

A Pathway to Health Care Citizenship for DACA Beneficiaries

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Since 2012, beneficiaries of Deferred Action for Childhood Arrivals (DACA) have enjoyed a certain normalization, however tenuous, of their status in the United States: they can legally work, their removal proceedings are deferred, and they cease to accrue unlawful presence. Regarding subsidized health coverage, however, DACA beneficiaries remain on the outside looking in. Although other deferred action beneficiaries are eligible for benefits through Medicaid, the Children's Health Insurance Program, and the Affordable Care Act, the Obama Administration specifically excluded DACA beneficiaries. This decision undermines DACA's goal of legitimizing beneficiaries' presence in the United States. From a health policy perspective, it weakens efforts to improve health care equity, health care system efficiency, and public health. Changed circumstances in immigration and health policy justify a change in the policy excluding DACA beneficiaries from subsidized health coverage. It is no longer necessary to subordinate health-related interests to the decade-old, constrained choices of immigration policymakers. As a necessary stopgap on the way to immigration reform and health reform, the Biden Administration should eliminate the DACA carve-out and extend the benefits of subsidized health coverage to all deferred action beneficiaries. The DACA carve-out is a useful case study illustrating how value-laden notions of deservingness in the laws governing eligibility for subsidized health care create systemic costs in the health care system and can harm public health.

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INTRODUCTION

For advocates of inclusive immigration and health policy, the current moment is uniquely promising. After years of stagnation and retrenchment, the executive and legislative branches are considering proposals for reform. The Biden Administration is committed to welcoming immigrants and to building on the Affordable Care Act (ACA) to expand access to affordable health care.¹ Among the potential immigration reforms, there are high hopes for a legalization program for the so-called Dreamers—those noncitizens within the purview of the Deferred Action for Childhood Arrivals (DACA) policy who were brought to the United States as children. On the health policy side, the devastation of the COVID-19 pandemic has renewed efforts to eliminate complex and arbitrary eligibility criteria for subsidized health coverage,² including some alienage restrictions.³ However, any contemplated large-scale immigration or health reform will take time and require compromise. Executive actions offer a pathway for the Administration to accomplish critical reforms in the interim. A pressing concern at the intersection of immigration and health law is the exclusion of DACA beneficiaries from eligibility for subsidized health coverage: the DACA carve-out.

The DACA carve-out is a regulation promulgated by the Department of Health and Human Services (HHS) during the Obama Administration, shortly after DACA became immigration policy in 2012. The rationale for DACA was to bring younger noncitizens out of the shadows and allow them to live a life of

1. See The White House, The Biden-Harris Administration Immediate Priorities, [whitehouse.gov](https://www.whitehouse.gov/priorities/), <https://www.whitehouse.gov/priorities/>.

2. See, e.g., John Nichols, *The Essential Pandemic Relief Bill Is Medicare for All*, THE NATION (Mar. 18, 2021), <https://www.thenation.com/article/politics/medicare-for-all-covid-congress/>.

3. See Biden-Sanders Unity Task Force Recommendations 36, <https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf> (recommending elimination of the five-year bar on eligibility for Medicaid and the Children’s Health Insurance Program for lawful permanent residents).

normalcy in the only country they have ever truly known. Policymakers shape the boundaries of belonging for DACA beneficiaries in numerous ways, including determining their access to subsidized health coverage. In the legal framework governing eligibility for public benefits, noncitizens who are granted deferred action on an ad hoc basis are considered “lawfully present,” and are thus eligible for benefits under the ACA, and can qualify for Medicaid and Children’s Health Insurance Program (CHIP) coverage through a state option.⁴ Rather than allow that provision to control DACA beneficiaries, however, the Obama Administration amended the regulation defining “lawfully present” to specifically *exclude* DACA beneficiaries.⁵

The DACA carve-out undermines the immigration policy goal of legitimizing beneficiaries’ presence in the United States, and weakens health policy efforts to improve health care equity, health care system efficiency, and public health. From the immigration perspective, singling out DACA beneficiaries for exclusion from subsidized health coverage is alienating, discouraging feelings of membership that the policy was intended to create. From a health policy perspective, the DACA carve-out has systemic costs: It contributes to the preexisting problem of stratified access to health care by immigration status and race, and it prevents some DACA beneficiaries from using health care efficiently. Additionally, any policy that discourages people from accessing health care is contrary to the public health goals of diagnosing and preventing transmission of infectious diseases.

