilities and threatening their food and housing security, medical debt has detrimental effects on key social

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[53] Nat'l Immigr. Law Ctr., *supra* note 22.
[54] *Id*.
[55] Nirmita Panchal et al., Kaiser Fam. Found., *How Does Use of Mental Health Care Vary by Demographics and Health Insurance Coverage?* (Mar. 24, 2022), https://www.kff.org/health-reform/issue-brief/how-does-use-of-mental-health-care-vary-by-demographics-and-health-insurance-coverage/.
[56] 42 U.S.C. § 18022(b)(1)(E).
[57] Madeline Guth et al., Kaiser Fam. Found., *Medicaid Coverage of Behavioral Health Services in 2022: Findings from a Survey of State Medicaid Programs* (Mar. 17, 2023), https://www.kff.org/medicaid/issue-brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs/.
[58] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).
[59] Lunna Lopes et al., Kaiser Fam. Found., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills* (Jun. 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/.

determinants of health associated with adverse health outcomes.[60] Additionally, medical debt can have significant financial consequences, including having bills going to collections, lower credit scores, and even bankruptcy, home foreclosures, or evictions.[61] In the 2022 survey, 71 percent of DACA recipient respondents reported being unable to pay medical bills or expenses in the past.[62] The Proposed Rule's expansion of affordable health coverage options to DACA recipients can alleviate this stark reality. Improved access to affordable health coverage results in multiple financial benefits, including reduced medical debt, credit score improvement, and fewer bankruptcy filings.[63]

Expanding access to affordable health coverage options for DACA recipients should also reduce uncompensated care costs in the overall health care system and lessen the strain on safety net providers. Currently, uninsured DACA recipients without a regular source of care rely on community health centers, hospital emergency rooms, and other safety net providers.[64] While some uninsured DACA recipients can access treatment for emergency medical conditions under Emergency Medicaid, this program does not provide the comprehensive services necessary to cultivate positive long-term health outcomes.[65] Additionally, delaying or forgoing care because of high out-of-pocket costs is not cost-effective, burdening the health care system with increased emergency department use and

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[60] David U. Himmelstein et al., *Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US*, 5 JAMA NETWORK OPEN (2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796358; *see also* Craig Gundersen & James P. Ziliak, *Food Insecurity and Health Outcomes*, 34 HEALTH AFFS. 1830 (2015), https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0645; Mario Sims et al., *Importance of Housing and Cardiovascular Health and Well-Being: A Scientific Statement from the American Heart Association*, 13 CIRCULATION: CARDIOVASCULAR QUALITY & OUTCOMES (2020), https://www.ahajournals.org/doi/10.1161/HCQ.0000000000000089.

[61] Lopes et al., *supra* 59.

[62] Nat'l Immigr. Law Ctr., *supra* note 22.

[63] Assistant Sec'y for Plan. & Evaluation Off. Health Pol'y, U.S. Dep't. Health & Human Srvs., *Marketplace Coverage and Economic Benefits: Key Issues and Evidence* (Jul. 20, 2022), https://aspe.hhs.gov/sites/default/files/documents/36e5e989516728adcc63e398b3e3d23d/aspe-marketplace-coverage-economic-benefits.pdf; Kyle J. Caswell & Timothy A. Waidmann, *The Affordable Care Act Medicaid Expansions and Personal Finance*, 76 MED. CARE RSCH. & REV. 538 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6716207/; Luojia Hu et al., *The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing*, 163 J. PUB. ECON. 99 (2018), https://www.sciencedirect.com/science/article/abs/pii/S0047272718300707?via%3Dihub.

[64] Nat'l Immigr. Law Ctr., *supra* note 37.

