

June 23, 2023

Submitted via www.regulations.gov

Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services

Attention: CMS–9894–P

Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS 9894-P: *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*

The 85 undersigned organizations dedicated to the health and well-being of children are writing in response to the Department of Health and Human Services (HHS) notice of proposed rulemaking (NPRM) published in the federal register on April 26, 2023. We are writing to share our support of the proposed rule and to make additional recommendations to strengthen the rule for children.

We strongly support the rule’s efforts to make Deferred Action for Childhood Arrivals (DACA) recipients eligible for federal healthcare programs, and believe the rule represents a long overdue correction to the arbitrary eligibility carve out implemented following the introduction of the DACA program in 2012. By specifically excluding DACA recipients from those classified as “lawfully present” and “lawfully residing” under HHS’ definitions for deferred action in the PCIP program, Medicaid, CHIP, the Basic Health Program (BHP) and the marketplace, hundreds of thousands of youth and young adults have been largely left without access to affordable healthcare. This exclusion not only harms recipients themselves, but also their U.S. citizen children, whose overall health and insurance coverage are closely linked to that of their parents.¹

We also support the proposed rule’s provisions to make youths with approved petitions for Special Immigrant Juvenile (SIJ) status eligible for federal health programs, as well as removing the waiting period for kids applying for asylum and other humanitarian programs. Access to health care, including mental health care, is particularly important for children and youth who have experienced trauma.

The undersigned organizations share child-focused missions and collective expertise in child development, child health, education, and child poverty. We are grateful for the opportunity to share the reasons why we believe the proposed rule is critical to improving the health and well-being of

¹ Jessica Schubel, “Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children,” Center on Budget and Policy Priorities (June 14, 2021), <https://www.cbpp.org/research/health/expanding-medicaid-for-parents-improves-coverage-and-health-for-both-parents-and-children>.

impacted child and youth populations and to provide recommendations for further strengthening the rule to maximize its potential for positive health outcomes.

I. The proposed rule will improve the health and well-being of DACA recipients.

Since its creation in 2012, the DACA program has promoted child well-being by protecting more than 800,000 immigrants who entered the U.S. as children and have grown up in the United States.² DACA removed the threat of deportation and family separation, allowed immigrant youth to pursue educational and career opportunities, and opened doors for recipients to provide for their families. Since the program's inception, DACA recipients have continued to further their education, contribute to the workforce, volunteer in their communities, and support civic engagement, all without any certainty of what their future might hold due to the precarious status of the DACA program. Most people with DACA are young adults, with over 60 percent between the ages of 21 and 30.³ A 2022 DACA survey revealed that more than a quarter are currently in school while nearly half hold a bachelor's degree or higher.⁴ Data shows that approximately 343,000 people with DACA in the workforce were employed as essential workers, representing more than three-quarters of working DACA recipients.⁵ Of those, a total of 20,000 were educators and 100,000 worked to maintain our food supply chain.⁶ Additionally, approximately 45,000 DACA recipients worked in health care settings, including during the height of the pandemic, despite lacking equitable access to protect their own health.⁷

Immigrants and their families have faced numerous barriers to public services and programs, with serious consequences.⁸ The arbitrary exclusion of DACA recipients from health care programs represents yet another layer of complexity to the various immigrant eligibility restrictions, and the resulting harm to DACA recipients has been significant. Estimates show that since the inception of the program, up to 47 percent of DACA-eligible individuals have been uninsured at some point, more than five times the rate of

² Nicole Prchal Svajlenka and Trinh Q. Truong, "The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition," Center for American Progress (November 24, 2021), <https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/>.

³ "Key Facts on Deferred Action for Childhood Arrivals," KFF (April 13, 2023), <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/>.

⁴ Tom K. Wong, Ignacia Rodriguez Kmec, and Diana Pliego, "DACA Boosts Recipients' Well-Being and Economic Contributions: 2022 Survey Results," Center for American Progress (April 27, 2023), <https://www.americanprogress.org/article/daca-boosts-recipients-well-being-and-economic-contributions-2022-survey-results/>.

⁵ Svajlenka and Truong, "The Demographic and Economic Impacts of DACA Recipients."

⁶ Svajlenka and Truong, "The Demographic and Economic Impacts of DACA Recipients."

⁷ Svajlenka and Truong, "The Demographic and Economic Impacts of DACA Recipients."

⁸ Elisa Minoff et al., "The Lasting Legacy of Exclusion: How the Law that Brought Us Temporary Assistance for Needy Families Excluded Immigrant Families & Institutionalized Racism in our Social Support System," Center on Poverty and Inequality, Georgetown Law (August 19, 2021), <https://www.georgetownpoverty.org/issues/lasting-legacy-of-exclusion/>.

the general U.S. population.⁹ While DACA recipients' access to employment authorization offers them increased access to health care coverage through employers, younger DACA recipients who cannot work may not be able to obtain coverage if their parents lack coverage, and those with employer-based coverage are often left without other options if they lose their job or have their work hours decreased and are no longer eligible for employer-based health insurance. The COVID-19 pandemic provided an example of this instability—nearly 20 percent of respondents to a 2021 survey of DACA recipients lost their employer-provided health insurance during the COVID-19 pandemic.¹⁰ Additionally, 71 percent of individuals who responded to the 2022 survey of DACA recipients reported that they or their family members couldn't pay medical bills, and nearly half of respondents delayed receiving medical care because of their status.¹¹ In that same survey, 57 percent of respondents stated that they believed that they were ineligible for health coverage due to their immigration status, and over half were unaware of alternative affordable care or coverage available to them.¹²