Preserving the DACA carve-out while legislative reforms are debated means preserving these problems, which are especially salient given present circumstances—a still-raging pandemic, coupled with economic misery for millions, and the need for additional legislative relief packages. Moreover, the prior administration’s efforts to undo both the ACA and DACA have created an unprecedented level of uncertainty in immigrant communities about their health care access rights. The politically expedient decision to exclude DACA beneficiaries from eligibility for subsidized health coverage in 2012 is no longer justified; DACA lives on, and there is no reason to believe the Biden Administration will disrupt that status quo. There is no reasonable basis to distinguish DACA beneficiaries from other beneficiaries of deferred action who remain eligible for subsidized health coverage. Therefore, the Biden Administration should act to delete the DACA carve-out as soon as practicable.

This analysis of the DACA carve-out has potentially far-reaching implications for scholars and advocates of inclusive, yet pragmatic, reforms in

4. 42 U.S.C. §§ 1396b(v)(4)(A), 1397gg(e)(1)(N) (2018) (giving states the option to cover lawfully residing children and/or pregnant women through Medicaid or CHIP). *See also* Letter from Cindy Mann, Director, Ctrs. for Medicare & Medicaid Servs., to State Health Officials (July 1, 2010) (construing “lawfully residing” as functionally equivalent to “lawfully present”).

5. Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52,614, 52,616 (Aug. 30, 2012) (promulgating 45 C.F.R. § 152.2(8) (2012)).

immigration or health law. For immigration law, the DACA carve-out is a useful case study illustrating that access to health care is an important element of social citizenship. For health law, it is an example of how value-laden notions of “deservingness” in the laws governing eligibility for subsidized health care create systemic costs in the health care system and can harm public health. More broadly, the case for deleting the DACA carve-out also supports more streamlined and universal access to health care for all people living in the United States.

I.

THE DACA CARVE-OUT IN THE AFFORDABLE CARE ACT

A. *DACA’s Origins*

The Obama Administration’s immigration policy was defined by its implementation of deferred action programs, as well as its renewed focus on prosecutorial discretion in making initial enforcement decisions. This Essay is concerned only with the Administration’s first initiative, the 2012 DACA policy.⁶ In the memorandum announcing DACA, the Department of Homeland Security (DHS) Secretary at the time, Janet Napolitano, established certain guidelines for the exercise of enforcement discretion and the conferral of limited benefits regarding “certain young people who were brought to [the United States] as children and know only this country as home.”⁷ If a noncitizen could meet the eligibility criteria established by the memorandum, they would be entitled to a renewable two-year period of prosecutorial discretion, whereby they would not be placed into removal proceedings, and have the opportunity to seek employment authorization.⁸ The eligibility criteria, as established by the 2012 memo, included that the noncitizen:

- came to the United States under the age of sixteen;
- has continuously resided in the United States for a[t] least five years preceding the date of this memorandum and is present in the United States on the date of this memorandum;
- is currently in school, has graduated from high school, has obtained a general education development certificate, or is an honorably discharged veteran of the Coast Guard or Armed Forces of the United States;
- has not been convicted of a felony offense, a significant

6. See generally Memorandum from Janet Napolitano, Sec’y of Homeland Sec., U.S. Dep’t of Homeland Security, *Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children* (June 15, 2012) (hereinafter “DACA Memo”), available at <http://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf>.

7. *Id.* at 1.

8. *Id.* at 2-3.

misdemeanor offense, multiple misdemeanor offenses, or otherwise poses a threat to national security or public safety; and

- is not above the age of thirty.⁹

The Obama Administration defended the legality of DACA as a legitimate exercise of its enforcement discretion, while framing its policy justification as a rational and humanitarian response to the large number of unlawfully present noncitizens who are productive members of U.S. society. For instance, in the DACA memo, Secretary Napolitano opined:

Our Nation's immigration laws must be enforced in a strong and sensible manner. They are not designed to be blindly enforced without consideration given to the individual circumstances of each case. Nor are they designed to remove productive young people to countries where they may not have lived or even speak the language. Indeed, many of these young people have already contributed to our country in significant ways.¹⁰

Napolitano's successor at DHS, Jeh Johnson, echoed these views two years later, writing that "[t]he reality is that most individuals in [the administration's deferred action programs] are hard-working people who have become integrated members of American society."¹¹