[65] 42 U.S.C. § 1396b(v)(4); 8 U.S.C. § 1611(b)(1)(A).

avoidable hospitalizations.[66] Because the ACA requires QHPs sold on Exchanges and incentivizes Medicaid through increased federal matching funds to cover recommended preventive health care services without cost-sharing, expanding access to these coverage options would improve DACA recipients' health outcomes while reducing health care costs.[67]

Extending ACA coverage to DACA recipients may additionally have a beneficial effect on Exchange risk pools because they are healthy young adults. DACA recipients generally are between the ages of 16 and 40, with an average age of 29.[68] Among individuals likely eligible for DACA, estimates find that 64 percent report their health as excellent or very good, while an additional 28 percent report their health as good.[69] These estimates align with the self-reported health status of U.S.-born individuals in the same age group.[70] Consequently, providing access to ACA Exchanges for DACA recipients may lead to reduced premiums and additional health care cost savings for all enrollees.

D. The Proposed Rule should be finalized without delay

NHeLP encourages HHS to finalize the Proposed Rule without delay, but no later than the target effective date of November 1, 2023. This would allow for alignment with the individual market Exchange open enrollment period.

If HHS has the capacity to implement the Proposed Rule sooner than this target effective date, there is no need to make DACA recipients and other beneficiaries continue to wait for access to health coverage. DACA recipients who become newly eligible to enroll in QHPs through the Exchanges should qualify immediately for a Special Enrollment Period (SEP) as individuals newly considered lawfully present under the ACA. Those who miss the opportunity to enroll during the SEP would be able to do so during open enrollment. Because Medicaid, CHIP, and the New York and Minnesota BHPs allow for enrollment year-round, DACA recipients who become newly eligible for these programs under the Proposed Rule can enroll immediately, as soon as the effective date. Additionally, States that already cover DACA

[66] Tolbert et al., *supra* note 35; Castaneda & Saygili, *supra* note 39.
[67] 42 U.S.C. § 300 gg-13; 42 U.S.C. §§ 1396d(a)(13), 1396d(b).
[68] U.S. Citizenship & Immigr. Srvs., *supra* note 20.
[69] Kaiser Fam. Found., *supra* note 27.
[70] *Id*.

recipients in their Medicaid programs with State-only funds can benefit immediately from the provided federal matching funds once the Proposed Rule is finalized.[71]

II. The Proposed Rule clarifies health coverage for other noncitizens through important technical changes, resulting in multiple benefits

The Proposed Rule makes important technical changes to the definitions of "lawfully present" applicable to eligibility for enrollment in a QHP through an Exchange, a BHP, and Medicaid and CHIP in States that have elected the CHIPRA 214 option.

A. <u>The Proposed Rule includes more appropriate terminology that is less biased and stigmatizing</u>

NHeLP supports the Proposed Rule's nomenclature change to replace the pejorative and outdated term "alien" in the existing regulatory definition of "lawfully present"[72] with the more accurate term "noncitizen" throughout the proposed definitions of "lawfully present" at 45 C.F.R. § 155.20 and 42 C.F.R. § 435.4. The term "alien" instigates increased stigma, dehumanization, and othering of individuals not born in the United States.[73] Additionally, research has shown that the negative term "alien" is associated with increased prejudice and greater support for punitive immigration policies compared to the more neutral term "noncitizen."[74] The term "alien" is particularly inappropriate in a health and public benefits context, in which we encourage the well-being of all and recognition that health is a human right. Adopting this change would also align with the Biden Administration's Executive Order 14012 on *Restoring Faith in Our Legal Immigration Systems and Strengthening Integration*

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[71] Kaiser Fam. Found., *Health Coverage and Care of Immigrants* (Mar. 30, 2023), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/.
[72] 45 C.F.R. § 152.2.
[73] Julian M. Rucker et al., *The Immigrant Labeling Effect: The Role of Immigrant Group Labels in Prejudice Against Noncitizens*, 22 GROUP PROCESSES & INTERGROUP RELATIONS 1139 (2019), https://journals.sagepub.com/doi/abs/10.1177/1368430218818744; Kai Wei et al., *The Role of Language in Anti-Immigrant Prejudice: What Can We Learn from Immigrants' Historical Experiences?*, 8 SOC. SCIS. 93 (2019), https://www.mdpi.com/2076-0760/8/3/93; Daniel Hernandez, *From 'Alien' to 'Noncitizen': Why the Biden Word Change Matters in the Immigration Debate*, L.A. TIMES (Feb. 18, 2021), https://www.latimes.com/entertainment-arts/story/2021-02-18/immigration-alien-noncitizen-language-politics-undocumented.
[74] Rucker et al., *supra* note 73.

