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June 23, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: 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, RIN 0938-AV23, CMS-9894-P, Document Number 2023-08635

Dear Administrator Brooks-LaSure:

On behalf of the Robert Wood Johnson Foundation (hereinafter "RWJF" or "the Foundation"), I am pleased to submit comments in response to the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS)' Notice of Proposed Rulemaking published in the Federal Register on April 26, 2023, regarding eligibility for federal health insurance coverage for recipients of Deferred Action for Childhood Arrivals (DACA) and other lawfully present immigrants. RWJF is the nation's largest philanthropy committed to improving health and health equity for all in the United States. In partnership with others, we are working to develop a Culture of Health rooted in equity. At RWJF, we believe that everyone in the United States should have the opportunity to live the healthiest life possible, no matter their immigration status. Overall community health is improved when everyone – including all immigrants regardless of immigration status – has access to preventive and regular healthcare and the ability to access services necessary to living a healthier life, such as access to the public health programs addressed in this Proposed Rule.

Health is more than an absence of disease. It is a state of physical, mental, and emotional wellbeing. It reflects what takes place in our communities, where we live and work, where our children learn and play, and where we gather to worship. That is why RWJF focuses on identifying, illuminating, and addressing the barriers to health caused by structural racism and other forms of discrimination, including sexism, ableism, xenophobia, and prejudice based on sexual orientation. Furthermore, RWJF recognizes that racial justice cannot be achieved without immigrant justice.

We rely on evidence to advance health equity. We cultivate leaders who work individually and collectively across sectors to address health equity. We promote policies, practices, and systems change to dismantle the structural barriers to wellbeing created by racism. We work to amplify voices to shift national conversations and attitudes about health and health equity.

Our comments are grounded in the perspectives and expertise of our grantees, who include organizations seeking to advance immigrants' access to healthcare programs and other social safety net programs. These include the Center on Budget and Policy Priorities, National Health Law Program, National Immigration Law Center, Protecting Immigrant Families Campaign, State Health and Value Strategies, and United We Dream as well as academic researchers who have significant experience identifying how immigrants' lack of access to healthcare and public programs creates health disparities. For instance, RWJF has supported substantial work documenting the ways in which immigration status is a social determinant of health and how states and federal government can expand health care coverage for immigrants as well as highlighted the ways that current immigrant eligibility restrictions harm health equity.

Therefore, RWJF offers its strong support for the CMS proposal to provide access to Exchanges, Basic Health Programs, and some state Medicaid and Children's Health Insurance Programs (CHIPs) to immigrants who are lawfully present in the United States and encourages CMS to continue to identify ways to ensure that health coverage is available to all people regardless of immigration status.
As outlined here, our comments present research that: underscores the importance of access to health coverage for DACA recipients and other lawfully present immigrant populations addressed in the Proposed Rule; identifies areas where CMS could strengthen the Proposed Rule; and identifies additional actions CMS could take to expand access to health coverage for immigrant populations.

I. DACA recipients' current exclusion from Marketplace and Medicaid creates significant barriers to accessing healthcare and widens health disparities.
II. Research demonstrates that DACA recipients are significantly contributing to their families and communities.
III. Other lawfully present immigrants addressed in the Proposed Rule need timely access to healthcare.
IV. Additional issues

I. DACA recipients' current exclusion from Marketplace and Medicaid creates significant barriers to accessing healthcare and widens health disparities.

The Proposed Rule supports RWJF's vision that all individuals should have the opportunity to live the healthiest life possible, no matter their immigration status. A neglected reality in the United States is the racist historical legacy of U.S. immigration policy, which has been imported into our healthcare system by limiting immigrants' eligibility for healthcare coverage. The Proposed Rule is essential to removing some of those structural barriers, will help to shift the narrative toward everyone deserving access to public programs, and will rectify some of these harmful practices.

There are currently about 580,000 DACA recipients living in the United States. DACA recipients – although lawfully present in the United States – are ineligible to enroll in Medicaid, CHIP, Basic Health Plans (BHP), or Marketplace insurance. According to a 2022 survey conducted by the National Immigration Law Center (NILC), United We Dream, and the Center for American Progress, DACA recipients are nearly three times as likely to be uninsured than the general population in the United States. High uninsurance is not due to lack of employment; survey respondents had an 83.1 percent employment rate. Of DACA recipients with health insurance, the survey found that 80 percent of respondents received coverage through an employer or union. In contrast, according to the Kaiser Family Foundation, roughly 57 percent of non-elderly individuals (ages 0-64) have employer-sponsored insurance.

