Statement for the Record
July 18, 2023

National Health Law Program
to the
House Committee on Oversight and Accountability
Subcommittee on Health Care and Financial Services

Subcommittee Hearing: "Why Expanding Medicaid to DACA Recipients Will Exacerbate the Border Crisis"

On behalf of the National Health Law Program (NHeLP), we submit this statement for the record for the House Committee on Oversight and Accountability, Subcommittee on Health Care and Financial Services hearing, "Why Expanding Medicaid to DACA Recipients Will Exacerbate the Border Crisis."

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 its mission, NHeLP strongly believes that health care is a human right and works to ensure that all people have access to high quality, affordable, and comprehensive health care.

Therefore, NHeLP supports the Centers for Medicare & Medicaid Services' (CMS) proposal to end the unjustifiable exclusion of Deferred Action for Childhood Arrivals (DACA) recipients from eligibility to obtain coverage under certain CMS health insurance affordability programs, outlined in the Notice of Proposed Rulemaking (NPRM) titled *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] Specifically, under the Proposed Rule, DACA recipients would no longer be excluded from the definition of "lawfully present"[2] used to determine eligibility for enrollment in:

- qualified health plans (QHPs) through the Affordable Care Act (ACA) Exchanges with financial assistance such as advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR), if otherwise eligible;
- Basic Health Programs (BHPs); and
- Medicaid or Children's Health Insurance Programs (CHIP) in States that have elected the CHIPRA 214 option to cover "lawfully residing" children and/or pregnant individuals.[3]

According to the Department of Homeland Security's (DHS) definition of lawful presence, DACA recipients, like other deferred action recipients, are considered "lawfully present."[4] DACA recipients' lawful presence should have provided eligibility for CMS insurance affordability programs available to other deferred action recipients. However, for over a decade, DACA recipients were treated unequally under the law, barred from accessing CMS insurance affordability programs due to an unnecessary and arbitrary carve-out in the regulatory text.[5] It is time to correct this unjust exclusion of DACA recipients and provide them with the health care coverage and services necessary to thrive.

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.[6] According to a 2022 survey, 27% of DACA recipient respondents were uninsured.[7] Of those with health insurance, 80% received coverage through an employer or union, illustrating how DACA recipients' health outcomes and coverage options are directly tied to their employment status.[8] Consequently, for a DACA recipient, the stark reality is that losing a job likely means losing health coverage.

The COVID-19 public health emergency particularly highlighted the need for DACA recipients to have access to CMS insurance affordability programs. During the pandemic, DACA recipients experienced exacerbated health inequities due to their ineligibility for 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, including:

- 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.[9]

Like many in the United States, DACA recipients were not immune to the pandemic-related economic downturn. A 2020 survey found that 45.1% of unemployed DACA recipient respondents lost their job due to the pandemic, while a 2021 survey found that almost 18% of DACA recipient respondents lost their employer-sponsored insurance during the pandemic.[10] However, despite their vital contributions on the front lines during the COVID-19 pandemic, DACA recipients had no other health coverage options to turn to once they lost their employer-sponsored insurance.

Additionally, 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 concerns that using health care services could negatively affect their immigration status as significant barriers to accessing coverage.[11] Furthermore, 48% of DACA recipient respondents reported previously delaying or forgoing medical care because of their immigration status, while 71% reported being unable to pay medical bills or expenses in the past.[12] For uninsured DACA recipients, concerns over the cost of health care services are further compounded by fears that seeking care may harm their immigration status.

