DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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[CMS–9894–F]

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Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule makes several clarifications and updates the definitions currently used to determine whether a consumer is eligible to enroll in a Qualified Health Plan (QHP) through an Exchange; a Basic Health Program (BHP), in States that elect to operate a BHP; and for Medicaid and Children's Health Insurance Programs (CHIPs). Specifically, Deferred Action for Childhood Arrivals (DACA) recipients and certain other noncitizens will be included in the definitions of ''lawfully present'' that are used to determine eligibility to enroll in a QHP through an Exchange, for Advance Payments of the Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSRs), or for a BHP.

DATES: These regulations are effective on November 1, 2024.

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SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act (ACA) [1] generally [2] requires that to enroll in a Qualified Health Plan (QHP) through an Exchange, an individual must be either a citizen or national of the United States or be ''lawfully present'' in the United States.[3] The ACA also generally requires that individuals be ''lawfully present'' to be eligible for insurance affordability programs for their Exchange coverage such as premium tax credits (PTC),[4] advance payments of the premium tax credit (APTC),[5] and cost-sharing reductions (CSRs).[6] Additionally, enrollees in a Basic Health Program (BHP) are required to meet the same citizenship and immigration requirements as QHP enrollees.[7] Further, the ACA required that individuals be ''lawfully present'' to qualify for the Pre-Existing Condition Insurance Plan Program (PCIP), which expired in 2014.[8] The ACA does not define ''lawfully present'' beyond specifying that an individual is only considered lawfully present if they are reasonably expected to be lawfully present for the period of their enrollment.[9] The ACA requires an Exchange to verify that Exchange applicants are lawfully present in the United States.[10]

Consistent with our statutory authority under the ACA and to facilitate the operation of its programs, CMS issued regulations in 2010 to define ''lawfully present'' for the purposes of determining eligibility for PCIP (75 FR 45013); in 2012 for purposes of determining eligibility to enroll in a QHP through an Exchange by cross-referencing the existing PCIP definition (77 FR 18309); and in 2014 to cross-reference the existing definition for purposes of determining eligibility to enroll in a BHP (79 FR 14111). In the proposed rule (88 FR 25313), we proposed to amend these three regulations to update the definition of ''lawfully present'' currently at 45 CFR 152.2, which is used to determine whether a consumer is eligible to enroll in a QHP through an Exchange and for a BHP.[11] Exchange regulations apply this definition to the eligibility standards for APTC and CSRs by requiring an applicant to be eligible to enroll through an Exchange in a QHP to be eligible for APTC and CSRs.[12] Accordingly, in the proposed rule, when we referred to the regulatory definition of ''lawfully present'' used to determine whether a consumer is eligible to enroll in a QHP through an Exchange, we were also referring to the regulatory definition used to determine whether a consumer is eligible for APTC and CSRs.

In the proposed rule, we proposed a similar definition of ''lawfully present'' applicable to eligibility for Medicaid and the Children's Health Insurance Program (CHIP) in States that elect to cover ''lawfully residing'' pregnant women and children under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (hereinafter ''CHIPRA 214 option''), codified at section 1903(v)(4) of the Social Security Act (the Act) for Medicaid (42 U.S.C. 1396b(v)(4)) and section 2107(e)(1)(O) of the Act (42 U.S.C. 1397gg(e)(1)(O)) for CHIP. In July 2010, CMS interpreted ''lawfully residing'' to mean individuals who are ''lawfully present'' in the United States and who are residents of the State in

[1] The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this rulemaking, the two statutes are referred to collectively as the ''Patient Protection and Affordable Care Act'', ''Affordable Care Act'', or ''ACA.''

[2] States may pursue a waiver under section 1332 of the ACA that could waive the ''lawfully present'' framework in section 1312(f)(3) of the ACA. See 42 U.S.C. 18052(a)(2)(B). There is currently one State (Washington) with an approved section 1332 waiver that includes a waiver of the ''lawfully present'' framework to the extent necessary to permit all State residents, regardless of immigration status, to enroll in a QHP and Qualified Dental Plan (QDP) through the State's Exchange, as well as to apply for State subsidies to defray the costs of enrolling in such coverage. Consumers who are newly eligible for Exchange coverage under the waiver remain ineligible for PTC for their Exchange coverage. While neither Colorado nor New York requested a waiver of the ''lawfully present'' framework, both States are permitted to use pass-through funding based on Federal savings from their 1332 waivers to support programs covering immigrants who are ineligible for PTC. Colorado provides premium and cost-sharing subsidies to individuals earning up to 300 percent of the Federal poverty level (FPL) who are otherwise ineligible for Federal premium subsidies, including undocumented individuals. Under New York's section 1332 waiver, some immigrants with household incomes up to 200 percent of FPL, including DACA recipients, will be eligible for coverage under the State's Essential Plan (EP) Expansion plan. Beginning August 1, 2024 DACA recipients with incomes up to 250 percent of FPL will also be eligible for coverage under the State's EP Expansion. For more information on the Colorado, Washington, and New York section 1332 waivers, see *https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers.*