DACA was also justified as a response to the lack of congressional movement on immigration reform. In his remarks on the afternoon of the DACA memo's release, President Obama rationalized the policy as a response to the DREAM Act's failure: "In the absence of any immigration action from Congress to fix our broken immigration system, what we've tried to do is focus our immigration enforcement resources in the right places."¹² But a necessary corollary of this sentiment was the desire to, effectively, document the undocumented and implicitly legitimize their status in the United States. In a subsequent memo, for instance, Secretary Johnson asserted that "[c]ase-by-case exercises of deferred action [under the administration's initiatives] are in this Nation's security and economic interests and make common sense, because they encourage these people to come out of the shadows, submit to background checks, pay fees, apply for work authorization, and be counted."¹³ This point was

9. *Id.* at 1.

10. *Id.* at 2.

11. Memorandum from Jeh Johnson, Sec'y of Homeland Sec., U.S. Dep't of Homeland Security, *Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children and with Respect to Certain Individuals Who Are the Parents of U.S. Citizens or Permanent Residents*, at 3 (Nov. 20, 2014) (hereinafter "DAPA Memo"), available at https://www.dhs.gov/sites/default/files/publications/14_1120_memo_deferred_action_2.pdf (last accessed August 2, 2016).

12. Barack Obama, President of the United States, Remarks by the President on Immigration (June 15, 2012), available at <http://www.whitehouse.gov/the-press-office/2012/06/15/remarks-president-immigration> (last accessed August 2, 2016).

13. DAPA Memo, *supra* note 10, at 3.

echoed in President Obama's televised remarks on November 22, 2014, in which he emphasized that the deferred action programs would "bring more undocumented immigrants out of the shadows so they can play by the rules, pay their full share of taxes, pass a criminal background check, and get right with the law."¹⁴

DACA *has* effectively brought a portion of the undocumented population out of the shadows by regularizing their status during the period when enforcement action is deferred, and the population covered by DACA is not insignificant. However, this explicit permission to reside in the United States, along with access to employment authorization and certain other limited benefits, did not include permission to access federal public benefits programs. In fact, as the next section demonstrates, the Obama Administration actively worked against such an outcome, limiting with one hand what it had given with the other.

B. Restrictions on Noncitizens' Eligibility for Subsidized Health Coverage

Federal law limits noncitizen access to subsidized health coverage both by excluding large classes of the noncitizen population (including, as a near-categorical matter, those not lawfully present in the United States), and by otherwise imposing an onerous waiting period between when a noncitizen obtains qualifying status and when they may be eligible for a benefit.¹⁵ The current structure of the law dates to 1996's Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA),¹⁶ which aimed to restrict "the ability of aliens to access federal public welfare benefits," including nearly all subsidized health coverage programs.¹⁷ PRWORA accomplished this by limiting eligibility for public benefits to "qualified aliens," defined to include lawful permanent residents, individuals granted asylum or admitted as refugees, and certain other limited classes of noncitizens admitted to or lawfully permitted entry into the United States.¹⁸

The intent to limit the eligibility of noncitizens for federal public benefits was largely carried over into the ACA. For example, eligibility to participate in the insurance exchanges established by the ACA is contingent on being a citizen or national of the United States, or a noncitizen who is lawfully present in the

14. Barack Obama, President of the United States, Weekly Address: Immigration Accountability Executive Action (Nov. 22, 2014), *available at* <https://www.whitehouse.gov/the-press-office/2014/11/22/weekly-address-immigration-accountability-executive-action> (last accessed August 2, 2016).

15. See Medha D. Makhlof, *Health Justice for Immigrants*, 4 U. PA. J.L. & PUB. AFF. 235, 247-64 (2019); Patrick Glen, *Health Care and the Illegal Immigrant*, 23 HEALTH MATRIX 197, 215 (2013); Nathan Cortez, *Embracing the New Geography of Health Care: A Novel Way to Cover Those Left Out of Health Reform*, 84 S. CAL. L. REV. 859, 866-67 & n.38 (2011).

16. Pub. L. No. 104-193, 110 Stat. 2105 (1996).

17. See *Bruns v. Mayhew*, 750 F.3d 61, 63 (1st Cir. 2014) (citing 8 U.S.C. §§ 1611, 1612, 1621, 1622).

18. See 8 U.S.C. §§ 1641(b), (c).

United States.¹⁹ Moreover, the ACA made no change to the alienage restrictions on eligibility for Medicaid and CHIP.