Limited access to health coverage impacts access to mental health care as well. DACA recipients experience a lot of fear and uncertainty about the future because of their status and constant threats to the DACA program. Yet, nearly half of respondents to the 2022 survey stated that though they have mental and behavioral health needs, they are not receiving any services from a mental health professional.¹³ Among the reasons for not getting care, 56 percent of respondents said that mental health services were too expensive.¹⁴ As youth mental health continues to be a concern nationally and while the DACA program remains at risk, it is important to ensure that DACA recipients and their families are able to access mental health services.¹⁵

As stated in the proposed rule, the exclusion of DACA recipients from affordable health care programs undermines the Affordable Care Act (ACA)'s goal to increase access to equitable health care coverage, and it also hinders the full potential benefits of the DACA program. According to HHS estimates, 129,000

⁹ "Key Facts on Deferred Action for Childhood Arrivals," KFF; Svajlenka and Truong, "The Demographic and Economic Impacts of DACA Recipients"; Jennifer Tolbert, Patrick Drake, and Anthony Damico, "Key Facts about the Uninsured Populations," KFF (December 19, 2022),

<https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.

¹⁰ "Key Facts on Deferred Action for Childhood Arrivals," KFF; Wong, Kmec, and Pliego, "DACA Boosts Recipients' Well-Being and Economic Contributions"; Kat Lundie et al., "Tracking DACA Recipients' Access to Health Care," National Immigration Law Center (June 1, 2022)

https://www.nilc.org/wp-content/uploads/2022/06/NILC_DACA-Report_060122.pdf.

¹¹ Isobel Mohyeddin and Ben D'Avanzo, "DACA Recipient's Access to Health Care: 2023 Report," National Immigration Law Center (May 2023),

https://www.nilc.org/wp-content/uploads/2023/05/NILC_DACA-Report_2023.pdf.

¹² Mohyeddin and D'Avanzo, "DACA Recipient's Access to Health Care."

¹³ Mohyeddin and D'Avanzo, "DACA Recipient's Access to Health Care."

¹⁴ Mohyeddin and D'Avanzo, "DACA Recipient's Access to Health Care."

¹⁵ U.S. Department of Health and Human Services, Office of the U.S. Surgeon General, *Youth Mental Health*, <https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html> (last accessed May 31, 2023).

DACA recipients stand to benefit from the proposed rule, and their expanded access to health care will also further support their ability to contribute to their communities.¹⁶

II. The proposed rule will improve the health and well-being of the children of DACA recipients.

Across the United States, over 1.3 million people live with a DACA recipient, including 300,000 U.S.-born children who have at least one parent with DACA.¹⁷ For years, uninsured rates for U.S. citizen children of immigrants have been double that of their peers with citizen parents despite their eligibility for federal health care programs, as their immigrant parents often face restrictions for coverage.¹⁸ A large body of research has documented the long term benefits when children have access to health care, including greater educational attainment and economic outcomes.¹⁹ Research also shows that children's access to health care coverage increases their use of preventive care, leading to better health as adults with fewer hospitalizations and emergency room visits.²⁰

Children are more likely to access health insurance and health services when their parents are insured

When parents gain access to health coverage, their children also gain access to health coverage, otherwise known as the “welcome mat” effect.²¹ A comprehensive body of research highlights the powerful effect of increases in parental access to insurance coverage on their children's access to insurance coverage. Following the ACA's passage, from 2013-2015, 710,000 children gained coverage, despite the fact that children's eligibility for coverage did not change under the ACA.²² This research also shows that when parents have health insurance coverage, children are more likely to access the routine and preventative health care they need to be healthy and thrive.²³ A study conducted in 2017 found that children whose parents are enrolled in Medicaid had a 29 percent higher chance of having an annual

¹⁶ Clarifying Eligibility for a Qualified Health Plan Through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reduction, a Basic Health Program, and for Some Medicaid and Children's Health Insurance Programs, 88 Fed. Reg. at 25313 at 25327, April 26, 2023.

¹⁷ Svajlenka and Truong, “The Demographic and Economic Impacts of DACA Recipients.”

¹⁸ “Health Coverage of Immigrants,” KFF (July 15, 2021), <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/>.

¹⁹ Karina Wagnerman, Alisa Chester, and Joan Alker, “Medicaid is a Smart Investment in Children,” Georgetown University Health Policy Institute: Center for Children and Families (March 2017) <https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf>.

²⁰ Julia Paradise, “The Impact of the Children's Health Insurance Program: What Does the Research Tell Us?,” KFF, (July 17, 2014), <https://www.kff.org/medicaid/issue-brief/the-impact-of-the-childrens-health-insurance-program-chip-what-does-t-he-research-tell-us/>; Laura Wherry et al., “Childhood Medicaid Coverage and Later Life Health Care Utilization,” National Bureau for Economic Research (February 2015), <http://www.nber.org/papers/w20929.pdf>.

²¹ Julie L. Hudson and Asako S. Moriya, “Medicaid Expansion For Adults Had Measurable ‘Welcome Mat’ Effects On Their Children,” *Health Affairs*, 36, no. 9, (2017): 1643-1651, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.034>.

²² Hudson and Moriya, “Medicaid Expansion For Adults Had Measurable ‘Welcome Mat’ Effects On Their Children.”