[3] 42 U.S.C. 18032(f)(3).

[4] 26 U.S.C. 36B(e)(2).

[5] 42 U.S.C. 18082(d).

[6] 42 U.S.C. 18071(e).

[7] 42 U.S.C. 18051(e).

[8] 42 U.S.C. 18001(d)(1).

[9] 42 U.S.C. 18032(f)(3), 42 U.S.C. 18071(e)(2).

[10] 42 U.S.C. 18081(c)(2)(B).

[11] 42 CFR. § 600.5.

[12] 45 CFR 155.305(f)(1)(ii)(A) and (g)(1)(i)(A).

which they are applying under the State's Medicaid or CHIP residency rules.[13] The definitions of ''lawfully present'' and ''lawfully residing'' used for Medicaid and CHIP are set forth in a 2010 State Health Official (SHO) letter (SHO #10–006, hereinafter ''2010 SHO'') and further clarified in a 2012 SHO letter (SHO #12–002, hereinafter ''2012 SHO'').[14]

We proposed several modifications to the definition of ''lawfully present'' currently articulated at 45 CFR 152.2 and described in the SHO letters for Medicaid and CHIP. First, we proposed to remove an exception that excludes Deferred Action for Childhood Arrivals (DACA) recipients from the definitions of ''lawfully present'' used to determine eligibility to enroll in a QHP through an Exchange, a BHP, or Medicaid and CHIP under the CHIPRA 214 option. We noted in the proposed rule that if this proposal were finalized, DACA recipients would be considered lawfully present for purposes of eligibility for these insurance affordability programs [15] based on a grant of deferred action, just like other similarly situated noncitizens who are granted deferred action. We also proposed to incorporate additional technical changes into the proposed ''lawfully present'' definition at 45 CFR 152.2, as well as to the proposed ''lawfully present'' definition at 42 CFR 435.4.

We received a large volume of comments, many in favor, and some opposed to a definition of ''lawfully present'' that includes DACA recipients. We are not finalizing a ''lawfully present'' definition for Medicaid and CHIP at this time. Rather, we are taking more time to evaluate and carefully consider the comments regarding our proposal with respect to Medicaid and CHIP, and specifically, to continue evaluating the potential impact of our proposed definition of ''lawfully present'' on State Medicaid and CHIP agencies. We received comments noting the many urgent and competing demands on State resources, raising concerns that finalizing the proposal for Medicaid and CHIP would add to that burden and divert resources dedicated to other matters. For example, State Medicaid and CHIP agencies continue to experience a significant workload to ''unwind'' (that is, to return to regular eligibility renewal operations) following the expiration of the continuous enrollment condition in section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) on March 31, 2023.[16] During unwinding, States must, over time, process renewals, consistent with Federal requirements, for all individuals who were enrolled in their Medicaid program as of March 31, 2023. States must disenroll individuals who are no longer eligible for Medicaid, determine their potential eligibility for other insurance affordability programs, and as appropriate, transfer the individual's account to the other insurance affordability programs.[17] We recognize, in addition to the concerns raised by the commenters, that States are dedicating significant additional resources to implement new statutory requirements, including mandatory 12-month continuous eligibility periods for children younger than 19 years old in Medicaid and CHIP in effect as of January 1, 2024 under the Consolidated Appropriations Act (CAA), 2023,[18] new requirements for State Medicaid and CHIP programs related to justice-involved individuals under CAA, 2023,[19] and several new requirements for State Medicaid and CHIP agencies regarding benefits, data collection, and eligibility under the Consolidated Appropriations Act, 2024 (CAA, 2024).[20] Many States are implementing various systems modernization initiatives to address lessons learned from unwinding, and States may also need to make system changes necessary to comply with the statutory changes described above. Given the significant comments that CMS continues to consider, including comments regarding these competing State Medicaid and CHIP priorities, increased workload, and finite resources, we are not finalizing definitions for ''lawfully present'' and ''lawfully residing'' for Medicaid and CHIP in this rule at this time. The rulemaking process with regard to that portion of the proposal is ongoing.

