NATIONAL IMMIGRATION LAW CENTER

April 11, 2025

Dr Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Via regulations.gov

Re: CMS-9884-P, Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

Dear Administrator Oz,

The National Immigration Law Center (NILC) is deeply concerned about many provisions in the Centers for Medicare and Medicaid Services' (CMS) proposal to erect barriers to coverage under the Affordable Care Act (ACA). We strongly oppose the proposal to end ACA coverage for people granted deferred action under the Deferred Action for Childhood Arrivals (DACA) program. We also oppose the other provisions in this proposed regulation that would make it more difficult for all U.S. residents to enroll in health coverage.

Founded in 1979, NILC is dedicated to defending and advancing the rights and opportunities of low-income immigrants and their families. NILC is one of the nation's leading substantive experts on immigrant eligibility and access to federal and state public benefits programs. For over 40 years, NILC has focused on issues that affect the well-being and economic security of low-income immigrants: health care and safety net programs; education and training; workers' rights; and other federal and state policies affecting immigrants. When necessary, NILC has successfully defended low-income immigrants and their families in litigation to protect their fundamental and constitutional rights. We believe that all people should have the opportunity to achieve their full human potential – regardless of their race, gender, immigration, or economic status.

Definitions; Deferred Action for Childhood Arrivals (§ 155.20)

Background – Deferred Action for Childhood Arrivals (DACA)

DACA was established in 2012 as an exercise of prosecutorial discretion by the U.S. Department of Homeland Security (DHS). Then-Secretary of Homeland Security Janet Napolitano announced the creation of DACA on June 15, 2012. A memorandum describing the DACA program (DACA Memorandum) set out guidelines for U.S. Citizenship and Immigration Services ("USCIS") to exercise its prosecutorial discretion to grant deferred action to certain young immigrants "who were brought to this country as children."[1]

The DACA Memorandum recited the long-established policy that our nation's immigration laws "are not designed to be blindly enforced without consideration given to the individual circumstances of each case," and that the limited resources of DHS must be "focused on people who meet our enforcement priorities." The DACA Memorandum incorporated findings that the individuals eligible to apply for DACA "have already contributed to our country in significant ways" and "lacked the intent to violate the law."[2]

The 2024 Final Rule is Consistent with Established Definitions of Lawful Presence

In passing the Affordable Care Act, Congress chose to include "lawfully present" immigrants as eligible for Advance Premium Tax Credits (APTC) and other provisions intended to make health insurance more accessible and affordable for United States residents. For decades, the term "lawfully present" has been understood to encompass noncitizens with a grant of deferred action. In implementing the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), the U.S. Attorney General determined that persons granted deferred action are "lawfully present" for purposes of Title II Social Security benefits eligibility.[3] The Department of Homeland Security (DHS) confirmed that DACA recipients, like all others granted deferred action, are "lawfully present" in the United States for the purpose of Title II Social Security benefits, under 8 CFR § 1.3(a)(4)(vi).[4] DHS also confirmed that DACA recipients are not considered "unlawfully present" for the purpose of inadmissibility under section 212(a)(9) of the Immigration and Nationality Act.[5] The REAL ID Act of 2005 similarly lists persons with "approved deferred action" among those with a "lawful status" that may obtain a REAL ID driver's license or identification card.[6] None of these laws or rules distinguish between deferred action recipients based on the underlying reasons for the grant or on the number of individuals who may be granted the relief.

HHS appropriately recognized deferred action recipients as lawfully present in the United States when it published the Affordable Care Act's Preexisting Condition Insurance Pool regulations in 2010.[7] However, when the agency issued updated regulations for the Pre-Existing Condition Insurance Plan Program in 2012, it excluded DACA recipients. In doing so, CMS stated only that when DHS issued its original DACA memo, it did not do so in order to extend coverage to them under the ACA. Deferred action is a long-standing administrative mechanism dating back to at least the 1960s.[8] HHS correctly recognized recipients of deferred action as lawfully present in 2010. HHS erred when it excluded DACA recipients from 45 CFR §152.2's definition of lawfully present. At the time, CMS did not provide statutory authority or precedent for excluding a subset of persons granted deferred action in this manner. As CMS noted in issuing its 2024 rule, there is "no statutory mandate to distinguish between recipients of deferred action under the DACA policy and other deferred action recipients."[9] In fact, the 2024 rule best aligned with the traditional understanding of lawful presence, by treating all deferred action recipients similarly for purposes of obtaining health coverage and subsidies under the Affordable Care Act.

