



THE STATE OF NEW JERSEY  
OFFICE OF THE ATTORNEY GENERAL

June 23, 2023

**Via Regulations.gov**

The Honorable Xavier Becerra  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

RE: **Notice of Proposed Rulemaking, 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, 88 Fed. Reg. 25,313 (April 26, 2023).**

Dear Secretary Becerra:

We write on behalf of the States of New Jersey, California, Connecticut, Delaware, Hawai'i, Illinois, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and the District of Columbia ("the States"), in support of the proposed rulemaking by the U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services (collectively, "Department") reducing barriers to healthcare access for individuals receiving deferred action pursuant to the Deferred Action for Childhood Arrivals ("DACA") policy. *See 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*, 88 Fed. Reg. 25,313 (Apr. 26, 2023) (to be codified at 42 C.F.R. Parts 435, 457, and 600, and 45 C.F.R. Parts 152 and 155) (the "Proposed Rule"). The Proposed Rule remedies a discrepancy in the current regulatory scheme, under which DACA recipients are the only type of deferred action recipients not eligible to enroll in and receive subsidies for health insurance plans on the exchanges established by the Affordable Care Act ("ACA"), or to enroll in Medicaid and the Children's Health Insurance Program ("CHIP") in states that have elected to cover non-citizens

who are lawfully present under Department rules, as well as Basic Health Programs in states that have created such programs under the ACA.<sup>1</sup>

DACA protects from removal and, due to longstanding regulations, extends work authorization to more than 580,000 active recipients—including 165,090 in California, 30,740 in Illinois, 23,780 in New York, 14,430 in New Jersey, 14,310 in Washington, 11,270 in Nevada, 8,430 in Oregon, 4,930 in New Mexico, 4,880 in Massachusetts, 4,690 in Michigan, 4,560 in Minnesota, 4,060 in Pennsylvania, 3,170 in Connecticut, 1,200 in Delaware, 800 in Rhode Island, 520 in the District of Columbia, 340 in Hawai'i, 60 in Maine, and 40 in Vermont—who grew up in this country; most of these individuals have known no home other than the United States.<sup>2</sup> DACA has allowed recipients to live, study, and work in the States (and throughout the country) as contributors and leaders in their communities. DACA recipients attend public and private universities and are employed by companies, nonprofit organizations, and governmental agencies and institutions, all of which benefit from their skills and productivity. DACA recipients provide critical financial support to their families, many of which include United States citizens and lawful permanent residents. DACA recipients also help to grow the economy, and contribute significantly to State and local revenues and tax bases. DACA enables recipients to open bank accounts, obtain credit cards, start businesses, purchase homes and cars, and participate in other aspects of daily life. And DACA has improved public health by allowing DACA recipients access to employer-sponsored health insurance. These positive effects have rippled throughout the States' economies.

However, under existing Department rules, DACA recipients are unable to obtain affordable health insurance through any means other than an employer-sponsored health plan. The federal government has a long history of deferred action, including 17 different deferred action policies that existed prior to DACA, and none of the recipients of those other programs were or are categorically denied access to government health insurance affordability programs. In contrast, the Department's current rules contain an exception that carves out DACA recipients alone from

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<sup>1</sup> Basic Health Programs cover citizens and lawfully present non-citizens whose incomes are too high to qualify for Medicaid, but are no more than 200% of the Federal Poverty Line. New York and Minnesota have created such programs. *See Basic Health Program*, Center for Medicaid & Medicare Services, <https://www.medicaid.gov/basic-health-program/index.html> (last visited June 20, 2023).