The category of lawfully present noncitizens is broader than the category of noncitizens who are eligible for other federal public benefits under PRWORA. For purposes of the ACA, “lawfully present” was initially defined in regulations promulgated by HHS in 2010,²⁰ and encompasses an expansive range of noncitizens, including qualified aliens; noncitizens with valid nonimmigrant visas; recipients of Temporary Protected Status and Deferred Enforced Departure; certain noncitizens who have been granted employment authorization; noncitizens with pending applications for adjustment of status, asylum, and Special Immigrant Juvenile Status; and, notably, “[a]liens currently in deferred action status.”²¹

C. Distinguishing DACA from Other Types of Deferred Action

Following the Obama Administration’s announcement of DACA, however, the definition of “lawfully present” was promptly amended to exclude DACA beneficiaries.²² In August 2012, HHS issued an Interim Final Rule, necessitated, according to the Department, by the need to forestall confusion about the eligibility status of DACA beneficiaries, given that the language of the 2010 regulation extended to *all* deferred action beneficiaries without limitation.²³ The 2012 regulation added a new subsection to the definition of “lawfully present”:

Exception: An individual with deferred action under the Department of Homeland Security’s Deferred Action for Childhood Arrivals process, as described in the Secretary of Homeland Security’s June 15, 2012, memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (7) of this definition.²⁴

HHS justified its exclusion of DACA beneficiaries from the definition of “lawfully present” on two interrelated grounds. First, HHS reasoned that because eligibility for subsidized health coverage was not a rationale that DHS itself had embraced in instituting DACA, there was no compelling basis on which to extend the definition of “lawfully present” to include all DACA beneficiaries. As explained in the *Federal Register* notice, “[b]ecause the reasons that DHS

19. See 42 U.S.C. § 18032(f)(3).

20. See Pre-Existing Condition Insurance Plan Program, 75 Fed. Reg. 45,014 (July 30, 2010).

21. 45 C.F.R. § 152.2 (2010).

22. HHS invoked an exception to the typical notice and comment procedures for proposed rulemaking to amend the regulation quickly. See Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52,614, 52,616 (Aug. 30, 2012) (promulgating 45 C.F.R. § 152.2(8) (2012)). The agency claimed good cause for expediting the rulemaking process based on the need to “provide clarity with respect to eligibility . . . before anyone with deferred action under the DACA process applies.” *Id.* at 52,616. At that time, the ACA program of concern was the Pre-Existing Condition Insurance Plan. See *id.*

23. See *id.*; see also *supra* note 21.

24. *Id.* at 52,616.

offered for adopting the DACA process do not pertain to eligibility for Medicaid or [CHIP], HHS has determined that these benefits should not be extended as a result of DHS deferring action under DACA.”²⁵ Second, HHS believed that including DACA beneficiaries among the noncitizens who are eligible for subsidized health coverage would conflict with DHS’s intent to grant limited and specific benefits, such as temporary employment authorization, to this group. In other words, HHS claimed that leaving the definition of lawfully present as is, which would have included DACA beneficiaries, would *expand* the benefits of DACA beyond those contemplated by DHS, the agency chiefly responsible for the policy.²⁶

II.

NONCITIZENS IN THE SHADOWS OF THE HEALTH CARE SYSTEM

The 2012 definition of “lawfully present,” with its carve-out for DACA beneficiaries, continues to govern eligibility for subsidized health coverage, participation in the ACA-created insurance exchanges, and other requirements and benefits under the ACA nearly a decade after the initiation of DACA. This Part explains how the DACA carve-out undermines the immigration policy goal of legitimizing beneficiaries’ presence in the United States and weakens health policy efforts to improve health care equity, health care system efficiency, and public health. Leaving DACA beneficiaries in the shadows of the health care system conflicts with DACA’s goal of treating them as “Americans in waiting.”²⁷ It also makes little sense from either an economic or a public health perspective.

A. *Undermining DACA’s Aim of Normalizing Presence*

The DACA carve-out undermines DACA’s goal of bringing certain undocumented immigrants “out of the shadows” by excluding beneficiaries from an important signifier of social membership: access to health care.²⁸ Social membership theory argues that noncitizens have moral claims to certain legal rights based on the number of years they have lived in the United States and their embeddedness within U.S. society.²⁹ Such moral claims may include certain health care access rights, which help to facilitate noncitizens’ full social and civic

25. *Id.* at 52,615.