The proposed rule quotes from a statement of Congress in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in attempting to justify its exclusion of DACA recipients from ACA coverage. Yet the ACA was passed many years after PRWORA and Congress's decision not to use the narrower "qualified" immigrant definition in that law demonstrates a different intent. The clear reading of the text is that Congress intended to provide access to health coverage to a broader group of lawfully present individuals, which, as discussed above, was not a new term. In fact, As HHS explained in 2024, the inclusion of DACA recipients effectuates Congress' intent in enacting the ACA: to increase access to health coverage.[10] HHS understood that extending eligibility to DACA recipients is consistent with that goal, by increasing insurance coverage, reducing delays in care, improving the ACA's risk pool and promoting the health and productivity of DACA recipients.[11] By proposing to reverse this decision, CMS goes against the intent of the ACA.

The proposed rule repeats the faulty logic of the 2012 interim rule, which assigns unsupported intent to DHS. The proposed rule cites as controlling the fact that DHS did not specify providing access to insurance affordability programs as its reason for creating DACA. Yet it also emphasizes that, "HHS' statutory authority and policy considerations for defining 'lawfully present' with regard to its programs are separate from DHS's." Under this reasoning, DHS would not have addressed benefits eligibility in its DACA rule. It is therefore flawed to draw any meaning from its absence.

HHS' proposed rule also suggests that DACA recipients should be treated differently because they belong to a relatively large group. Nothing in the ACA, however, indicates that individuals granted deferred action or any other lawfully present category on a large scale should be considered differently. The fact that other categories of lawfully present noncitizens are also large doesn't render them any less lawfully present. For as long as these individuals are, like others granted deferred action, authorized by the federal government to be present in the US, there is no basis for the proposed disparate treatment. HHS should adopt the most reasonable interpretation of the statute and include all recipients of deferred action.

Repealing Access to ACA Coverage Would Have Negative Health Impacts

According to data collected in the most recent annual survey from NILC, the Center for American Progress, and United We Dream, 87% of insured respondents report that their access to health care depends on maintaining their current employment status.[12] Compared to the U.S. citizen rate of employment-sponsored insurance (60% in 2023),[13] DACA recipients are in a disproportionately more precarious position when it comes to maintaining health coverage during the "little disturbance" that President Trump said will occur in his Joint Address to Congress.[14] Two of every five uninsured respondents (41%) reported that they felt their immigration status was a major barrier to obtaining coverage.[15]

Data strongly suggests that expanding access to health care coverage is critical to positive individual and public health outcomes. Extensive research demonstrates that uninsured adults receive poorer quality of care, and experience worse health outcomes than those with insurance.[16]

Repealing the Existing Rule Would Cause Economic Harm to DACA Grantees and Broader Communities

Through taxes and insurance premiums, DACA recipients and other immigrants have been paying for a system that they are either chilled from or barred from accessing.[17] Forty-three percent of respondents to the latest NILC-CAP-UWD survey indicated that they skipped a medical test or treatment due to the cost, and 44% reported the same about dental care.[18]

The exclusion of DACA grantees from ACA Marketplace coverage led to roughly a decade of inequitable health outcomes for DACA recipients, including higher rates of medical debt, sustained fear of accessing care, and routine skipping of critical medical and dental tests and treatments.[19] Providing expanded eligibility to uninsured young adults would reduce the exposure to tragic health outcomes and unaffordable medical costs for those individuals and their families.[20] For DACA recipients, the option to gain access to health care through the ACA marketplace means more affordable coverage, and better health outcomes for all. Expanded coverage also benefits the larger community, while eliminating ACA eligibility for DACA will harm the larger community.

Researchers have also found that a higher community uninsurance rate leads to a higher probability of difficulty obtaining needed care for individuals with private insurance.[21] One study revealed that the amount privately insured patients pay for emergency department services increased with the percentage of uninsured community members. Making sure that everyone in the country has access to the care that they need is how we can make the United States healthier.[22]

The need to improve access to coverage and care became particularly clear during the height of the COVID pandemic. While representing a significant number of health care and other essential workers, DACA recipients were disproportionately uninsured. DACA recipients, whose average age is just over 30, have lived in the US for at least 18 years –some potentially for as long as 43 years. HHS' proposed rule recognizes that, because DACA recipients are young, they tend to be healthier, and that excluding them from coverage in the ACA's Exchanges would have a negative impact on the individual market risk pool.[23] The agency anticipates that, contrary to the ACA's goals, the majority who lose Exchange or BHP coverage would become uninsured, resulting in costs to both the federal government and the states, as well as to hospitals in potentially uncompensated care, when some individuals forego treatment until the condition becomes a more costly emergency.