<sup>2</sup> *See Count of Active DACA Recipients By State or Territory As of December 31, 2022*, U.S. Citizenship and Immigr. Servs., [https://www.uscis.gov/sites/default/files/document/data/Active\\_DACA\\_Recipients\\_Dec\\_FY23\\_qtr1.pdf](https://www.uscis.gov/sites/default/files/document/data/Active_DACA_Recipients_Dec_FY23_qtr1.pdf).

eligibility, effectively locking recipients out of the government health insurance programs their tax dollars help fund. This means that unless a DACA recipient's employer provides health insurance benefits for employees, the recipient will likely be unable to secure insurance coverage for themselves or their children. This barrier to insurance coverage translates to high uninsured rates among the DACA population and results in economic and health precarity that is felt by recipients' families, communities, and the States.<sup>3</sup>

As state Attorneys General, we support the Department's Proposed Rule because it will provide health and economic benefits for DACA recipients residing in our territories and support the communities in which they live. A substantial portion, 34 percent, of DACA recipients are uninsured, and access to coverage through the Proposed Rule would provide substantial health and financial benefits to the recipients and their communities.<sup>4</sup> The Proposed Rule is substantively valid and advances public health and societal interests by giving DACA recipients the opportunity to procure health insurance for themselves and their dependents, regardless of whether their employer provides health insurance coverage. Because such a rule would be consistent with the public interest, and would help the States in their efforts to protect the health, safety, and well-being of their residents, we strongly support the Department's Proposed Rule.

#### I. The Proposed Rule is Substantively Valid

The Proposed Rule is a lawful exercise of the Department's authority under the ACA and better effectuates the statute's purposes than the current regulatory scheme. The ACA uses the phrase "lawfully present" as an eligibility criterion in numerous provisions.<sup>5</sup> In doing so, Congress conveyed a clear policy directive: individuals who are lawfully present, and only those lawfully present, would receive access to the ACA's benefits.<sup>6</sup> Although the ACA does not define "lawfully present," the phrase is also used in 8 U.S.C. § 1611(b)(2), which predates the ACA, as an eligibility

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<sup>3</sup> See Comment Letter of 24 State Attorneys General, in response to proposed rule, *Deferred Action for Childhood Arrivals*, 86 Fed. Reg. 53,736 (November 19, 2021), at 3-4, <https://www.nj.gov/oag/newsreleases21/DACA-NPRM-Multistate-Comment-2021-1119.pdf>.

<sup>4</sup> See 88 Fed. Reg. at 25,315-16.

<sup>5</sup> See 42 U.S.C. § 18032(f)(3) (eligibility to enroll in a health plan on the exchange); 26 U.S.C. § 36B(e) (eligibility for refundable premium tax credits); 42 U.S.C. § 18071(e) (eligibility for cost sharing); 42 U.S.C. 18081(c) (process by which lawful presence will be verified); 42 U.S.C. § 18082(d) (advanced payment of credits or cost sharing).

<sup>6</sup> See *id.*

criterion for Social Security. That section grants authority to the Attorney General (now the Secretary of Homeland Security) to define who is lawfully present.<sup>7</sup>

Since passage of the ACA in 2010, Centers for Medicare & Medicaid Services (“CMS”) has promulgated regulations to effectuate Congress’s purpose with respect to lawful presence. However, CMS has not been consistent in its treatment of recipients of deferred action, nor has the federal government been consistent in its definition of the phrase across agencies and programs. As explained in the Notice of Proposed Rulemaking, CMS first codified a definition of “lawfully present” in 2010. Under that definition, codified at 45 C.F.R. § 152.2, all recipients of deferred action were considered lawfully present. In reaching that conclusion, CMS drew on two sources: a guidance letter to state health officials (“2010 SHO”)<sup>8</sup> and a Department of Homeland Security (“DHS”) regulation defining the phrase for purposes of Social Security. Both of these sources defined “lawfully present” to include all recipients of deferred action.<sup>9</sup>

But in August 2012, CMS abruptly changed course after DACA was announced: CMS modified the definition of “lawfully present” in 45 C.F.R. § 152.2 to explicitly carve out DACA recipients from eligibility for qualified health plans, despite maintaining eligibility for other types of deferred action recipients.<sup>10</sup> The 2012 changes also excluded DACA recipients from the definition of “lawfully present” for purposes of Section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (“CHIPRA”), under which states may elect to expand Medicaid and CHIP to lawfully present pregnant individuals and/or children.<sup>11</sup> DHS did not change the definition of “lawfully present” as it is used in the Social Security regulation at 8 C.F.R. § 1.3. The result for the past decade has been that DACA recipients are incongruously considered “lawfully present” for purposes of Social Security benefits, but not for several federal health programs.<sup>12</sup>

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<sup>7</sup> See 8 U.S.C. § 1103(a)(1).