26. *See id.* (“HHS is amending its definition of ‘lawfully present’ in the PCIP program, so that the PCIP program interim final rule does not inadvertently expand the scope of the DACA process.”).

27. HIROSHI MOTOMURA, *AMERICANS IN WAITING: THE LOST STORY OF IMMIGRATION AND CITIZENSHIP IN THE UNITED STATES* (2007).

28. *See, e.g.,* Rachel Fabi & Holly A. Taylor, *Publicly Funded Health Care for Pregnant Undocumented Immigrants: Achieving Moral Progress Through Overlapping Consensus*, 31 *KENNEDY INST. ETHICS J.* 77, 84 (2021) (summarizing the argument for providing subsidized health coverage to noncitizens based on social membership theory).

29. *Id.*

participation in American life.³⁰ This theory provides a values-based justification for extending health care access rights to DACA beneficiaries alongside other benefits like employment authorization and temporary protection from removal.

During the rulemaking process, HHS failed to consider how the DACA carve-out would undermine the policy's goal of legitimizing beneficiaries' presence. HHS opined that because the rationale for implementing DACA had nothing to do with the provision of health care, there were no compelling reasons for including DACA beneficiaries among those eligible for subsidized health coverage.³¹ Yet the rationale for DACA *was* to bring those unlawfully present out of the shadows and provide a semblance of regularity to their continued presence in the United States. Health care, like the employment authorization that was extended, is part and parcel with a lawful presence under deferred action generally. The fact that providing access to health coverage was not a prime impetus behind DACA thus has little bearing on whether such benefits *should* be extended once DACA has been granted.

HHS's reasoning that inclusion of DACA beneficiaries among the lawfully present noncitizens who are eligible for subsidized health coverage would constitute an impermissible expansion of the DACA policy³² is faulty because HHS is the agency charged with determining the eligibility criteria for subsidized health coverage programs. The mere fact that public benefits eligibility was not contemplated in DHS's implementing memorandum for DACA—while other benefits, like employment authorization, were—does not justify the DACA carve-out. It made sense for DHS to extend employment authorization as an explicit benefit in the memo because that is a benefit that DHS *alone* was entitled to extend.³³ But it lies with HHS, not DHS, to define the scope of benefits under statutes that *it* is charged with administering, including the ACA. HHS was surely entitled to maintain the inclusion of DACA beneficiaries in the definition of “lawfully present.” Noncitizen eligibility for health coverage may be considered a “shared regulatory space” in which Congress has assigned HHS and DHS “different primary missions but requires them to cooperate on certain

30. See generally Cristina M. Rodriguez, *Guest Workers and Integration: Toward a Theory of What Immigrants and Americans Owe One Another*, 2007 UNIV. CHI. LEGAL FORUM 219, 246-47, n. 71 (2007) (explaining how laws limiting noncitizen eligibility for public benefits are obstacles to integration because they “arguably impede[] economic advancement by removing temporary safety nets, as well as longer term forms of insurance, such as health care coverage for adults and children alike”).

31. See 77 Fed. Reg. at 52615.

32. 77 Fed. Reg. at 52615 (stating that it would “inadvertently expand the scope of the DACA process”).

33. See 8 C.F.R. § 274a.12(c)(14) (granting discretionary authority to United States Citizenship and Immigration Services to consider requests for employment authorization from “[a]ny alien who has been granted deferred action”).

tasks.”³⁴ On some issues, these agencies may have conflicting goals.³⁵ However, their goals are aligned with respect to the normalization of DACA beneficiaries’ presence. The ancillary benefit of eligibility for subsidized coverage cannot, in any real sense, be considered an expansion of DACA’s scope and is justified by the need to maximize gains from DACA for both agencies.³⁶

Nor is it likely that eligibility for subsidized health coverage would inadvertently or otherwise inflate the number of DACA applicants. DACA has set temporal cut-off dates, meaning that it applies only to individuals who are currently present and have been for some time; recent arrivals cannot use this program as a “back door” to qualify for subsidized health coverage. More fundamentally, however, the desire to enroll in public benefits is not a driving force behind migration patterns into the United States.³⁷

Moreover, if the key question under the regulation is whether presence should be deemed “lawful” for the limited purpose of subsidized health coverage, it makes no sense to distinguish between different classes of deferred action beneficiaries. The beneficiaries under DACA are presumably as “lawfully present” as the beneficiaries granted such status on an ad-hoc basis, so there is no legal or other reasonable basis for limiting eligibility for subsidized health coverage to the latter group while categorically excluding the former. The moral claims of DACA beneficiaries to public benefits are arguably stronger than the claims of other deferred action beneficiaries because it is expected, through a forthcoming immigration reform, that they will one day gain full political membership in the community. This is in addition to the social membership they already possess, which was acknowledged when the policy was established.³⁸

Contrary to HHS’s justifications for the DACA carve-out, it is neither required nor advisable under immigration law or policy; in fact, it compromises DACA’s goal of incorporating beneficiaries into American society.