and Inclusion Efforts for New Americans, as well as modern Department of Justice practices.[75]

B. The Proposed Rule facilitates more streamlined and simplified eligibility verification processes for insurance affordability programs

The Proposed Rule's technical changes would promote access to health coverage by eliminating unnecessary complexity in eligibility verification processes for insurance affordability programs. The existing regulatory definition of "lawfully present" can be read to require CMS to determine whether an individual with a nonimmigrant status has violated the terms of that status.[76] However, such determinations of immigration compliance are the responsibility of DHS, not CMS. Currently, ACA Exchanges and Medicaid programs already perform data matches using the DHS Systematic Alien Verification for Entitlements (SAVE) system to verify an applicant's nonimmigrant status. HHS proposes to convert the requirement that CMS determine that an applicant has "not violated the terms" of a nonimmigrant status to the requirement that CMS determine the status to be "valid." This would clarify that an individual's nonimmigrant status can be verified solely using the existing SAVE process, streamlining eligibility verification processes and promoting program administration and integrity through alignment with DHS processes. Accordingly, NHeLP supports the modification of this language in the proposed definitions of "lawfully present" at 45 C.F.R. § 155.20 and 42 C.F.R. § 435.4 to clarify that an individual with a valid nonimmigrant status would be deemed lawfully present.

C. The Proposed Rule reduces burdens on impacted noncitizens and eligibility determination agencies

The Proposed Rule's clarifications and technical changes to the definitions of "lawfully present" would ease burdens on impacted noncitizens and eligibility determination agencies.

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[75] Exec. Order No. 14,012, 86 Fed. Reg. 8277-8280 (Feb. 2, 2021), https://www.federalregister.gov/documents/2021/02/05/2021-02563/restoring-faith-in-our-legal-immigration-systems-and-strengthening-integration-and-inclusion-efforts; U.S. Dep't. Justice, Memorandum, *Clarify the Agency's Use of Terminology Regarding Noncitizens* (Jul. 23, 2021), https://www.justice.gov/eoir/book/file/1415216/download.

[76] 45 C.F.R. § 152.2. The definition of "lawfully present" in this section includes a specific reference to individuals with nonimmigrant status in subsection (2).

i. Individuals eligible to apply for employment authorization

NHeLP recommends HHS include individuals eligible to apply for employment authorization, regardless of whether they have been granted an Employment Authorization Document (EAD), in the proposed definitions of "lawfully present" at 45 C.F.R. § 155.20 and 42 C.F.R. § 435.4. The existing regulatory definition of "lawfully present" includes individuals granted employment authorization under specific subsections of 8 C.F.R. § 274a.12(c).[77] While the Proposed Rule seeks to include as lawfully present individuals granted an EAD under 8 C.F.R. § 274a.12(c), without regard to subsection, we recommend HHS instead clarify that "lawfully present" includes individuals eligible to apply for employment authorization, regardless of whether they have been granted an EAD.

An immigrant's lawful status should not depend on whether they have been granted an EAD, as eligibility for employment authorization should already indicate an individual is lawfully present. Clarifying this in the proposed definitions of "lawfully present" would reduce administrative burden on eligibility determination agencies by simplifying and streamlining the eligibility verification process. With this clarification, eligibility and enrollment workers would only have to determine whether individuals are eligible for employment authorization, rather than whether they have applied for an EAD and how long their EAD application has been pending. Additionally, the current employment authorization requirement imposes particular burdens on children and individuals with disabilities who cannot work or face accessibility barriers to applying for employment authorization.[78] Low-income families and individuals cannot easily afford the fees to apply for and obtain an EAD, particularly if they do not otherwise need it. Lastly, the waiting period before an individual can obtain an EAD ultimately results in unnecessarily delaying coverage for individuals who will have access to health coverage once the EAD is granted.