<sup>8</sup> Medicaid Coverage of “Lawfully Residing” Children and Pregnant Women, Center for Medicaid, CHIP and Survey Certification (July 1, 2010), at 3, 8, 10-11, <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/sho10006.pdf>.

<sup>9</sup> 8 C.F.R. § 1.3; 88 Fed. Reg. 25,315.

<sup>10</sup> 88 Fed. Reg. 25,315.

<sup>11</sup> *Id.* at 25,314-15; see also Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Individuals (May 4, 2023), <https://www.medicare.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-individuals>.

<sup>12</sup> See 88 Fed. Reg. 25,316-17.

The incongruity of this status quo is further demonstrated by how DHS treats DACA recipients for the purposes of immigration law. Although DACA (and deferred action generally) is not a form of “lawful status,” the agency does not consider those subject to a grant of deferred action to be *unlawfully* present in the U.S. as long as the deferred action is in effect.<sup>13</sup> Unlawful presence has serious ramifications: a person who accrues unlawful presence in the U.S. and leaves the country and tries to reenter may be barred and deemed inadmissible for 3 or 10 years, depending on the length of unlawful stay.<sup>14</sup> DACA recipients do not accrue that unlawful presence time, so long as their individualized grant of their DACA requests and renewals remains valid.<sup>15</sup> Furthermore, DACA recipients and other recipients of deferred action are, due to decades-old DHS regulations, eligible for work authorization.<sup>16</sup> Taken as a whole, for the past decade, current DACA recipients have been eligible to live and work in the U.S. and have been eligible to receive benefits like Social Security, but they *cannot* access crucial aspects of the healthcare system—at least not with public assistance. This is despite the fact that according to one estimate, as of 2021, DACA recipients and their households pay \$6.2 billion in annual federal taxes and about \$3.3 billion in annual State and local taxes—meaning that DACA recipients are paying into the very same benefits from which they are barred.<sup>17</sup>

The Proposed Rule appropriately corrects that longstanding error. It would revise the definition of “lawfully present” in 45 C.F.R. 152.2 and related provisions<sup>18</sup> and thereby harmonize the definition of a single statutory phrase across agencies and applications, following the lead of

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<sup>13</sup> See *What is Deferred Action for Childhood Arrivals?*, U.S. Citizenship and Immigr. Servs., <https://www.uscis.gov/humanitarian/consideration-of-deferred-action-for-childhood-arrivals-daca/frequently-asked-questions> (last updated May 30, 2023).

<sup>14</sup> Immigration and Nationality Act (INA), 8 U.S.C. § 1182(a)(9)(B)(i)(1). See also *Unlawful Presence and Inadmissibility*, U.S. Citizenship and Immigr. Servs., <https://www.uscis.gov/laws-and-policy/other-resources/unlawful-presence-and-inadmissibility><https://www.uscis.gov/laws-and-policy/other-resources/unlawful-presence-and-inadmissibility> (last updated June 24, 2022).

<sup>15</sup> See *What is Deferred Action for Childhood Arrivals?*, *supra* note 13.

<sup>16</sup> 8 C.F.R. §§ 274a.12, 274a.13.

<sup>17</sup> Nicole Prchal Svajlenka & Trinh Q. Truong, *The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition*, Center for American Progress (Nov. 24, 2021), <https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/>.

<sup>18</sup> The Proposed Rule would also make changes to 42 C.F.R. §§ 435.4, 457.320(c), 600.5 and 45 C.F.R. §§ 152.2, 155.20.

the federal agency best suited to make immigration determinations—DHS. The Proposed Rule also better effectuates the purpose of the ACA by ensuring that a class of individuals considered “lawfully present” for other federal programs and purposes receives access to the ACA’s benefits. And it corrects a fundamental error of CMS’s 2012 regulation, which treated DACA recipients as a *sui generis* class of deferred action recipients when, in fact, DACA is just one in a long line of deferred action programs in the nation’s history.<sup>19</sup>

## II. The Proposed Rule is Needed and Timely

The Proposed Rule is urgently necessary for two interrelated reasons: (1) the high rates of uninsured among DACA recipients; and (2) the aging DACA population’s increasing need for coverage.