²³ Maya Venkataramani, Craig Evan Pollack, and Eric T Roberts, “Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services,” *Pediatrics* 160, no. 6 (2017), DOI: 10.1542/peds.2017-0953.

well-child visit.²⁴ Lack of health care coverage and the inability to afford medical costs leads to significant burden on families, including the accumulation of medical debt or bills, stress around out-of-pocket costs, and the delaying or forgoing of treatment due particularly to financial constraints.²⁵ For uninsured parents, this can mean choosing between securing food for the table or receiving needed treatment and medical care to maintain a healthy life and therefore, providing and supporting their children.

Parental health is positively associated with child health

Parents and caregivers play a primary role in children's development, and therefore research shows that good or excellent parental health is positively associated with child health.²⁶ Parents who receive adequate health care are better equipped to take care of, provide for, and support their children. Improved parental insurance coverage and health outcomes consistently benefit children in the short- and long-term through improved family health and financial security.²⁷ Similarly, a parent's mental health is strongly correlated to a child's mental health as demonstrated by research showing that maternal depression affects children's development, academic success, and overall future professional achievement.²⁸ As previously mentioned, DACA parents face unique stressors given the uncertainty of their status which often trickle down to their children.²⁹ A wide range of child development literature has found that exposure to such stress and trauma can have detrimental long-term developmental impacts, especially for young children.³⁰

Improved health care coverage for pregnant people leads to healthier infant and maternal health outcomes

The proposed rule would improve the health of pregnant people and their children by allowing DACA recipients and other covered populations who become pregnant to be eligible for Medicaid and CHIP benefits in states that have opted to cover all lawfully residing children or pregnant people. The proposed rule would include coverage for care delivered during pregnancy and the post-partum period

²⁴ Schubel, "Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children."

²⁵ Alejandra Muñoz-Rivera, "How do health care costs impact household finances and access to care?" Social Policy Institute, Washington University in St. Louis (2022), <https://socialpolicyinstitute.wustl.edu/how-healthcare-costs-impact-household-finances-and-access-to-care/>.

²⁶ David Murphey et al., "The Health of Parents and Their Children: A Two-Generation Inquiry," Child Trends (2018), https://cms.childtrends.org/wp-content/uploads/2018/10/AECFTwoGenerationHealth_ChildTrends_October2018.pdf.

²⁷ Schubel, "Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children."

²⁸ "Affordable Health Care Keeps Children And Families Healthy," Center for Hunger-Free Communities, Drexel University (2009), <https://drexel.edu/hunger-free-center/research/briefs-and-reports/affordable-healthcare/#:~:text=High%20medica,%20care%20and%20prescription,of%20their%20mothers%20also%20suffer>; Schubel, "Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children."

²⁹ Jorge M. Chavez et al., "Sufren Los Niños: Exploring the impact of unauthorized immigration status on children's well-being," *Family Court Review* 50, no. 4 (2012): 638–649, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3821695/>.

³⁰ Hirokazu Yoshikawa, *Immigrants Raising Citizens: Undocumented Parents and Their Young Children* (New York: Russell Sage Foundation, 2011), pgs 14-15.

(up to 12 months after birth, depending on the state). Studies have shown that when insurance coverage is expanded to include pregnant people, they are more likely to enroll, seek, and receive prenatal health care.³¹ For instance, an expansion in Emergency Medicaid coverage for immigrants increased receipt of recommended prenatal care screenings and vaccines.³² Proper care before, during, and after birth is associated with a number of positive outcomes for both the child and pregnant person, including reduced risk of infant mortality, maternal mortality, birth complications, and alcohol use during pregnancy, among other benefits.³³

III. The proposed rule would improve the health and well-being of young people granted Special Immigrant Juvenile (SIJ) Status.

We strongly support the proposed rule's clarification that youth who have been *approved* for SIJ status are considered lawfully present, not only those with pending petitions, as is currently described in 45 C.F.R § 152.2(7)—resolving an inadvertent omission that has excluded this vulnerable population from coverage.³⁴

Special Immigrant Juvenile status, which was first enacted into law in 1990 and subsequently strengthened through the Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA), is a form of humanitarian relief that protects child survivors of abuse and other mistreatment from being returned to harm.³⁵ Eligibility for SIJ protection derives from a finding by a state juvenile court that a child cannot viably reunify with one or both parents due to abuse, abandonment, neglect, or a similar basis under state law, and that it is not in the child's best interests to be returned to their country of origin.³⁶ In such

³¹ Esther Kathleen Adams et al., "Pregpregnancy Insurance and Timely Prenatal Care for Medicaid Births: Before and After the Affordable Care Act in Ohio," *Journal of Women's Health* 28, no. 5 (May 2019): 654–64, <https://www.liebertpub.com/doi/abs/10.1089/jwh.2017.6871>; Laura R. Wherry et al., "State And Federal Coverage For Pregnant Immigrants: Prenatal Care Increased, No Change Detected For Infant Health," *Health Affairs* 36, no. 4 (2017): 607–15, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1198>.

³² Maria I. Rodriguez et al., "Association of Expanded Prenatal Care Coverage for Immigrant Women With Postpartum Contraception and Short Interpregnancy Interval Births," *JAMA Network Open* 4, no. 8 (August 2, 2021), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2782573>.