RECOMMENDATION: Amend subsection (6) of the proposed definition of "lawfully present" at 45 C.F.R. § 155.20 to read as follows:

[77] 45 C.F.R. § 152.2. The definition of "lawfully present" in this section includes a specific reference to individuals who have been granted employment authorization in subsection (4)(iii).
[78] Paola Echave & Dulce Gonzalez, Urb. Inst., *Being an Immigrant with Disabilities: Characteristics of a Population Facing Multiple Structural Challenges* (Apr. 25, 2022), https://www.urban.org/research/publication/being-immigrant-disabilities.

(6) Is granted employment authorization ***or is eligible to apply for employment authorization*** under 8 C.F.R. § 274a.12(c);

RECOMMENDATION: Amend subsection (6) of the proposed definition of "lawfully present" at 42 C.F.R. § 435.4 to read as follows:

(6) Is granted employment authorization ***or is eligible to apply for employment authorization*** under 8 C.F.R. § 274a.12(c);

ii. Individuals with pending applications for adjustment of status

NHeLP supports the Proposed Rule's clarification that individuals with a pending application for adjustment of status are not required to have an approved immigrant visa petition in order to be considered lawfully present. The existing regulatory definition of "lawfully present" includes individuals with pending adjustment of status only if they have an approved visa petition.[79] This limitation unjustifiably excludes many family-based and other immigrants who are not required to have an approved visa petition when they apply to adjust their status. Eliminating the unnecessary requirement for an approved visa petition in the proposed definitions of "lawfully present" at 45 C.F.R. § 155.20 and 42 C.F.R. § 435.4 would correct this exclusion, simplify eligibility verification processes, reduce administrative burden, and align with DHS procedures.

iii. Individuals with pending applications for asylum, withholding of removal, or relief under the Convention Against Torture (CAT)

NHeLP recommends HHS include applicants for asylum, withholding of removal, or relief under CAT, regardless of whether they have been granted employment authorization, in the proposed definitions of "lawfully present" at 45 C.F.R. § 155.20 and 42 C.F.R. § 435.4. The existing regulatory definition of "lawfully present" includes pending applicants for asylum, withholding of removal, or relief under CAT only if they have been granted employment authorization or are children under the age of 14 who have had their application pending for at

[79] 45 C.F.R. § 152.2. The definition of "lawfully present" in this section includes a specific reference to individuals with pending applications for adjustment of status in subsection (4)(vii).

least 180 days.[80] The Proposed Rule seeks to eliminate the 180-day waiting period for children under the age of 14, which we strongly support, but we also encourage HHS to eliminate the requirement that adults and older youth applying for asylum, withholding of removal, and relief under CAT obtain employment authorization before being considered lawfully present. Asylum seekers, from young children to older youth and adults, who seek humanitarian protection have experienced violence and critically need access to health care.[81] Many asylum seekers, particularly children, experience high rates of depression, anxiety, and post-traumatic stress disorders.[82] Many also have common health conditions, such as diabetes and cardiac disease or hypertension, which require ongoing management.[83] Additionally, asylum seekers are vulnerable to acquiring infectious and other diseases due to crowded and unsanitary conditions near the U.S. border, especially children seeking asylum who have been found to be commonly behind in receiving routine medical care and vaccinations.[84]

RECOMMENDATION: Amend subsection (11) of the proposed definition of "lawfully present" at 45 C.F.R. § 155.20 to read as follows:

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[80] 45 C.F.R. § 152.2. The definition of "lawfully present" in this section includes a specific reference to individuals with pending applications for asylum, withholding of removal, or relief under the Convention Against Torture in subsection (5).

[81] Tamaryn Nelson & Hajar Habbach, Physicians for Hum. Rts., *"If I Went Back, I Would Not Survive": Asylum Seekers Fleeing Violence in Mexico and Central America* (Oct. 9, 2019), https://phr.org/our-work/resources/asylum-seekers-fleeing-violence-in-mexico-and-central-america/.