As a result, the definition of ''lawfully present'' used in determining eligibility for Medicaid and CHIP under the CHIPRA 214 option, the current policy, based on the 2010 SHO and the 2012 SHO, continues to apply. Individuals, including DACA recipients, who are not considered ''lawfully present'' under the 2010 and 2012 SHOs for purposes of Medicaid and CHIP under the CHIPRA 214 option, will remain ineligible under that specific Medicaid and CHIP State option. DACA recipients, however, may continue to be eligible for limited Medicaid coverage for the treatment of an emergency medical condition consistent with 8 U.S.C. 1611(b)(1)(A) and the regulation at 42 CFR 435.406(b). Because we are continuing to evaluate and consider public comments and State burdens in connection with our proposal for Medicaid and CHIP for DACA recipients, the discussion on the definition of ''lawfully present'' in this final rule will focus exclusively on eligibility for enrollment through the Exchanges and BHP.

The definitions finalized in this rule are solely for the purpose of determining eligibility for specific Department of Health and Human Services (HHS) health programs and are not intended to define lawful presence for purposes of any other law or program. This rule does not provide any

[13] Centers for Medicare & Medicaid Services. (2010). *SHO #10–006: Medicaid and CHIP Coverage of ''Lawfully Residing'' Children and Pregnant Women.* Available at: *https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/sho10006.pdf.*

[14] SHO #10–006, see footnote 13; Centers for Medicare & Medicaid Services. State Health Official letters (*SHO) #12–002: Individuals with Deferred Action for Childhood Arrivals* (issued August 28, 2012). Available at *https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-002.pdf.*

[15] *See* the definition of ''insurance affordability program'' at 45 CFR 155.300(a) and 42 CFR 435.4.

[16] *See* Centers for Medicare & Medicaid Services (CMS), State Health Official letter (SHO)# 23–002, ''Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023,'' January 27, 2023, available at *https://www.medicaid.gov/media/149291;* additional guidance for State Medicaid and CHIP agencies is available at *https://www.medicaid.gov/unwinding.*

[17] CMS, SHO# 22–001, ''Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID–19 Public Health Emergency,'' March 3, 2022, available at *https://www.medicaid.gov/media/135211.*

[18] Title V, Subtitle B, Section 5112 of the Consolidated Appropriations Act, 2023 (CAA, 2023) amended titles XIX and XXI of the Act to require that States provide 12 months of continuous eligibility for children under the age of 19 in Medicaid and CHIP effective January 1, 2024. *See also,* CMS,*SHO #23–004: Section 5112 Requirement for all States to Provide Continuous Eligibility to Children in Medicaid and CHIP under the Consolidated Appropriations Act, 2023* (issued September 29, 2023). Available at: *https://www.medicaid.gov/media/163771.*

[19] Under Division FF, Title V, Section 5121 of the Consolidated Appropriations Act, 2023, starting January 1, 2025, State Medicaid and CHIP programs are required to have a plan in place and, in accordance with such plan, provide certain services to eligible juveniles within 30 days of their scheduled date of release from a public institution following adjudication, and CHIP programs are required to suspend, rather than terminate, CHIP coverage.

[20] Division G, Title I, Subtitle B of the Consolidated Appropriations Act (CAA), 2024 requires that State Medicaid agencies provide certain services for beneficiaries; that Medicaid and CHIP agencies engage in certain data collection and monitoring activities; and that Medicaid and CHIP agencies must no longer terminate eligibility for incarcerated adults, including targeted low-income pregnant individuals, and must instead suspend eligibility in Medicaid. States may also suspend eligibility in CHIP.

noncitizen relief or protection from removal or convey any immigration status or other authority for a noncitizen to remain in the United States under existing immigration laws or to become eligible for any immigration benefit available under the U.S. Department of Homeland Security (DHS)'s or Department of Justice (DOJ)'s purview.