³³ Cristian I. Meghea et al., "Statewide Medicaid Enhanced Prenatal Care Programs and Infant Mortality," *Pediatrics* 136, no. 2 (2015), <https://publications.aap.org/pediatrics/article-abstract/136/2/334/33829/Statewide-Medicaid-Enhanced-Prenatal-Care-Programs>; Erica L. Eliason, "Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality," *Women's Health Issues* 30, no. 3 (May 1, 2020): 147–52, <https://doi.org/10.1016/j.whi.2020.01.005>. <https://www.sciencedirect.com/science/article/abs/pii/S1049386720300050>; "What Is Prenatal Care and Why Is It Important?," NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development (January 31, 2017) <https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care>; Katherine Dejong, Amy Olyaei, and Jamie O. Lo, "Alcohol Use in Pregnancy," *Clinical Obstetrics and Gynecology* 62, no. 1 (March 2019): 142, https://journals.lww.com/clinicalobgyn/Abstract/2019/03000/Alcohol_Use_in_Pregnancy.17.aspx.

³⁴ See 88 Fed. Reg. at 25,319; see also Proposed 45 CFR § 155.2(13) (stating that "lawfully present" includes a noncitizen who "[h]as a pending or approved petition for Special Immigrant Juvenile classification as described in 8 U.S.C. 1101(a)(27)(J)").

³⁵ See Immigration Act of 1990, Pub. L. No. 101-649, Nov. 29, 1990, at Sec. 153; William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008, Pub. L. No. 110-457, Dec. 23, 2008, at Sec. 235(d)(1).

³⁶ Immigration and Nationality Act, Sec. 101(a)(27)(J).

cases, a child may submit a petition to U.S. Citizenship and Immigration Services for classification as an SIJ (Form I-360). On the basis of SIJ classification, a young person may apply for adjustment of status to lawful permanent residence (LPR) (Form I-485), but may only do so if a visa is available.

When Congress enacted the SIJ statute in 1990, and later when CMS developed definitions and interpretations of “lawful presence,” children granted SIJ status were generally able to apply to adjust to LPR status without delay. Recognizing the potential for health care coverage gaps for children whose SIJ applications were still under consideration, regulations and guidance defining “lawful presence” and “lawfully residing” specified that children with pending SIJ applications are eligible for federal healthcare programs.³⁷ However, likely because a visa backlog did not exist before April 2016 and was not foreseen, the regulations and guidance did not address children whose SIJ applications had been *approved* but who might nevertheless face delays in obtaining LPR status because a visa is not currently available.³⁸

Since May 2016, however, a growing SIJ visa backlog has delayed the ability of many SIJ-approved youth from El Salvador, Guatemala, Honduras, Mexico, and India to timely obtain LPR status.³⁹ As of April 2021, this backlog reached more than 44,000 children, with some children having to wait several years for a visa to become available.⁴⁰ In March 2023, the Department of State took steps to correct the overstated wait times resulting from earlier misapplications of the law in prior Visa Bulletins, resulting in modest advances in the dates on which a visa will become available for SIJ-based applicants from El Salvador, Guatemala, and Honduras, while moving back visa availability dates for all other countries.⁴¹

As a result of long delays in being able to adjust to LPR status, many SIJ recipients have experienced ongoing uncertainty and risk of deportation that only compound their trauma and impede healing. These delays have created real and detrimental impacts for children’s wellbeing and erected barriers to opportunities and essential supports, including public health programs.⁴² Although some states have permitted children with approved SIJ applications to apply for certain public health programs, this has not occurred uniformly, and many children are hindered in accessing coverage due to regulatory

³⁷ See, e.g., Center for Medicaid and Medicare Services, Letter to State Health Officials, Re: Medicaid and CHIP Coverage of “Lawfully Residing” Children and Pregnant Women (July 1, 2010), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf>.

³⁸ See 88 Fed. Reg. at 25,319 (“Due to high demand for visas in this category, for many applicants it can take several years for a visa number to become available. SIJs are an extremely vulnerable population and as such, we propose to close this unintentional gap so that all children with an approved petition for SIJ classification are deemed lawfully present.”).

³⁹ Rachel Leya Davidson and Laila L. Hlass, “‘Any Day They Could Deport Me:’ Over 44,000 Immigrant Children Trapped in SIJS Backlog,” The End SIJS Backlog Coalition and The Door, at 9 (November 2021), <https://static1.squarespace.com/static/5fe8d735a897d33f7e7054cd/t/61a7bceb18795020f6712eff/1638382830688/Any+Day+They+Could+Deport+Me-+Over+44%2C000+Immigrant+Children+Trapped+in+the+SIJS+Backlog+%28FULL+REPORT%29.pdf>.

⁴⁰ Davidson and Hlass, “‘Any Day They Could Deport Me,’” pp 11-12.

⁴¹ Employment-Based Preference Immigrant Visa Final Action Dates and Dates for Filing for El Salvador, Guatemala, and Honduras, 88 Fed. Reg. 18,252 (Mar. 28, 2023), <https://www.federalregister.gov/documents/2023/03/28/2023-06252/employment-based-preference-immigrant-visa-final-action-dates-and-dates-for-filing-for-el-salvador>.

⁴² Davidson and Hlass, “‘Any Day They Could Deport Me,’” 24-25.

language, confusion about eligibility for various forms of immigration relief, and misunderstandings about whether Social Security numbers are required in every case.