As mentioned earlier, a 2021 survey indicated that 34% of DACA recipients do not possess health insurance.<sup>20</sup> This number is even greater when expanded to include individuals who likely would have been eligible for DACA; the Kaiser Family Foundation estimates that approximately 47% of such individuals are uninsured.<sup>21</sup> Moreover, recent events such as the COVID-19 pandemic have had a negative impact on health insurance coverage among DACA recipients; an estimated 18% of DACA recipients lost their employer-provided health insurance during the COVID-19 pandemic.<sup>22</sup>

The uncertainty DACA recipients face in relation to health insurance coverage has created additional obstacles to accessing critical healthcare—obstacles that extend to DACA recipients as well as their children and other family members who rely on them. In a 2021 survey of over 1,000

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<sup>19</sup> See Ben Harrington, *An Overview of Discretionary Reprieves from Removal: Deferred Action, DACA, TPS, and Others*, Congressional Research Service (April 10, 2018), <https://sgp.fas.org/crs/homesec/R45158.pdf>.

<sup>20</sup> See 88 Fed. Reg. 25,315-16.

<sup>21</sup> *Key Facts on Deferred Action for Childhood Arrivals*, Kaiser Family Foundation <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/> (April 26, 2023). DHS is currently bound by an injunction that permits it to continue to renew deferred action for current DACA recipients but precludes it from granting any new DACA requests. See *Texas v. United States*, No. 1:18-CV-00068, 2021 WL 3022434 (S.D. Tex. July 16, 2021).

<sup>22</sup> Nat’l Immigr. Law Center, *Tracking DACA Recipients’ Access to Health Care*, at 2 (June 1, 2022), [https://www.nilc.org/wp-content/uploads/2022/06/NILC\\_DACA-Report\\_060122.pdf](https://www.nilc.org/wp-content/uploads/2022/06/NILC_DACA-Report_060122.pdf).

DACA recipients, 61% of recipients surveyed identified their immigration status as a “significant barrier” to receiving health insurance and healthcare, while 50% reported that they were unaware of any affordable care or coverage available to them.<sup>23</sup> Additionally, 47% of respondents reported delaying medical care due to their immigration status, while 67% indicated that they or a family member were unable to pay medical bills or expenses.<sup>24</sup> In short, a significant number of DACA recipients either lack health insurance or face significant barriers to accessing health care. The Proposed Rule helps to ameliorate these issues by expanding access to the ACA exchanges, Medicaid, and CHIP. In California alone, by one estimate, approximately 40,000 uninsured DACA recipients would qualify for ACA subsidies under the Proposed Rule.<sup>25</sup>

Additionally, the DACA population is aging and having increasing numbers of children, further exacerbating these healthcare access and coverage issues. The average age of DACA recipients at the time of their arrival to the United States was 7 years old, with recipients having arrived on average in 1999.<sup>26</sup> The same demographic data gathered in 2021 indicated that the average age across 590,070 DACA recipients was 26 years old.<sup>27</sup> As the DACA population ages, it will face new and different health challenges requiring insurance coverage.

Critically, the percentage of DACA recipients with children has more than doubled over the last ten years; in 2012, an estimated 22% of DACA recipients had children, while an estimated 48% had children in 2021.<sup>28</sup> There is also great need among the DACA population for public health care options. In New York, roughly two-thirds of DACA recipients have an income below 100% of the Federal Poverty Line (FPL) and nearly a third have an income between 100-138% FPL.<sup>29</sup>

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<sup>23</sup> *Id.* at 2.

<sup>24</sup> *Id.*

<sup>25</sup> Miranda Dietz et. al, *Extending Covered California Subsidies to DACA Recipients Would Fill Coverage Gap for 40,000 Californians*, UC Berkeley Labor Center (June 6, 2023), <https://laborcenter.berkeley.edu/extending-covered-california-subsidies-to-daca-recipients-would-fill-coverage-gap-for-40000-californians/>.