[82] Suzan Song & Sara Teichholtz, Am. Psychiatric Ass'n, *Mental Health Facts on Refugees, Asylum-seekers, & Survivors of Forced Displacement* (2020), https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Refugees.pdf; Kevin Ackerman et al., Physicians for Hum. Rts., *"There is No One Here to Protect You": Trauma Among Children Fleeing Violence in Central America* (Jun. 10, 2019), https://phr.org/our-work/resources/there-is-no-one-here-to-protect-you/.

[83] Rigoberto I. Delgado et al., *Cost of Care for Asylum Seekers and Refugees Entering the United States: The Case of Volunteer Medical Providers in El Paso, Texas*, 17 PLOS ONE (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9714800/.

[84] Megan Diamond et al., Harv. Glob. Health Inst., *A Population in Peril: A Health Crisis Among Asylum Seekers on the Northern Border of Mexico* (Jul. 28, 2020), https://globalhealth.harvard.edu/wp-content/uploads/2020/07/A_Population_in_Peril.pdf; Jaime M. La Charite et al., *Understanding the Healthcare Needs of Migrant Children in Government Custody*, 149 PEDIATRICS 121 (2022), https://publications.aap.org/pediatrics/article/149/1%20Meeting%20Abstracts%20February%202022/121/185757/Understanding-the-Healthcare-Needs-of-Migrant.

(11)~~(i)~~ Has a pending application for asylum under 8 U.S.C. 1158, for withholding of removal under 8 U.S.C. 1231, or for relief under the Convention Against Torture; ~~and~~ ~~(ii) Is under the age of 14;~~

RECOMMENDATION: Amend subsection (11) of the proposed definition of "lawfully present" at 42 C.F.R. § 435.4 to read as follows:

(11)~~(i)~~ Has a pending application for asylum under 8 U.S.C. 1158, for withholding of removal under 8 U.S.C. 1231, or for relief under the Convention Against Torture; ~~and~~ ~~(ii) Is under the age of 14;~~

iv. Individuals with approved Special Immigrant Juvenile (SIJ) petitions

NHeLP supports the Proposed Rule's clarification that individuals with approved SIJ petitions are included in the proposed definitions of "lawfully present" at 45 C.F.R. § 155.20 and 42 C.F.R. § 435.4. SIJ classification is available to minors who have sought the protection of juvenile court to obtain relief from abuse, neglect, or abandonment and who meet other requirements. The existing regulatory definition of "lawfully present" only refers to individuals with "pending application[s] for [SIJ] status," unintentionally excluding individuals with approved SIJ petitions.[85] At the time the definition was drafted, individuals with approved SIJ petitions generally were able to adjust to lawful permanent residence almost immediately. However, the waiting period for a visa to become available can now take years for these individuals due to high demand and processing backlogs. This oversight has created confusion and unnecessary disruptions in the continuity of health coverage for this vulnerable population. Accordingly, this clarification would help ensure that these young people have access to health care coverage and services, including mental health supports.

D. The Proposed Rule should include a more explicit definition of "qualified noncitizen" at 42 C.F.R. § 435.4

NHeLP recommends HHS provide a more detailed definition of "qualified noncitizen" at 42 C.F.R. § 435.4 that explicitly lists the categories covered by 8 U.S.C. §§ 1641(b) and (c), as well as additional categories that Medicaid agencies are required to cover as a result of

[85] 45 C.F.R. § 152.2. The definition of "lawfully present" in this section includes a specific reference to individuals with pending applications for Special Immigrant Juvenile status in subsection (7).

subsequently enacted legislation that has not been codified in 8 U.S.C. §§ 1641(b) and (c). Such additional categories may include certain groups who are treated as refugees, such as victims of trafficking and certain Afghans, Iraqis, Amerasians, and Ukrainians.[86] We recommend keeping the statutory citation to 8 U.S.C. §§ 1641(b) and (c) in the definition of "qualified noncitizen" at 42 C.F.R. § 435.4, listing statuses that are not codified in 1641(b) and (c),[87] and including a residual category that encompasses any statuses created by subsequent legislation or other changes to the statute after the Proposed Rule is finalized. NHeLP has noted that immigrant eligibility for health insurance affordability programs is complex and causes significant confusion.[88] Codifying a clear, comprehensive definition of "qualified noncitizen" would reduce confusion and burden on individuals seeking Medicaid coverage, legal services attorneys, and Medicaid agencies.