While there is limited research on this population's access to health care coverage, anecdotal evidence from organizations that work with SIJ youth demonstrate the dire consequences young people have faced as a result of not being able to access health care coverage after being approved for SIJ. For example:

After aging out of Office of Refugee Resettlement care, Lucas was able to access healthcare through CHIP Medicaid expansion to obtain needed mental health and rehabilitation services. Once reaching 19, however, their CHIP coverage was discontinued and they were denied eligibility for Medicaid due to their immigration status—despite having been approved for SIJ and having a pending asylum application. Without access to public health programs, they have had to rely on sporadic, emergency services, rather than receiving the inpatient and outpatient care they need.⁴³*

Carmen, a SIJ-approved youth with a pending application to adjust to LPR status, has been unable to access public health programs to address medical needs requiring specialty care and a future surgery. Although she has received some assistance from a hospital with mounting medical bills, Carmen faces outstanding balances in medical debt that leave her unable to afford the surgery she needs. Due to confusion about the complicated application process for private health insurance she has decided to wait until she becomes eligible for employer-based insurance after finishing her first year of employment.⁴⁴*

The Biden Administration has taken important steps to address such harmful impacts, most notably by issuing a deferred action policy in March 2022 under which USCIS automatically considers children with approved SIJ applications for deferred action and work authorization.⁴⁵ Owing to this policy, many SIJ-approved children and youth have obtained a measure of stability, and in the process, also gained eligibility for some federal health programs. Nevertheless, some SIJ recipients have yet to be approved for deferred action or ultimately may not be. Additionally, like all administrative policies, SIJ deferred action could be subject to potential changes in the future. In order to promote consistency and predictability and to align with Congress' intent to provide durable access to health programs, we strongly support the inclusion of the proposed regulatory changes, which will facilitate enduring clarity about SIJ-approved youth's eligibility for federal health programs, even if they are delayed in their ability to adjust their status.

IV. The proposed rule would provide states with additional flexibility to expand access to equitable healthcare to more children, youth, and families.

⁴³ KIND client, with pseudonym used to protect confidentiality, in discussion with KIND.

⁴⁴ KIND client, with pseudonym used to protect confidentiality, in discussion with KIND.

⁴⁵ U.S. Citizenship and Immigration Services, U.S. Department of Homeland Security, "USCIS to Offer Deferred Action for Special Immigrant Juveniles," (March 7, 2022), <https://www.uscis.gov/newsroom/alerts/uscis-to-offer-deferred-action-for-special-immigrant-juveniles>.

Many states are working towards universal health care coverage for all residents regardless of immigration status. Twelve states cover children and eleven states provide health coverage to some parents or other adults regardless of immigration status using state-only funds.⁴⁶ States have also taken advantage of federal options, with some federal financing, to provide health care coverage to more immigrant communities. However, federal limits on immigrant eligibility for health care coverage programs undermine state progress because limited state resources must stretch even further. The complexity of federal rules also make it hard for states to communicate clearly about available coverage options for different immigrant groups. The proposed rule would make it easier for states to achieve their universal coverage goals. With DACA grantees newly eligible for federally-funded Marketplace coverage and financial assistance, and in select circumstances, Medicaid/CHIP coverage, state-only funding would be freed up to cover other uninsured groups and to conduct robust outreach campaigns to enroll harder to reach populations.

Similarly, two states to date have used the ACA's §1332 "innovation waivers" to offer more widespread coverage. Washington and Colorado use §1332 to provide Marketplace coverage regardless of immigration status.⁴⁷ According to Census data, this gave an estimated 100,000 previously ineligible immigrants, 23% of Washington's uninsured population, access to healthcare.⁴⁸ Other states, including California, have pending legislation to enact similar policies.⁴⁹ By giving DACA grantees access to federally funded Marketplace coverage and financial assistance, the proposed rule would give states additional flexibility to use §1332 innovation waiver funds to reach other immigrant groups.

V. The proposed rule would improve health care access for children and families by simplifying the eligibility process.

We strongly support the rule's efforts to simplify and clarify eligibility categories in ways that benefit vulnerable immigrant children. A child's access to the care they need, when and where they need it, should not be contingent on their or their parents' immigration status. Accessible health insurance coverage for all people, including children, should pose minimal enrollment and renewal burdens,

⁴⁶ Tricia Brooks et al., "Table 3., State Adoption of Options to Cover Immigrant Populations, January 2023, from Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision," KFF (April 4, 2023), <https://files.kff.org/attachment/Table-3-Medicaid-and-CHIP-Eligibility-Enrollment-and-Renewal-Policies-as-States-Prepare-for-the-Unwinding-of-the-Pandemic-Era-Continuous-Enrollment-Provision.pdf>.

⁴⁷ Laura Buddenbaum, Liz Hagan, and Rachel Bonesteel, "USofCare Highlights Innovative Opportunities for States to Use 1332 Waivers to Promote Affordability," United States of Care (May 19, 2023), <https://unitedstatesofcare.org/usofcare-highlights-innovative-opportunities-for-states-to-use-1332-waivers-to-promote-affordability/>.

⁴⁸ Washington Health Benefit Exchange, Washington Section 1332 Waiver Application revised June 1, 2022, submitted May 2022, <https://www.wahbexchange.org/content/dam/wahbe-assets/legislation/WA%20Section%201332%20Waiver%20Application-updated%206-8.pdf>.

⁴⁹ An Act to amend Section 100522 of the Government Code, relating to health care, CA - A.B. 4. Accessed June 14, 2023. (CA 2023) https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202320240AB4.

commence with the minimal waiting period needed to verify eligibility, offer continuous eligibility for a minimum of 12 months, and be portable across states.