<sup>26</sup> Nicole Prchal Svajlenka & Trinh Q. Truong, *The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition*, Ctr. for Am. Progress (Nov. 24, 2021), <https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/>.

<sup>27</sup> *Id.*

<sup>28</sup> *DACA 11 Years Later*, FWD.us (June 12, 2023), <https://www.fwd.us/news/daca-anniversary/>.

<sup>29</sup> Information provided by New York State Dep’t of Health (NYSDOH).

Allowing DACA recipients to purchase Marketplace plans and access Medicaid and CHIP for children and pregnant individuals will benefit families and expand health insurance coverage for children. For instance, one study found that children living in states with expanded health benefits for all individuals regardless of immigration status experienced lower uninsured rates, and fewer of them had forgone medical, dental, and preventative care.<sup>30</sup> And although U.S.-born children of DACA recipients are eligible to participate in Medicaid and CHIP, increased fear and uncertainty causes decreased enrollment for children in these programs relative to U.S.-citizen children with U.S.-born parents.<sup>31</sup>

In 2021, DACA recipients had more than 250,000 U.S.-born children, who depend on their parents for insurance coverage.<sup>32</sup> For DACA recipients who do not receive employer-based insurance and who do not meet the income eligibility criteria for Medicaid and CHIP coverage, the Proposed Rule will allow them to purchase affordable insurance coverage in the Marketplace to cover themselves and their dependent children.

### III. The Proposed Rule's Benefits Will Redound to DACA Recipients' States

The expansion of healthcare coverage in the Proposed Rule will benefit not just DACA recipients themselves, but also the communities in which they live. Access to health insurance improves public health.<sup>33</sup> A large body of research has documented the economic benefits of Medicaid expansion under the ACA, including a per-person reduction in medical debt of more than \$1,100, improved access to credit, greater labor mobility, and a drop in uncompensated

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<sup>30</sup> Julia Rosenberg et al, *Insurance and Health Care Outcomes in Regions Where Undocumented Children are Medicaid-Eligible*, 150(3) *Pediatrics* (Sept. 2022), available at <https://publications.aap.org/pediatrics/article-abstract/150/3/e2022057034/189211/Insurance-and-Health-Care-Outcomes-in-Regions>.

<sup>31</sup> Samantha Artiga & Anthony Damico, *Nearly 20 Million Children Live in Immigrant Families that Could Be Affected by Evolving Immigration Policies*, Kaiser Family Foundation (Apr. 18, 2018), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/nearly-20-million-children-live-in-immigrant-families-that-could-be-affected-by-evolving-immigration-policies>.

<sup>32</sup> See Svajlenka & Truong, *supra* note 26.

<sup>33</sup> See *The Importance of Health Coverage*, Am. Hospital Ass'n (Oct. 2019), [https://www.aha.org/system/files/media/file/2019/10/report-importance-of-health-coverage\\_1.pdf](https://www.aha.org/system/files/media/file/2019/10/report-importance-of-health-coverage_1.pdf).



medical care, which improved hospital budgets.<sup>34</sup> States that participated in Medicaid expansion also saw greater utilization of preventative care and improved health outcomes, including fewer premature deaths, with at least 19,000 lives saved from 2014 to 2017 alone, and greater utilization of care for mental illness and addiction, including for opioid use disorders.<sup>35</sup> In fact, Medicaid expansion is associated with lower opioid overdose rates compared to states that have not expanded.<sup>36</sup> Medicaid expansion is also an effective form of economic stimulus, with one study finding that every \$100,000 of additional federal Medicaid spending would result in 3.8 net job-years (i.e., one job that lasts one year).<sup>37</sup> Another study estimated that if the remaining non-expansion states expanded Medicaid, it would create more than 1 million jobs nationwide.<sup>38</sup> Medicaid expansion was also associated with greater food and housing security, increased child support payments, and even reductions in violent crime.<sup>39</sup> Children who became Medicaid-eligible (or whose mothers gained Medicaid while they were *in utero*) experienced fewer hospital visits and hospitalizations later in life, and higher graduation rates.<sup>40</sup>