B. Jeopardizing Health Policy Aims

The DACA carve-out weakens health policy efforts to improve health care equity, health care system efficiency, and public health. First, laws and policies that limit noncitizens’ eligibility for subsidized health coverage contribute to the

34. Jody Freeman & Jim Rossi, *Agency Coordination in Shared Regulatory Space*, 125 HARV. L. REV. 1131, 1145 (2012) (describing this type of Congressional delegation to two or more agencies as “interacting jurisdictional assignments”).

35. See, e.g., Medha D. Makhoul, *Health Care Sanctuaries*, 20 YALE J. HEALTH POL’Y, L. & ETHICS (forthcoming 2021) (analyzing conflicts between immigration and health policy goals arising from immigration surveillance in health care).

36. Freeman & Rossi, *supra* note 32, at 1149.

37. See, e.g., Marc L. Berk, et al., *Health Care Use Among Undocumented Latino Immigrants*, 19 HEALTH AFF. 44, 49, 53 (2000) (noting that less than 1% of illegal immigrants cited obtaining public benefits or other social services as a key rationale for the decision to immigrate).

38. DACA Memo, *supra* note 5, at 2. See also DAPA Memo, *supra* note 10, at 3.

phenomenon of health care stratification by immigration status and race.³⁹ They are a primary reason why, even after the ACA, there are substantial disparities in access to health coverage based on citizenship and immigration status, with undocumented noncitizens having the lowest rates of coverage.⁴⁰ The DACA carve-out intensifies, rather than ameliorates, the marginalization of DACA beneficiaries by rendering them health care pariahs even among the disfavored category of noncitizens with temporary protection from removal. Policies that entrench existing disparities in access to health care or create new categories of exclusion undermine health care equity, a central goal of the ACA and U.S. health reform efforts generally.⁴¹

Second, the DACA carve-out exacerbates two sources of inefficiency in the health care system that contribute to the high cost of health care in the United States. People without access to affordable health coverage tend to delay and avoid seeking health care until their illness or injury is advanced or urgent. The DACA carve-out steers beneficiaries away from relatively inexpensive preventative care and treatment and toward higher-cost emergency services.⁴² The carve-out also excludes a generally younger and healthier segment of the population from the risk pools that make up the ACA insurance market, thereby forgoing an opportunity to mitigate systemic costs.⁴³ These economic rationales were noted during the public comment period when the DACA carve-out was proposed,⁴⁴ in a 2012 letter from more than eighty members of Congress asking President Obama to eliminate the DACA carve-out,⁴⁵ and, more recently, in a letter from members of Congress to President Biden and Acting HHS Secretary

39. Tiffany D. Joseph, *Still Left Out: Healthcare Stratification Under the Affordable Care Act*, 43 J. ETHNIC & MIGRATION STUD. 2089 (2017); see also Dahai Yue et al., *Racial/Ethnic Differential Effects of Medicaid Expansion on Health Care Access*, 53 HEALTH SERV. RES. 3640, 3650 (2018) (finding that Hispanics, among all racial/ethnic groups, had the fewest gains in health insurance coverage under the ACA's Medicaid expansion and noting that immigration status may have influenced this result).

40. See, e.g., Thalia Porteny et al., *Immigrants and the Affordable Care Act: Changes in Coverage and Access to Care by Documentation Status*, forthcoming, J. IMM. & MINORITY HEALTH (Nov. 25, 2020) (manuscript at 7) (describing how, after the ACA, the disparity in Medicaid coverage decreased between citizens and lawful permanent residents in California but that "significant disparities" persist between undocumented immigrants and the rest of the population); Sergio Gonzales & Benjamin D. Sommers, *Intra-Ethnic Coverage Disparities among Latinos and the Effects of Health Reform*, 53 HEALTH SERV. RES. 1373, 1382-83 (2018) (finding that variations in access to health coverage among Latinos coincided with the proportion of citizens in each group).