Reduced complexity for DACA recipients

Under §214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), states can extend Medicaid and CHIP coverage to income-eligible children considered to be lawfully residing in the country without a five-year waiting period.⁵⁰ A majority of states have adopted the CHIPRA §214 expansion.⁵¹ In the proposed rule, HHS states that the new lawfully present definition will expand coverage under CHIPRA §214 to DACA recipients who are under 21 or pregnant. Some studies have found that DACA recipients avoid the health care system, reporting barriers to care including cost, limited intergenerational knowledge about the health care system, lack of a driver’s license, and mistrust of providers due to fear of discrimination and deportation.⁵² In families with mixed-immigration status, adult DACA recipients tend to mirror the health-seeking behaviors of their DACA-ineligible parents, who have less access to health care.⁵³ Historically, expansions to child coverage under CHIP were successful in reducing paperwork and simplifying enrollment and renewal processes.⁵⁴ Similarly, by simplifying eligibility through this rule, some barriers to access will lift, and insurance coverage rates and health outcomes for DACA recipients and their children will likely improve. As stated earlier, improved parental insurance coverage, and trust in the health care system leads to improved coverage and care for children, including improved access to pregnancy-related care.

Reduced complexity for SIJ youth

As discussed above, young people received SIJ and LPR status at more or less the same time, which in turn would make them eligible for Medicaid and other affordable health insurance options. However, due to the visa backlog, they may now need to wait for several years for their green cards. This gap has caused confusion and interfered with access to health care. As the explanatory text to the proposed rule acknowledges, youth granted SIJ status are “an extremely vulnerable population” who have been

⁵⁰ Jonathan Beier and Karla Fredricks, “A Path to Meeting the Medical and Mental Health Needs of Unaccompanied Children in U.S. Communities,” American Academy of Pediatrics and Migration Policy Institute (April 2023), https://www.migrationpolicy.org/sites/default/files/publications/aap-mpi_unaccompanied-children-report-2023_final.pdf.

⁵¹ Julie M. Linton et al., “Providing Care for Children in Immigrant Families,” *Pediatrics* 144, no. 3 (2019), <https://publications.aap.org/pediatrics/article/144/3/e20192077/38449/Providing-Care-for-Children-in-Immigrant-Families>.

⁵² Marissa Raymond-Flesch et al., “There is no help out there and if there is, it’s really hard to find”: A qualitative study of the health concerns and health care access of Latino “DREAMers,” *Journal of Adolescent Health* 55, no. 3 (2014): 323-328.

⁵³ Ghida El-Banna, Kimberly Higuera, and Fernando S. Mendoza, “The Intergenerational Health Effects of the Deferred Action for Childhood Arrivals Program on Families With Mixed Immigration Status,” *Academic Pediatrics* 22, no. 5 (2022): 729-735.

⁵⁴ Suzanne Wikle et al., “States can reduce Medicaid’s administrative burdens to advance health and racial equity,” Center on Budget and Policy Priorities (July 19, 2022), <https://www.cbpp.org/research/health/states-can-reduce-medicaids-administrative-burdens-to-advance-health-and-racial>.

abused, neglected, or abandoned by one or both of their parents and it is therefore especially important for these youth to be able to access affordable medical and mental health care and other services. One form of neglect that is relied upon for SIJ status determinations is medical neglect, which is the failure to provide or the withholding of medical treatment or mental health care needed by the child.⁵⁵ For this very reason, a young person approved for SIJ status should immediately be considered lawfully present so that they may be eligible for Medicaid or CHIP and have a form of insurance coverage for the medical and mental health services they need.

Reduced complexity for other vulnerable children

CHIPRA §214 also applies to children under the age of 14 with asylum applications that have been pending for 180 days. We strongly support the proposed rule's provision to remove the 180-day waiting period for children under the age of 14 who have a pending application for asylum, or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231), or under the Convention Against Torture as is required under the current definition of lawfully present for purposes of health insurance eligibility. While under 8 CFR 274a.12(c) applicants for asylum and other related forms of protection must wait at least 180 days before they can be granted employment authorization, children under the age of 14 are not usually working and so this is an illogical link to make for these younger children. Removing the waiting period is a common sense fix that would improve health care access for this group of immigrant children.

VI. We recommend that the proposed rule be improved to further simplify the eligibility process and cover more vulnerable young people.

Removal of the waiting period for vulnerable youth over age 14

To ensure all children and youth have access to the health care they need, we urge the administration to remove the waiting period for children over age 14 with a pending application for asylum or related forms of protection as well. The original language drawing a distinction between children under 14 and older children was based on Immigration and Naturalization Service (INS) regulatory language at 8 C.F.R. § 103.12(a). The preamble in connection with issuance of the original INS language states that "The characteristic common to all the classes of aliens defined as "lawfully present in the United States" is that their presence in the United States has been sanctioned by a policy determination that a particular class of aliens should be allowed to remain in the United States, and that policy determination has almost always been implemented by an official act having the force of law." 61 Fed. Reg. 47039, 47040 (September 6, 1996). However, the preamble does not explain the basis for permitting children under 14 to be considered lawfully present based on having an application pending for 180 days while requiring an Employment Authorization Document (EAD) for other groups. Presumably, the logic at the time was that older children and pregnant women could attain EADs at or after 180 days, but that is no longer the case

⁵⁵ Child Welfare information Gateway and Children's Bureau of the Administration for Children and Families, U.S. Department of Health and Human Services, "Definitions of Child Abuse and Neglect," (May 2022), <https://www.childwelfare.gov/pubPDFs/define.pdf>.

in light of the revised EAD regulations. Moreover, while employment authorization can be crucially important for asylum seekers, it is not entirely apparent why the presence or lack of employment authorization should matter for determining whether someone is lawfully present.