This illustrates that, for DACA recipients, there have been limited pathways to affordable health coverage – namely, through employer-sponsored insurance. However, that pathway to affordable health insurance is constrained because DACA recipients are disproportionately employed in low-wage jobs and industries

that are less likely to offer employer-sponsored insurance. Even for those DACA recipients with employer-sponsored insurance, coverage is precarious; losing their job likely means losing access to an affordable coverage option.

DACA recipients face additional ongoing barriers to accessing healthcare coverage and services. They mentioned their immigration status, the lack of available affordable care or coverage options, and their concern that using healthcare services could negatively affect their own or their family's immigration status as significant barriers to accessing coverage. 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.

For uninsured DACA recipients, concerns over the cost of healthcare services aligns with those of the general uninsured population, but DACA recipients additionally harbor fears that seeking care may harm their immigration status. Because DACA recipients face such compounded barriers to accessing health coverage and care, the Proposed Rule will greatly benefit this population.

A Kaiser Family Foundation analysis of the Current Population Survey Annual Social and Economic Supplement (CPS-ASEC) data found that nearly half of DACA recipients are uninsured, compared to 10% of U.S.-born persons in the same age groups. DACA recipients "without access to affordable coverage through an employer or who cannot afford coverage on the individual market are left with limited options" due to their inability to enroll in Medicaid, CHIP, and Marketplace coverage. Nearly twenty percent of respondents in a 2021 survey of DACA recipients reported that they had lost employer-sponsored health coverage during the peak of the COVID-19 pandemic. Unlike many of their peers, DACA recipients were unable to turn to the Affordable Care Act marketplaces and public sources of coverage during this time. More than two-thirds of respondents stated that they or a family member had difficulty paying medical bills, and almost half reported that they had delayed seeking medical care.

Access to health coverage improves health outcomes. People with health coverage are more likely to have a regular source of care and to receive preventive care, timely diagnosis of disease, and assistance with management of chronic conditions. Studies repeatedly demonstrate that uninsured individuals are less likely than insured individuals to access preventive care for major health conditions and chronic diseases. Health coverage improves consumer wellbeing through reduced debt, improved credit scores, and decreased bankruptcy filings.

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. Moreover, community health centers and other safety net providers have limited resources and capacity, and not all uninsured individuals have the necessary geographic access. 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. And when hospitalized, uninsured individuals receive fewer treatments and procedures and experience higher mortality rates compared to the insured. Providing DACA recipients with access to affordable health coverage options could reduce uncompensated care costs in the overall health care system and lessen the strain on safety net providers.

Further, access to preventive healthcare services and coverage is critical for the health of children. While only 6,700 DACA recipients are under age 21, these individuals are most likely still in school and uninsured, as they cannot access employer-sponsored coverage. Consequently, this demographic will particularly benefit from the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in

Medicaid and some CHIP programs. 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. Additionally, 300,000 U.S.-born children have at least one parent who is a DACA recipient. Studies repeatedly have shown that children are more likely to be insured when their parents have health insurance, meaning parents' access to healthcare services often affects their children's access. Accordingly, expanding health coverage options for DACA recipient parents will likely open the doors to coverage for their children.

II. Research demonstrates that DACA recipients are significantly contributing to their families and communities.

Significant evidence documents the contributions DACA recipients make to their families, communities, and society as a whole. The Center for American Progress found that DACA boosts recipients' well-being and their economic security. According to the American Immigration Council, households containing DACA recipients have $24 billion in after-tax spending power that they can spend in the community.

Many DACA recipients served on the frontlines during the COVID public health emergency. At the height of the pandemic, 343,000 DACA recipients were employed in jobs deemed "essential" by the U.S. Department of Homeland Security (DHS). This included: 34,000 healthcare workers providing patient care; 11,000 individuals working in healthcare settings to keep facilities functioning; 20,000 educators; and 100,000 individuals working in the food supply chain. Yet in part due to their contributions on the frontlines of the pandemic, DACA recipients experienced exacerbated health inequities due to their ineligibility for some relief programs and overrepresentation among essential workers.