41. See Medha D. Makhlouf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, 95 N.Y.U. L. REV. 1680, 1730-33 (2020) (describing the emergence of equity as a central aim of U.S. health policy).

42. See Glen, *supra* note 14, at 218-229 (arguing for the extension of publicly funded health benefits to all noncitizens based on economic and public health considerations and the lack of any compelling countervailing argument for continued exclusion).

43. *Id.*

44. Fatma Marouf, *Alienage Classifications and the Denial of Health Care to Dreamers*, 93 WASH. U.L. REV. 1271, 1282 (2016).

45. See Office of Rep. Barbara Lee, Letter to Obama: Reinstate Healthcare to DREAMers (Dec. 18, 2012), <https://lee.house.gov/news/press-releases/letter-to-obama-reinstate-healthcare-to-dreamers>.

Cochran, urging the same.⁴⁶ Providing DACA beneficiaries with access to subsidized health coverage may also be economically beneficial in a larger sense because access to health care promotes better health, which helps people to be more productive members of the workforce.⁴⁷

Third, the DACA carve-out weakens efforts to combat public health threats like COVID-19 because it makes health care less accessible for hundreds of thousands of beneficiaries. In theory, DACA beneficiaries can obtain health insurance through their employers or purchase insurance on the private market. Practically speaking, however, many DACA beneficiaries do not have access to employer-sponsored insurance⁴⁸—especially during a period of record unemployment—and are not able to afford unsubsidized health insurance.⁴⁹ Delayed testing or treatment for COVID-19 contributes to the uncontrolled spread of the virus.⁵⁰ Moreover, many DACA beneficiaries have worked continuously in essential jobs throughout the pandemic.⁵¹ Protecting their health is a public health imperative and also, arguably, morally required because of their service.⁵²

III.

DELETING THE DACA CARVE-OUT

Deleting the DACA carve-out would be a wise course of action for the Biden Administration, and it is a relatively easy fix. To put DACA beneficiaries on the path to “health care citizenship,” the HHS secretary should repeal the 2012 amendment to the definition of “lawfully present” that excluded DACA beneficiaries from this category of noncitizens. This could be done through an Interim Final Rule (IFR) rather than more expansive notice-and-comment

46. Letter from Joaquin Castro, Member of Congress, to Hon. Joseph R. Biden, President of the United States, and Hon. Norris Cochran, Acting Secretary, Department of Health and Human Services 2 (Jan. 26, 2021) (Castro Letter), <https://castro.house.gov/imo/media/doc/1.26.20%20Castro-Markey%20Letter%20for%20Sanctuary%20Relief%20FINAL.pdf>.

47. See PATRICIA ILLINGWORTH & WENDY E. PARMET, *THE HEALTH OF NEWCOMERS: IMMIGRATION, HEALTH POLICY, AND THE CASE FOR GLOBAL SOLIDARITY* 130 (2017).

48. See Marouf, *supra* note 41, at 1285.

49. Although DACA beneficiaries may be able to access affordable health care from federally qualified health centers or other safety-net providers, these providers are overwhelmed and are not able to meet the needs of all prospective patients. See Marouf, *supra* note 41, at 1286.

50. See Medha D. Makhoul & Jasmine Sandhu, *Immigrants and Interdependence: How the COVID-19 Pandemic Exposes the Folly of the New Public Charge Rule*, 115 NW. U. L. REV. ONLINE 146, 159 (2020) (describing how public charge, an immigration policy that discourages noncitizens from accessing health care, will weaken the fight against COVID-19); Castro Letter, *supra* note 43, at 1 (stating that the DACA carve-out “puts the health of DACA recipients, their families, and the wider community at risk”). See generally ILLINGWORTH & PARMET, *supra* note 44, at 127 (describing how the health of individuals in a community affects the health of all members).

51. See Castro Letter, *supra* note 43, at 1 (stating that “202,500 DACA recipients [have been] employed as essential workers on the frontlines to keep our country healthy and running”).