Repealing DACA recipients' Eligibility Would Have a Negative Impact on the Economy

Expanding access to health insurance has proven to be economically advantageous. A meta-data study of 34 independent research samples revealed a "strongly positive correlation" between positive economic outcomes and health insurance.[24] In 2022, the New York City Comptroller estimated that expanding health care coverage to New Yorkers who would otherwise be excluded due to their immigration status would result in nearly $710 million in economic benefits, including increased labor production and the prevention of premature deaths.[25]

Studies comparing states that have or have not expanded their Medicaid coverage indicate that hospitals in expansion states have better financial performance and are less likely to close.[26] Access to affordable coverage allows individuals and families to spend their disposable income on essential goods and services. On top of the increase in tax revenues, this additional spending produces a "multiplier effect," as higher business revenues are passed on to suppliers and employees. One estimate puts the multiplier effect of Medicaid expansion at between 1.5 and 2 times the amount of new federal Medicaid spending.[27] Repealing DACA recipients' eligibility similarly would deprive communities of the economic advantages of having insured, and more productive people.

Communities suffer economic burdens when people are uninsured. Data shows that uninsured individuals who become hospitalized experience a host of financial setbacks in the subsequent four years, including reduced access to credit and a significantly higher likelihood of filing for bankruptcy.[28] Access to affordable health coverage improves consumer well-being through reduced debt, improved credit scores and decreased bankruptcy filings.[29]

Clarifications and Technical changes to the Lawfully Present Definition

We support HHS' decision to retain the 2024 rule's technical and clarifying changes to the lawfully present definition. As HHS explains, the other changes to the lawfully present definition in the 2024 final rule were primarily technical or clarifying. They corrected unintentional errors in the prior definition, simplified its implementation, or added very small populations to the lawfully present group. For example, the rule clarified that the definition includes youth with *approved* Special Immigrant Juvenile (SIJ) petitions, rather than only those with *pending* petitions for SIJ classification. It removes a waiting period for children under 14 years old who have fled persecution. And it includes a small group with employment-based visa petitions who are transitioning to lawful permanent residence. These clarifications will help vulnerable individuals and facilitate implementation of the program.

Other Provisions that Undermine Access to Health Care

We also oppose the many provisions in the proposed rule that would make health care more expensive, more restrictive, and more difficult to enroll in for immigrants and citizens living in the United States. CMS acknowledges that many people will lose health coverage due to these changes. This includes proposing:

- Banning states from including gender affirming care from their essential health benefits, imposing meritless discrimination on people with gender dysphoria and restricting state flexibility intended by the ACA.
- Shortening open enrollment periods, which will make it harder for hard-to-reach populations to learn about and make time to enroll in health coverage. Combined with CMS's decision to cut Navigator funding by 90%, this proposal would especially hurt those with lower health literacy or complex eligibility scenarios who may need more time to enroll.
- Eliminating the special enrollment period for people earning less than 150% percent of the Federal Poverty Level, the negative impacts of which are again exacerbated by cutting Navigator funding. CMS justifies this action by blaming bad actor brokers and agents yet chooses to punish low-income Americans instead of cracking down on those who prey on them.
- Cutting the window for applicants to resolve inconsistencies, which will have a disproportionate impact on immigrants who need time to gather the resources necessary to verify their identity and status. This harm will be exacerbated by the proposal to require additional verification for income mismatches, given that many immigrants work in the informal economy or in multiple jobs.
- Ending automatic reenrollment and other policies that simplify enrollment, creating barriers for individuals who may lack familiarity with the U.S. health care system.

Conclusion

This proposed rule undermines the Affordable Care Act by stripping DACA recipients of their health coverage and making it more difficult for all United States residents to apply for and receive health insurance. It uses flimsy reasoning to justify these decisions while admitting that many thousands of people will go uninsured due to these policies. CMS should withdraw it and focus instead on strategies for improving the country's health.

[1] Mem. from Janet Napolitano, Sec'y of Homeland Security, to Alejandro Mayorkas, Dir., U.S. Citizenship and Immigration Servs., Exercising Prosecutorial Discretion With Respect to Individuals Who Came to the United States as Children, June 15, 2012, https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf The DACA Memorandum states that individuals who came to the United States as children, lack a serious criminal history, attend school or participate in the Armed Services, and meet other criteria

may request that the Secretary grant deferred action, a discretionary form of relief from removal, for a period of two years, subject to renewal. Those granted deferred action in this manner could also obtain employment authorization and a Social Security card.

[2] *Ibid*.

[3] 61 Fed. Reg. 47039 (Sept. 6, 1996).

[4] 87 Fed. Reg. 53152, 53208 (Aug. 30, 2022).