II. Summary of the Provisions of the Proposed Rule and Analysis of and Responses to Public Comments

A. Pre-Existing Condition Insurance Plan Program (45 CFR 152.2)

We proposed to remove the definition of ''lawfully present'' currently at 45 CFR 152.2 and insert the proposed definition of ''lawfully present'' at 45 CFR 155.20. The regulations at 45 CFR 152.2 apply to the PCIP program, which ended in 2014. Further, we proposed to update BHP regulations at 42 CFR 600.5 that currently cross-reference 45 CFR 152.2 to instead cross-reference the definition proposed in the proposed rule at 45 CFR 155.20. While we do not believe the definition at 45 CFR 152.2 is used for any other current CMS programs, we proposed to modify the regulation at 45 CFR 152.2 to cross-reference Exchange regulations at 45 CFR 155.20 to help ensure alignment of definitions for other programs. We sought comment on whether, alternatively, we should remove the definition of ''lawfully present'' currently at 45 CFR 152.2 instead of replacing it with a cross-reference to 45 CFR 155.20.

We did not receive public comments on these proposals to remove the definition of ''lawfully present'' at 45 CFR 152.2, to insert a definition of ''lawfully present'' at 45 CFR 155.20, and to update 45 CFR 152.2 and 42 CFR 600.5 to cross-reference the definition at 45 CFR 155.20. We are finalizing these provisions as proposed.

B. Exchange Establishment Standards and Other Related Standards Under the ACA (45 CFR 155.20)

1. DACA Recipients

The ACA generally requires that to enroll in a QHP through an Exchange, an individual must be a ''citizen or national of the United States or an alien lawfully present in the United States.'' [21] While individuals who are not eligible to enroll in a QHP are also not eligible for APTC, PTC, or CSRs to lower the cost of the QHP, the ACA specifies that individuals who are not lawfully present are also not eligible for such insurance affordability programs for their Exchange coverage.[22] The ACA does not include a definition of ''lawfully present.'' [23]

In a 2022 rulemaking, DHS discussed its definition of individuals who are considered ''lawfully present'' for purposes of applying for Social Security benefits in 8 CFR 1.3, reiterating that it is a ''specialized term of art'' that does not confer lawful status or authorization to remain in the United States, but instead describes noncitizens who are eligible for certain benefits as set forth in 8 U.S.C. 1611(b)(2) (*Deferred Action for Childhood Arrivals,* final rule, (87 FR 53152, 53156) (August 30, 2022) (''DHS DACA final rule'')). DHS also stated that HHS and ''other agencies whose statutes independently link eligibility for benefits to lawful presence may have the authority to construe such language for purposes of those statutory provisions.'' (87 FR 53211). We discuss this authority in further detail later in this section.

We first established a regulatory definition of ''lawfully present'' for purposes of the PCIP program in 2010 (75 FR 45013). In that 2010 rulemaking, we adopted the definition of ''lawfully present'' already established for Medicaid and CHIP eligibility for children and pregnant individuals under the CHIPRA 214 option articulated in the 2010 SHO establishing eligibility for lawfully present individuals. The definition of ''lawfully present'' articulated in the 2010 SHO was also informed by DHS regulations now codified at 8 CFR 1.3(a) defining ''lawfully present'' for the purpose of eligibility for certain 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.

In March 2012, we issued regulations regarding eligibility to enroll in a QHP through an Exchange that cross-referenced the definition of ''lawfully present'' set forth in the 2010 PCIP regulations (77 FR 18309). As the DACA policy had not yet been implemented, the definitions of ''lawfully present'' set forth in the 2010 PCIP regulations and the 2012 QHP regulations did not explicitly reference DACA recipients. However, these definitions specified that individuals granted deferred action were considered lawfully present for purposes of eligibility to enroll in a QHP through an Exchange.

In June 2012, DHS issued the memorandum ''Exercising Prosecutorial Discretion for Individuals Who Came to the United States as Children,'' announcing the DACA policy.[24] DHS noted in this memorandum that DACA is a form of deferred action, and the forbearance of immigration enforcement action afforded to a DACA recipient is identical for immigration purposes to the forbearance afforded to any individual who is granted deferred action in other exercises of enforcement discretion. DHS stated that the DACA policy was ''necessary to ensure that [its] enforcement resources are not expended on these low priority cases.'' [25] DHS did not address DACA recipients' ability to access any insurance affordability programs, as the statutory authority to address matters related to eligibility for such programs rests with HHS, not DHS.