The Department does not appear to be strictly bound by the terms of the INS/DHS regulation, in that the July 1, 2010 guidance explained “The basis of our construction of lawful presence is the broad definition provided in DHS regulations at 8 C.F.R. §103.12(a) for the specific purpose of Title II Social Security benefits, with some revisions necessary for updating or clarifying purposes, or as otherwise deemed appropriate for the Medicaid and CHIP programs consistent with the Act.” For these reasons, we believe HHS should remove the waiting period for all children under 18 years of age with a pending application for asylum or related forms of protection. Ideally, all states should expand Medicaid and CHIP eligibility to all income-eligible children, regardless of immigration status. However, as previously mentioned, only a handful of states offer such coverage currently.⁵⁶

Clarification and oversight regarding state agencies’ use of Social Security Numbers (SSNs)

Realizing the underlying goals of this rule to expand health care coverage and other efforts, such as CMS’ recent rulemaking to streamline application processes for health care programs, requires also addressing additional barriers that prevent eligible children and youth from timely obtaining coverage.⁵⁷ One barrier is the confusion about the use of Social Security numbers (SSNs) in application processes. We urge additional clarifications in the context of the current rulemaking and related state and federal policy guidance to further address such barriers.

Federal regulations generally provide for use of SSNs as a condition of eligibility for Medicaid and CHIP, with important exceptions.⁵⁸ State agencies are required to assist applicants in applying for an SSN or requesting the number where an applicant cannot recall the number or one has not been issued.⁵⁹ Regulations are clear, however, that agencies “must not deny or delay services to an otherwise eligible individual pending issuance or verification of the individual’s SSN by SSA [Social Security Administration]” and that there are individuals to whom the SSN requirement does not apply. This exception includes individuals who are not eligible to receive an SSN, or who do not have an SSN and may only be issued one for a “valid non-work reason.”⁶⁰ Despite these provisions, many children and youth who are eligible for HHS health programs and who do not have an SSN or who are only eligible for a non-work SSN have faced challenges, delays, or denials in receiving coverage.

⁵⁶ Linton et al., “Providing Care for Children in Immigrant Families.”

⁵⁷ Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, 87 Fed. Reg. 54,760 (Nov. 7, 2022) <https://www.federalregister.gov/documents/2022/09/07/2022-18875/streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health-program-application>.

⁵⁸ Use of Social Security Number, 42 CFR § 435.910, <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR9b4bff9082050a1/section-435.910>; Application for and Enrollment in CHIP, 42 CFR § 457.340(b), <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-C/section-457.340>.

⁵⁹ 42 CFR § 435.910 (e).

⁶⁰ 42 CFR § 435.910 (h)(1)(i)-(iii).

In order to facilitate compliance and eliminate harmful barriers for eligible children and families, we recommend that CMS do the following:

- 1) Increase oversight regarding the use of SSNs by state Medicaid and CHIP agencies in their application processes. Specifically, we recommend the addition of language either within 42 CFR § 435.910 or relevant record keeping regulations (42 CFR §§ 431.17 and 457.96) providing for periodic audits by the federal government of state agency records to assist in identifying any instances in which enrollment has been incorrectly denied or delayed for a child or family due to their inability to provide an SSN;
- 2) reissue and update guidance to State Health Officials clarifying SSN requirements and exceptions, including providing examples of acceptable alternative identifiers⁶¹ and instructing state agencies to archive and label outdated information and update all relevant state regulations, guidance, forms, database and application systems, and documents related to eligibility and application processes (such as trainings, eligibility verification plans, policy manuals, external outreach materials, and public-facing websites) to accurately reflect current federal regulations and requirements; and
- 3) include clarifications to the exception at 42 CFR § 435.910(h)(1) to state directly that *“No state shall require the submission of an SSN as a condition of eligibility from an individual (including a child) who”* meets one of the enumerated exceptions and require states to facilitate alternative forms of verification and identifiers for such individuals.

VII. We urge HHS to allow these changes to go into effect when the final rule is published so that impacted children and youth can access health care as soon as possible.

As stated earlier, access to health care is critical to children’s development, and many of the young people who would benefit from this proposed rule have been forced to wait for such care for too long already. Delays of weeks, months, or even years in accessing health care deprive children of access to preventive services and increase the risk that medical conditions may be overlooked or deteriorate without timely attention. DACA recipients have been waiting for more than a decade to access federal health programs, and thousands of SIJ-approved youth have also been forced to wait years for a visa to become available and have therefore also been left with limited to no access to affordable health care. No child should be forced to wait even a day for health care that could save their life. Therefore we support implementation of the rule’s changes through a special enrollment period after the rule is finalized before November 1, 2023, and then again for general open enrollment on November 1, 2023.

VIII. We urge HHS to conduct robust outreach to ensure children and youth are informed about and supported in accessing health care they are eligible for.

⁶¹ See, e.g., U.S. Department of Health and Human Services, “Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children’s Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefit” (revised May 24, 2006).

We applaud HHS for the work it is currently doing to ensure that all communities are informed of their eligibility and rights when it comes to health care programs. We recommend that HHS update or create new materials after the proposed rule is finalized to ensure those with expanded access are aware of their eligibility and have support enrolling in health care benefits. For reasons stated earlier, it is important to note that issuing these updated outreach materials is not a valid reason to delay implementation of the new rule. Partners and stakeholders can begin to engage community members while official materials are in development and ensure their efficient distribution upon release.