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<sup>34</sup> Center on Budget and Policy Priorities, *The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion*, at 2, 13, 16-17, <https://www.cbpp.org/sites/default/files/atoms/files/10-2-18health.pdf> (updated Oct. 21, 2020); see also Kyle J. Caswell, Timothy A. Waidmann, *The Affordable Care Act Medicaid Expansions and Personal Finance*, 76(5) *Med Care Research and Review*. 538-571 (Sept. 16, 2017), <https://journals.sagepub.com/doi/10.1177/1077558717725164>.

<sup>35</sup> *The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion*, *supra* note 34 at 2, 10.

<sup>36</sup> Nicole Kravitz-Wirtz et al., *Association of Medicaid Expansion with Opioid Overdose Mortality in the United States*, *JAMA* (Jan. 10, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2758476>.

<sup>37</sup> Gabriel Chodorow-Reich et al., *Does State Fiscal Relief During Recessions Increase Employment? Evidence from the American Recovery and Reinvestment Act*, 4(3) *Am. Econ. J.: Econ. Pol'y* 121 (2012), <https://www.aeaweb.org/articles?id=10.1257/pol.4.3.118>.

<sup>38</sup> Leighton Ku and Erin Brantley, *The Economic and Employment Effects of Medicaid Expansion Under the American Rescue Plan*, *The Commonwealth Fund* (May 20, 2021), <https://www.commonwealthfund.org/publications/issue-briefs/2021/may/economic-employment-effects-medicaid-expansion-under-arp>.

<sup>39</sup> The White House, *The Effects of Earlier Medicaid Expansions, A Literature Review* (June 22, 2021), <https://www.whitehouse.gov/cea/written-materials/2021/06/22/the-effects-of-earlier-medicaid-expansions-a-literature-review/>.

<sup>40</sup> *Id.*

Similarly, research has found that creation of the ACA insurance marketplace has had health and financial benefits. The marketplace is particularly beneficial for small businesses and self-employed individuals, resulting in lower healthcare costs for the former and dramatically reduced uninsured rates for the latter.<sup>41</sup> Similar to Medicaid expansion, increased access to private insurance is associated with fewer bankruptcy filings and an average reduction in total debt of over one thousand dollars per person.<sup>42</sup>

Further, research indicates that increased eligibility for Medicaid is associated with uptake among the DACA population. One study found that after New York and California extended eligibility for their state Medicaid programs to DACA recipients, DACA-eligible immigrants were 4% more likely to report insurance coverage in those states than in other states that did not extend Medicaid coverage to low-income DACA recipients.<sup>43, 44</sup> In New York alone, more than 13,000 DACA recipients have enrolled in Medicaid, aided by specially trained enrollment assistors in numerous languages.<sup>45</sup> And in 2023, New Jersey expanded Medicaid and CHIP to children under

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<sup>41</sup> See *Marketplace Coverage and Economic Benefits: Key Issues and Evidence*, U.S. Dep't of Health and Human Servs., Assistant Sec'y for Planning and Evaluation, Office of Health Policy (July 20, 2022), <https://aspe.hhs.gov/sites/default/files/documents/36e5e989516728adcc63e398b3e3d23d/aspe-marketplace-coverage-economic-benefits.pdf>.

<sup>42</sup> *Id.* at 5. See also Bhashkar Mazumder & Sarah Miller, *The Effects of the Mass. Health Reform on Household Fin. Distress*, 8(3) Am. Econ. J.: Econ. Pol'y 285-286, 305 (Aug. 2016), <https://www.aeaweb.org/articles?id=10.1257/pol.20150045>; Caswell & Waidmann, *supra* note 34.

<sup>43</sup> California has extended its Medicaid program, Medi-Cal, to all adults who are income eligible regardless of immigration status, using state funds. See also *State Spotlight: California's Landmark Coverage Expansion for Immigrant Populations*, Manatt Health (Nov. 2022), <https://www.shvs.org/wp-content/uploads/2022/11/SHVS-State-Spotlight-Californias-Landmark-Coverage-Expansion-for-Immigrant-Populations.pdf>.