[5] 8 CFR § 236.21(c)(4), added by 87 Fed. Reg. 53152, 53298 (Aug. 30, 2022).

[6] P.L. No. 109-13 (May 11, 2005) § 202(c)(2)(B)(viii), codified at 49 USC § 30301 note.

[7] Interim Final Rule, Pre-Existing Condition Insurance Plan Program, 75 FR 45014, http://www.federalregister.gov/documents/2010/07/30/2010-18691/pre-existing-condition-insurance-plan-program

[8] Mem. from Janet Napolitano

[9] 89 Fed. Reg. 39392, 39395 (May 8, 2024).

[10] 89 Fed. Reg. at 39395.

[11] 89 Fed. Reg. at 39396.

[12] "DACA Recipients' Access to Health Care: 2025 Report," National Immigration Law Center. 2025.

[13] Gary Claxton, Matthew Rae, and Aubrey Winger. "Employer-Sponsored Health Insurance 101," Kaiser Family Foundation. May 28, 2024.

[14] Donald J. Trump, Remarks in Joint Address to Congress, The White House (March 4, 2025).

[15] *Ibid*, n. xii.

[16] *See, e.g.,* Steffie Woolhandler and David U. Himmelstein, "The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?," Annals of Internal Medicine (Sept. 19, 2017), *available at* https://www.acpjournals.org/doi/10.7326/m17-1403; J Michael McWilliams, "Health consequences of uninsurance among adults in the United States: recent evidence and implications," Milbank Q. (June 2009)87(2):443-94 *available at* https://pubmed.ncbi.nlm.nih.gov/19523125/.

[17] See, eg., Zallman L, Woolhandler S, Himmelstein D, Bor D, McCormick D. Immigrants contributed an estimated $115.2 billion more to the Medicare Trust Fund than they took out in 2002-09. Health Aff (Millwood). 2013;32(6):1153-1160. doi:10.1377/hlthaff.2012.1223, Zallman L, Wilson FA, Stimpson JP, et al. Undocumented immigrants prolong the life of Medicare's trust fund. J Gen Intern Med. 2016;31(1):122-127. doi:10.1007/s11606-015-3418-z.

[18] *Ibid.*, n. xii.

[19] *See, e.g., Ibid,* n. xii, Isobel Mohyeddin, "DACA Recipients' Access to Health Care: 2024 Report" (May 29, 2024), Ben D'Avanzo and Isobel Mohyeddin, "DACA Recipients' Access to Health Care: 2023 Report" (May 26, 2023).

[20] Gerald F Kominski, Narissa J Nonzee, and Andrea Sorensen, "The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations," Annu Rev Public Health. (Mar 2017) 38:489-505., *available at:* https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-031816-044555

[21] Carole Roan Gresenz , José J Escarce, "Spillover effects of community uninsurance on working-age adults and seniors: an instrumental variables analysis," Med Care (Sep. 2011) 49(9):e14-21., *available at* https://pubmed.ncbi.nlm.nih.gov/21865890/.

[22] Kirby JB, Cohen JW, "Do People with Health Insurance Coverage Who Live in Areas with High Uninsurance Rates Pay More for Emergency Department Visits?" Health Serv Res. (Apr. 2018) 53(2):768-786., *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5867177/.

[23] 90 Fed. Reg. 12942, 13010 (March 19, 2025).

[24] Fan C, Li C, Song X. The relationship between health insurance and economic performance: an empirical study based on meta-analysis. Front Public Health. 2024 Apr 3;12:1365877. doi: 10.3389/fpubh.2024.1365877. PMID: 38633240; PMCID: PMC11021690.

[25] Economic Benefits of Coverage for All, New York City Comptroller (March 15, 2022).

[26] Richard C. Lindrooth, Marcelo C. Perraillon, Rose Y. Hardy, and Gregory J. Tung, Understanding the Relationship Between Medicaid Expansions And Hospital Closures, Health Affairs Vol. 37, No. 1, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0976.

[27] Michael Chernew, "The Economics of Medicaid Expansion," Health Affairs Blog, March 21, 2016, http://healthaffairs.org/blog/2016/03/21/the-economics-of-medicaid-expansion/.

[28] Luojia Hu, Robert Kaestner, Bhashkar Mazumder, Sarah Miller, and Ashley Wong, The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing (Federal Reserve Bank of Chicago, September 2016), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2857533.

[29] Marketplace Coverage and Economic Benefits: Key Issues and Evidence, (ASPE Office of Health Policy, July 2022), https://aspe.hhs.gov/sites/default/files/documents/36e5e989516728adcc63e398b3e3d23d/aspe-marketplace-coverage-economic-benefits.pdf.