III. The Proposed Rule provides funding and flexibility for States seeking to expand health coverage to the uninsured

A. <u>The Proposed Rule supports States that currently use State-only funds to cover DACA recipients and other noncitizens</u>

Extending Medicaid and CHIP coverage under the CHIPRA 214 option to DACA recipients and other noncitizens would support States that currently use State-only funds to cover children, pregnant individuals, or both, regardless of immigration status. As of January 2023, 11 States and the District of Columbia use State-only funds to cover all income-eligible children, regardless of immigration status.[89] Maine and Vermont also provide State-funded

[86] Proposed Rule, *supra* note 1, at 25321 n.43.
[87] For instance, 8 U.S.C. § 1641 does not include American Indians born in Canada or members of a tribe recognized by the federal government in the list of qualified immigrants. However, other provisions indicate that they are treated as qualified immigrants for purposes of Medicaid eligibility. *See* 8 U.S.C. §§ 1612(b)(2)(E), 1613(d)(1).
[88] Sarah Grusin & Catherine McKee, Nat'l Health Law Prog., *Medicaid Coverage for Immigrants* (May 17, 2021), https://healthlaw.org/resource/medicaid-coverage-for-immigrants/.
[89] As of January 2023, these States are California, Connecticut, Illinois, Maine, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington. Connecticut only covers children under age 13, with coverage continuing until age 19 if they remain eligible. Tricia Brooks et al., Kaiser Fam. Found., *Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision* (Apr. 4, 2023), https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-prepare-for-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision-report/.

coverage to pregnant individuals, regardless of immigration status.[90] Additionally, six States and the District of Columbia have used State-only funds to extend 12-month postpartum coverage to pregnant individuals, regardless of immigration status.[91] The Proposed Rule would provide federal matching funds to help cover these populations, allowing these States to use the potential savings to provide State-only funded coverage to other uninsured individuals.

B. HHS should release further guidance on the usage of Section 1332 waivers

NHeLP encourages HHS to release guidance on the usage of Section 1332 waivers by States to allow individuals not considered "lawfully present" to enroll in QHPs through State-based Exchanges (SBEs). Currently, Washington is the one State with an approved Section 1332 waiver for this purpose.[92] It waives the "lawfully present" framework in section 1312(f)(3) of the ACA to permit State residents, regardless of immigration status, to enroll in QHPs through Washington's SBE and apply for State subsidies for such coverage.[93] Further guidance and clarification on the usage of Section 1332 waivers for this purpose would provide the other 17 SBEs the choice to pursue such waivers to continue expanding coverage to the uninsured.[94]

IV. The Proposed Rule intends that various provisions of the clarified definitions of "lawfully present" be severable

NHeLP supports the Proposed Rule's inclusion of severability clauses to ensure that in the event that any portion of the rule is declared invalid, the remainder of the rule is not affected. We agree with HHS that the proposed changes are well-supported in law and practice and

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[90] Nat'l Immigr. Law Ctr., *Table: Medical Assistance Programs for Immigrants in Various States* (Mar. 2023), https://www.nilc.org/issues/health-care/medical-assistance-various-states/.

[91] As of January 2023, these States are Connecticut, Maryland, Massachusetts, New York, Rhode Island, and Washington. Additionally, 4 states (California, Illinois, Minnesota, and Virginia) have extended 12-month postpartum coverage to pregnant individuals, regardless of immigration status, using CHIP health service initiative funding. Brooks et al., *supra* note 89.