HHS should ensure that its outreach grants fund trusted messengers and programs like community health workers or the Parent Mentor outreach program so that DACA recipients and others newly eligible for benefits get intensive person-to-person outreach to learn about the programs for which they are eligible and have culturally and linguistically appropriate support to enroll in programs. HHS should also provide guidance, training, and materials to Medicaid agencies, brokers, assisters, navigators, and other entities to ensure that they are aware of the new rule, trained on it, and can effectively support newly eligible individuals. It is also important that HHS encourages state agencies and outreach partners to remain in contact over time.⁶²

HHS should use a diverse range of communication mediums to communicate changes to the rules and encourage states, particularly states that have taken up the CHIPRA §214 option, to implement public information campaigns to reach those who are newly eligible. HHS should clearly state that using ACA, Medicaid, and CHIP benefits will not affect the immigration status of immigrants and their family members.⁶³ Providing detailed information about changes, connecting with trusted information sources, and directly addressing immigration and public charge questions have been found to improve enrollment of immigrants and their families.⁶⁴

Conclusion

We thank you for the opportunity to weigh in on this important policy and urge HHS to move quickly on finalizing the rule with the recommendations we have made to improve its reach and efficacy. By ensuring that all lawfully present children - including young DACA recipients, SIJ youth, and children seeking humanitarian protection - have health care access, the proposed rule will advance public health, equitable access to health coverage, and healthy outcomes for future generations.

Signed,

⁶² Isabel Clementa and Armelle Casau, "Covering all Kids: Strategies to Connected Children of Undocumented Status to Health Coverage," Center for Health Care Strategies (February 14, 2023), <https://www.chcs.org/covering-all-kids-outreach-enrollment-and-retention-strategies-to-connect-children-of-undocumented-status-to-health-care-coverage/>.

⁶³ A 2022 survey found that 1 in 5 DACA recipients stated that they were concerned that health care services would negatively impact their own or their family's immigration status. See Wong, Kmec, and Pliego, "DACA Boosts Recipients' Well-Being and Economic Contributions."

⁶⁴ Michele Cordoba, "Effective messaging About the Med-Cal Expansion to Older Adults," California Health Center Foundation (July 19, 2022), <https://www.chcf.org/publication/effective-messaging-medi-cal-expansion-older-adults/>.

National Organizations

AIDS Alliance for Women, Infants, Children, Youth & Families
American Academy of Family Physicians
American Academy of Pediatrics
American Federation of Teachers (AFT)
Center for Law and Social Policy
Children's Defense Fund
Children's HealthWatch
Educare Learning Network
End SIJS Backlog Coalition
Family Voices
First Focus on Children
Futures Without Violence
Georgetown Center for Children and Families
ImmSchools
Kids In Need of Defense (KIND)
National Association of Counsel for Children
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Center for Parent Leadership, Advocacy, and Community Engagement (National PLACE)
National Education Association
National Family Association for DeafBlind (NFADB)
National Immigrant Justice Center
National League for Nursing
Partnership for America's Children
Prevent Blindness
Prevention Institute
Save the Children
The National Alliance to Advance Adolescent Health
U.S. Committee for Refugees and Immigrants (USCRI)
Werner-Kohnstamm Family Giving Fund
Young Center for Immigrant Children's Rights

State and Local Organizations

Abrazar, Inc. (CA)
Adults Pushing Forward Inc. (GA)
APNI, Inc (apoyo a padres de niños con impedimentos) (PR)
Association for Special Children and Families (NJ)
Buen Vecino (CA)
California Primary Care Association
Centro Legal de la Raza (CA)

CHILDREN AT RISK (TX)

Children First (PA)

Children Now (CA)

Children's Law Center of Massachusetts

Colorado Children's Campaign

Community Legal Services in East Palo Alto

Connecticut Institute for Refugees and Immigrants

Corridor Community Action Network (IA)

Desert Healthcare District & Foundation (CA)

Disability Rights California

Disability Rights Washington

Family Connection of SC

Family Voices NJ

Farmworker & Immigration Rights Clinic (FL, GA, AL)

Federation for Children with Special Needs (MA)

Florida Legal Services, Inc.

Florida's Children First

Gardner Health Services (CA)

Greater Hartford Legal Aid, Inc. (CT)

Hawaii Children's Action Network Speaks!

HISPANIC SERVICES COUNCIL INC (FL)

Immigrant Defenders Law Center (CA)

Immigrant Legal Defense (CA)

Immigration Center for Women and Children (CA)

Justice Center of Southeast Massachusetts

Kansas Action for Children

Legal Counsel for Youth and Children (LCYC) (WA)

Maine Parent Federation

Massachusetts Law Reform Institute

Michigan League for Public Policy

Montgomery County Federation of Families for Children's Mental Health, Inc. (MD)

NC Pediatric Society

New Jersey Consortium for Immigrant Children

New Mexico Chapter of American Academy of Pediatrics

Northwest Immigrant Rights Project (WA)

Oasis Legal Services (CA)

Parent Information Center of Delaware

Partners for Our Children (WA)

PEAK Parent Center (CO)

Pennsylvania Association for the Education of Young Children

Pennsylvania Partnerships for Children

Show and Tell (CO)

Sinergia, Inc. (NY)

The Children's Partnership (CA)

The Parents' Place of Maryland

University of San Francisco Immigration & Deportation Defense Clinic

Voices For Utah Children