Providing DACA recipients with access to affordable health coverage options would increase their access to preventive care and improve health outcomes. Studies repeatedly demonstrate that uninsured individuals are less likely than insured individuals to access medical and dental care, receive recommended follow-up care, complete referrals for outside specialty care, and obtain prescription medications.[13] Uninsured individuals are also more likely to be admitted to hospitals through the emergency department after their health conditions have worsened from delaying care.[14] Moreover, because of the statutory requirements governing covered services in QHPs, Medicaid, and CHIP, the Proposed Rule would particularly expand access to mental health services, children's health services, and sexual and reproductive health care services for DACA recipients.[15]

The Proposed Rule would also improve DACA recipients' financial well-being, while reducing overall health care costs and strain on the health care safety net. Improved access to affordable health coverage results in multiple financial benefits, including reduced medical

debt, credit score improvement, and fewer bankruptcy filings.[16] Expanding access to affordable health coverage options for DACA recipients should also reduce uncompensated care costs by reducing avoidable emergency department use and hospitalizations that result from delayed or forgone medical care.[17] Additionally, extending coverage to the healthy and young DACA population may have a beneficial effect on Exchange risk pools, possibly leading to reduced premiums and additional health care cost savings for all enrollees.

Under the Proposed Rule, DACA recipients, like all other enrollees, would need to meet all other eligibility requirements in order to qualify for enrollment and coverage under CMS insurance affordability programs. In the Medicaid and CHIP context, this means that only DACA recipients who are children or pregnant would be able to enroll in Medicaid and CHIP in States that have elected the CHIPRA 214 option to cover lawfully residing children and/or pregnant individuals. Therefore, of the 129,000 uninsured DACA recipients estimated to benefit from the Proposed Rule, CMS estimates that 13,000 would enroll in health care coverage in States that adopted the Medicaid or CHIP under the CHIPRA 214 option, while 112,000 would enroll in QHPs in Marketplaces and 4,000 in BHPs.[18]

In summary, NHeLP supports CMS' proposal to end the exclusion of DACA recipients from accessing CMS health insurance affordability programs. We strongly believe that the Proposed Rule would greatly benefit the health outcomes and financial well-being of DACA recipients, while reducing overall health care system costs and strain on the health care safety net. Additionally, the Proposed Rule better aligns HHS policy with the primary goals of the ACA and DACA—specifically, to expand access to affordable health coverage for the uninsured and to integrate childhood arrivals into the fabric of their communities. Therefore, correcting this unjustifiable exclusion of DACA recipients is long overdue.

Thank you for your consideration of our statement. We provide additional details in our comments to the Proposed Rule, submitted June 15, 2023. If you have any questions or need further information, please contact Michelle Yiu, Policy Fellow, at yiu@healthlaw.org or Mara Youdelman, Managing Attorney (DC Office), at youdelman@healthlaw.org.

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[1] Ctrs. for Medicare & Medicaid 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.

[2] 45 C.F.R. § 152.2(8).

[3] 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 Jul. 18, 2023).

[4] U.S. Dep't. Homeland Sec., *Deferred Action for Childhood Arrivals*, 87 FR 53152-53300, https://www.federalregister.gov/documents/2022/08/30/2022-18401/deferred-action-for-childhood-arrivals.

[5] 45 C.F.R. § 152.2(8); *see* 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; Ctrs. for Medicare & Medicaid Srvs., Dear State Health Official, *SHO #12-002: Individuals with Deferred Action for Childhood Arrivals* (Aug. 28, 2012), https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-002.pdf.

[6] 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/.

[7] *Id.*

[8] *Id*.

[9] 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/.

[10] 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; 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/.

[11] Nat'l Immigr. Law Ctr., *supra* note 6.

[12] *Id*.

[13] 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/; 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/; 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.

[14] Tolbert et al., *supra* note 13; 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.

[15] QHPs offered through the Marketplaces must cover mental health services as part of their essential health benefits package and provide a range of sexual and reproductive health care services without any cost-sharing. *See* 42 U.S.C. § 18022(b)(1)(E); 42 U.S.C. § 300 gg-13; 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/. Additionally, Medicaid and CHIP provide a range of behavioral health and preventive sexual and reproductive health care services, as well as a comprehensive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for children. Note that EPSDT is not required in separate CHIP programs. *See* 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/; 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); 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

[16] 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.

[17] Tolbert et al., *supra* note 13; Castenada & Saygili, *supra* note 14.

[18] Ctrs. for Medicare & Medicaid Srvs., *supra* note 1.