III. Other lawfully present immigrants addressed in the Proposed Rule need timely access to healthcare.

RWJF supports CMS' clarification that individuals with a pending application for adjustment of status are not required to have an approved immigrant visa petition 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. 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" will correct this exclusion, simplify eligibility verification processes, reduce administrative burden, and align with DHS procedures.

RWJF also supports the Proposed Rule's clarification that individuals with approved Special Immigrant Juvenile (SIJ) petitions are included in the proposed definitions of "lawfully present." 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 a "**pending** application for [SIJ] status" (emphasis added), unintentionally excluding individuals with **approved** SIJ petitions. 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 can now take years due to high demand and processing backlogs. This oversight has created confusion and unnecessary disruptions in the continuity of health coverage for this population. Accordingly, this clarification will help ensure that these young people have access to healthcare coverage and services, including mental health supports.

As evidence supporting these changes, a study of Central American children seeking asylum in the United States by Physicians for Human Rights researchers found that 76% of children studied were suspected or diagnosed to have at least one major mental health diagnosis, most commonly post-

traumatic stress disorder (PTSD), (64%), major depressive disorder (40%), and anxiety disorder (19%). In addition to the physical and cognitive effects of witnessing and being subjected to violence in their home countries and while traveling to the United States, children seeking asylum are commonly behind in receiving routine medical care, including vaccinations. These care delays increase their vulnerability to communicable and other diseases, a risk that is magnified by crowded and unsanitary conditions near the U.S. border. Volunteer physicians working at the border have reported both fever and respiratory conditions as being common among asylum seekers. Ensuring timely access to care for these populations will help remedy health disparities.

IV. Additional Issues

RWJF supports CMS' proposal to use the term "noncitizen" instead of the pejorative and outdated term "alien." The term "alien" instigates increased stigma, dehumanization, and othering of individuals not born in the United States. Additionally, research has shown that using the negative term "alien" is associated with increased prejudice and greater support for punitive immigration policies when compared to the more neutral term "noncitizen." The term "alien" is particularly inappropriate in a health and public benefits context where the wellbeing of all is encouraged. Adopting this change will also align with President Biden's Executive Order 14012 on *Restoring Faith in Our Legal Immigration Systems and Strengthening Integration and Inclusion Efforts for New Americans* as well as updated U.S. Department of Justice practices.

While we fully support the Proposed Rule, we recommend CMS work to expand access to other immigrant populations who continue to be left out of affordable healthcare coverage options. As noted earlier, RWJF's vision is that all individuals should have the opportunity to live the healthiest life possible, no matter their immigration status. Yet many immigrants will continue to be excluded from public programs despite the Proposed Rule. A May 2023 issue brief by Urban Institute and funded by RWJF, "The Health Coverage of Noncitizens in the United States, 2024," estimates that 8.6 million adults under 65 who are not citizens will be uninsured in 2024. Nonelderly nonimmigrants would make up nearly one-third of the nation's projected 27 million uninsured. The Proposed Rule would improve access to healthcare coverage for just a portion of the overall uninsured population of immigrant and noncitizen individuals.

CMS also must recognize that the prior administration's public charge rule continues to have a chilling effect on immigrants eligible for public programs who have concerns about enrolling. As noted by RWJF grantee State Health & Value Strategies, fears remain despite the Biden Administration's changes to the prior public charge rule. Thus CMS must "reshape the narrative" on public charge to reach those eligible. Once this Proposed Rule is finalized, RWJF recommends CMS engage in direct outreach and education to the impacted individuals and communities to ensure those who are eligible will enroll in the relevant public programs. RWJF further encourages CMS to include messaging directly addressing the lingering fears about public charge.

We thank you for the opportunity to comment on the Proposed Rule. We have included numerous citations to supporting research, including direct links to the research. We direct CMS 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 comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS 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.

We look forward to continuing to work with the Department and other partners to ensure that everyone has access to affordable, quality health insurance coverage and care services.

Sincerely,

Richard E. Besser, M.D.
President & CEO
Robert Wood Johnson Foundation