[92] Ctrs. for Medicare & Medicaid Srvs., *Approval Letter for Washington Section 1332 State Innovation Waiver* (Dec. 9, 2022), https://www.cms.gov/files/document/1332-wa-approval-letter-stcs.pdf.

[93] *Id*; 42 U.S.C. §§ 18052(a)(2)(B), 18032(f)(3).

[94] As of January 2023, there are 18 State-based Exchanges (SBEs): California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, and Washington. Ctrs. for Medicare & Medicaid Srvs., *State-based Exchanges*, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/state-marketplaces (last visited Jun. 1, 2023).

reflect sound policy. The changes identified in the Proposed Rule are not dependent on one another and could be implemented independently. Accordingly, these severability clauses are key to realizing the significant benefits of the Proposed Rule.

V. HHS should develop robust outreach and enrollment strategies for DACA recipients and other noncitizens

NHeLP strongly encourages HHS to develop robust outreach and enrollment strategies for DACA recipients and other noncitizens affected by the Proposed Rule, including messaging that directly addresses the persisting fears related to public charge. This is necessary in order to address individuals' fears that accessing health care coverage and services could negatively affect their immigration status.[95] The chilling effects of the Trump Administration's 2019 public charge rule have continued to persist.[96] This is particularly important after the Senate recently passed a Congressional Review Act joint resolution of disapproval in an attempt to reverse the Biden Administration's 2022 public charge rule.[97] Therefore, HHS should be prepared to conduct outreach to the targeted population through partnerships and collaborations with trusted organizations, particularly community-based ones, with connections to affected immigrant communities. HHS should also ensure that Medicaid agencies, brokers, assisters, navigators, and other entities involved with outreach and enrollment for ACA and Medicaid coverage are sufficiently trained on the new rule as soon as possible, including training to provide messaging that eases fears related to public charge.

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[95] *See* Nat'l Immigr. Law Ctr., *supra* note 22.

[96] Hamutal Bernstein et al., Urb. Inst., *Adults in Low-Income Immigrant Families Were Deeply Affected by the COVID-19 Crisis Yet Avoided Safety Net Programs in 2020* (May 26, 2021), https://www.urban.org/research/publication/adults-low-income-immigrant-families-were-deeply-affected-covid-19-crisis-yet-avoided-safety-net-programs-2020; Randy Capps et al., Migration Pol'y Inst., *Anticipated "Chilling Effects" of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families* (Dec. 2020), https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real; Jennifer M. Haley et al., Urb. Inst., *One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019* (Jun. 18, 2020), https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019; *see* Eskedar Girmash et al., Nat'l Health Law Prog., *Comments in Response to Proposed Rulemaking: Public Charge Ground of Inadmissibility* (Apr. 25, 2022), https://healthlaw.org/resource/comments-in-response-to-proposed-rulemaking-public-charge-ground-of-inadmissibility/.

[97] S.J. Res. 18, 118th Cong. (2023).

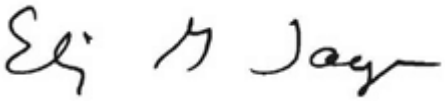
VI. Conclusion

NHeLP supports the HHS Proposed Rule providing DACA recipients access to CMS health insurance affordability programs and the additional technical changes to the regulatory definitions of "lawfully present" used to determine eligibility for these programs. The proposed modifications would greatly benefit the overall health and well-being of DACA recipients and other noncitizens in addition to supporting States in expanding health coverage to the uninsured. With that said, we urge HHS to develop robust outreach and enrollment strategies for DACA recipients and other noncitizens once the proposed changes are finalized.

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comments, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for your attention to our comments. If you have any questions or need further information, please reach out to Michelle Yiu, Policy Fellow, at yiu@healthlaw.org, Sarah Grusin, Senior Attorney, at grusin@healthlaw.org, or Mara Youdelman, Managing Attorney, at youdelman@healthlaw.org.

Sincerely,



Elizabeth G. Taylor
Executive Director