<sup>44</sup> Osea Giuntella & Jakub Lonsky, *The Effects of DACA on Health Insurance, Access to Care, and Health Outcomes*, IZA Institute of Labor Economics (April 2018), at 10, <https://repec.iza.org/dp11469.pdf>.

<sup>45</sup> Information provided by NYSDOH; see also *Fast Facts on Health Insurance for Immigrants*, NYSDOH (Sept. 2015), [https://info.nystateofhealth.ny.gov/sites/default/files/Immigrants%20Fact%20Sheet\\_3.pdf](https://info.nystateofhealth.ny.gov/sites/default/files/Immigrants%20Fact%20Sheet_3.pdf).

19 whose families meet income and eligibility requirements regardless of immigration status.<sup>46</sup> Within the first six months of this expansion, 17,896 children who did not previously qualify due to immigration status had enrolled.

DACA itself is also associated with improved healthcare utilization. After 2012, DACA-eligible individuals were 20% less likely to delay care because of financial constraints, and in California, DACA increased the likelihood of having a primary care doctor by 13%.<sup>47</sup> DACA recipients in California were also more likely to receive mental healthcare services, though there was no evidence of increased doctor or ER visits.<sup>48</sup> This data indicates that, should the Department finalize the Proposed Rule, DACA recipients will enroll in health insurance coverage and it will serve as an important safety net, safeguarding their financial and overall wellness.

This overwhelming body of evidence as to the health and economic benefits of the ACA and access to affordable health insurance strongly suggests that should the Proposed Rule be implemented, not only will DACA recipients themselves see improved health and financial outcomes, but states and communities with large DACA populations will see reductions in uncompensated care expenses and increased economic growth. And indeed, the proposed rule (to the extent it impacts eligibility for Medicaid and CHIP) only impacts States that affirmatively choose to extend Medicaid and CHIP to lawfully present pregnant individuals and/or children, a choice current law does not require them to make. For these reasons, the Signatory States strongly support the proposed rule.

## CONCLUSION

DACA recipients in the States are small-business owners, employees, students, healthcare workers, and, perhaps most importantly, valued community members, friends, and family. Their presence, and the presence of DACA-eligible individuals, has enriched the States in countless ways. The States urge the Department to finalize regulations expanding access to the insurance Marketplace, Medicaid, and CHIP to DACA recipients. The Department's Proposed Rule is not only a valid exercise of regulatory authority, it would also increase health and wellbeing among a vulnerable population and allow DACA recipients to better support themselves and their communities.

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<sup>46</sup> See *Governor Highlights Expanded Eligibility for NJ FamilyCare Health Care Coverage as Administration Continues Efforts to Cover All Kids*, N.J. Dep't of Human Servs. (Jan. 18, 2023), <https://www.nj.gov/humanservices/news/pressreleases/2023/approved/20230118.shtml>.

<sup>47</sup> *State Spotlight: California's Landmark Coverage Expansion for Immigrant Populations*, *supra* note 43 at 11.

<sup>48</sup> *Id.* at 11 and 30.

Sincerely,



Matthew J. Platkin  
New Jersey Attorney General



Brian L. Schwalb  
District of Columbia Attorney  
General



Rob Bonta  
California Attorney General



Anne E. Lopez  
Hawaii Attorney General



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Andrea Joy Campbell  
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Dana Nessel  
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Keith Ellison  
Minnesota Attorney General



Aaron D. Ford  
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Raúl Torrez  
New Mexico Attorney General



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Pennsylvania Attorney General



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The Honorable Xavier Becerra

June 23, 2023

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A handwritten signature in black ink that reads "Charity R. Clark". The signature is written in a cursive style with a large, looped "C" at the beginning.

Charity R. Clark

Vermont Attorney General

A handwritten signature in blue ink that reads "Bob Ferguson". The signature is written in a cursive style with a long, horizontal stroke at the end.

Bob Ferguson

Washington Attorney General