52. See Fabi & Taylor, *supra* note 26, at 94 (describing a philosophical argument for extending subsidized health coverage to undocumented noncitizens based on reciprocity for their participation in the economy).

rulemaking.⁵³ The DACA carve-out was itself promulgated as an amendment to a prior IFR with immediate effect,⁵⁴ which HHS justified by reference to the public interest: It was deemed important that HHS provide sufficient clarity to DACA applicants quickly, so as to forestall any confusion about eligibility to enroll in the covered programs under the ACA.⁵⁵ Implementing repeal through an IFR could similarly be justified as imperative, given the ongoing pandemic and widespread reports of noncitizens delaying or declining health care due to fear of immigration-related consequences.⁵⁶ For the same reasons, the repeal should be effective immediately upon issuance of the IFR. Any delay in the effective date of the new rule would exacerbate the health-related and social marginalization problems associated with the DACA carve-out.

The IFR provides a perfect mechanism for quick repeal, but the Administration would still have to justify its regulatory change with “reasoned analysis.”⁵⁷ This Essay provides the blueprint. First, the Administration should note that the initial justifications for excluding DACA beneficiaries were not compelling. HHS should argue that it is entitled to determine the eligibility criteria for subsidized health coverage, and that interpreting “lawfully present” to include DACA beneficiaries does not expand the scope of DACA or otherwise infringe on the authority of DHS. Moreover, HHS should point to the legally indistinguishable class of deferred action beneficiaries that is *already* included in the definition of “lawfully present” that denotes eligibility for Medicaid, CHIP, and ACA benefits. With the exclusionary subsection eliminated, all beneficiaries of deferred action would have access to subsidized health coverage on equal terms. Second, the Administration should address developments subsequent to the Obama Administration’s adoption of the DACA carve-out, as well as general considerations relating to public health and health equity. Although DACA was adopted in 2012 as a temporary stop on the hoped-for pathway to permanent status, it continues to exist nine years later, and the pathway has only begun to be constructed. Whatever justification there may have been for excluding DACA beneficiaries in 2012 has been undermined by that continued existence and the need to provide some access to subsidized health coverage to that class. This is especially true given current circumstances: The COVID-19 pandemic has highlighted problems of access and equity in the U.S.

53. See 5 U.S.C. § 553(b)(3)(B) (allowing an exception to notice and comment rulemaking “when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.”).

54. See 77 Fed. Reg. at 52,616.

55. See *id.* (“Because the PCIP program—a temporary program with limited funding—is currently enrolling eligible individuals and providing benefits for such enrollees, it is important that we provide clarity with respect to eligibility for this new and unforeseen group of individuals as soon as possible, before anyone with deferred action under the DACA process applies to enroll in the PCIP program.”).

56. See Makhlof, *supra* note 35.

57. See *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 42 (1983).

health care system, including issues that disproportionately affect noncitizens. Eliminating the DACA carve-out provides a simple and straightforward way to begin addressing a source of these inequities.

Along with this regulatory fix, which would address eligibility for ACA subsidies, the Centers for Medicare and Medicaid Services (CMS) should also send updated guidance to the states regarding DACA beneficiaries' eligibility for benefits under those programs. In the wake of the 2012 IFR, CMS sent a guidance letter to the states expressing the view that DACA beneficiaries should not be eligible for Medicaid or CHIP benefits under any state option, and supported that view by reference to the same justifications HHS used in its rulemaking.⁵⁸ With the proposed amended regulation in place, CMS should reverse its 2012 guidance and provide that DACA beneficiaries may be eligible for state options under the same terms as any other deferred action beneficiary.

CONCLUSION

DACA beneficiaries, as well as other noncitizens, are right to hope for changes in immigration and health policy from the Biden Administration—but that hope should not morph into myopia. The best-case scenario certainly does entail a path to citizenship for Dreamers and others, but the legislative process will take time. Meanwhile, as the pandemic continues, health care will continue to be a priority for all Americans. In the interstices of hope and realization lies reality, and it is to that reality that this Essay is addressed. Even if it is only, effectively, a temporary measure, the Biden Administration should reverse the DACA carve-out and ensure that all deferred action beneficiaries may enjoy the benefits of subsidized health coverage. The DACA carve-out lacked a compelling rationale when it was issued in 2012, and it makes even less sense now after beneficiaries have had nearly a decade to further entwine themselves in American society.

58. See Letter from Cindy Mann, Director, to State Health Official, Medicaid Director, Re: Individuals with Deferred Action for Childhood Arrivals (Aug. 28, 2012), *available at* [Medicaid.gov/Federal-Policy-Guidance/downloads.SHO-12-002.pdf](https://www.medicaid.gov/Federal-Policy-Guidance/downloads.SHO-12-002.pdf) (last accessed May 11, 2021).