In August 2012, we amended the regulatory definition of ''lawfully present'' at 45 CFR 152.2, used for both PCIP and Exchange purposes, to add an exception stating that an individual granted deferred action under DHS' DACA policy was not considered lawfully present for purposes of qualifying for the PCIP program or to enroll in a QHP through an Exchange (77 FR 52614), thereby treating DACA recipients differently from other deferred action recipients for purposes of these benefit programs. We also issued the 2012 SHO excluding DACA recipients from the definition of ''lawfully residing'' for purposes of Medicaid or CHIP eligibility under the CHIPRA 214 option. In 2014, we issued regulations establishing the framework governing a BHP, which also adopted the definition of ''lawfully present'' at 45 CFR 152.2, thereby aligning the definition of ''lawfully present'' for a BHP with Exchanges, Medicaid, and CHIP. As a result, DACA recipients, unlike all other deferred action recipients, are not currently eligible to enroll in a QHP through an Exchange, or for APTC or CSRs in connection with enrollment in a QHP through an Exchange, nor are they eligible to enroll in a BHP or Medicaid or CHIP under the CHIPRA 214 option because they are not considered lawfully present for purposes of these programs. In the August 2012 rulemaking that excluded

[21] 42 U.S.C. 18032(f)(3).

[22] 26 U.S.C. 36B(e)(2), 42 U.S.C. 18082(d), 42 U.S.C. 18071(e).

[23] 42 U.S.C. 18001(d)(1).

[24] U.S. Department of Homeland Security. (2012). Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children. *https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf.*

[25] U.S. Department of Homeland Security. (2012). Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children. *https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf.*

DACA recipients from CMS definitions of ''lawfully present,'' we reasoned that, because the rationale that DHS offered for adopting the DACA policy did not pertain to eligibility for insurance affordability programs, these benefits should not be extended as a result of DHS deferring action under DACA.

HHS has now reconsidered its position and proposed to change its interpretation of the statutory phrase ''lawfully present'' to treat DACA recipients the same as other deferred action recipients as described in current regulations in paragraph (4)(iv) of the definition at 45 CFR 152.2. As proposed, DACA recipients would be considered lawfully present to the same extent as other deferred action recipients for purposes of the ACA at 42 U.S.C. 18032(f)(3) for the Exchange, and 42 U.S.C. 18051(e) for a BHP. We also proposed to establish rules in the Medicaid and CHIP programs to recognize that DACA recipients are ''lawfully residing'' in the United States for purposes of the CHIPRA 214 option. We are finalizing our proposal to consider DACA recipients to be lawfully present for purposes of the ACA at 42 U.S.C. 18032(f)(3) for the Exchange, and 42 U.S.C. 18051(e) for a BHP. We are not finalizing a definition for purposes of Medicaid and CHIP eligibility at this time, for the reasons detailed in section I.

In previously excluding DACA recipients from the definition of ''lawfully present,'' we had posited that other definitions of lawful presence should not be used as a touchstone for eligibility if the program in question was not established with the explicit objective of expanding access to health insurance affordability programs. However, given the broad aims of the ACA to increase access to health coverage, we now assess that this rationale for excluding certain noncitizen groups from such coverage was not mandated by the ACA, and it failed to best effectuate congressional intent in the ACA. Additionally, HHS previously reasoned that considering DACA recipients eligible for insurance affordability programs was inconsistent with the relief that the DACA policy afforded. However, on further review and consideration, it is clear that the DACA policy is intended to provide recipients with a degree of stability and assurance that would allow them to obtain education and lawful employment, including because recipients remain lower priorities for removal. Extending eligibility to these individuals is consistent with those goals. There also was no statutory mandate to distinguish between recipients of deferred action under the DACA policy and other deferred action recipients.

While HHS' administration of insurance affordability programs and DHS' administration of the DACA policy are separate matters, HHS has determined that changing its own definitions of ''lawfully present'' for purposes of Exchange and BHP eligibility is consistent with DHS' explanation of this definition in the DHS DACA final rule. In the DHS DACA Final Rule, DHS suggested that an individual ''whose temporary presence in the United States the Government has chosen to tolerate for reasons of resource allocation, administrability, humanitarian concern, agency convenience, and other factors'' could be lawfully present (87 FR 53152, 53156).[26] This rule's change to no longer exclude DACA recipients from definitions of ''lawfully present'' applicable to Exchanges and the BHP is consistent with DHS' stated conception of lawful presence. It also aligns with the longstanding DHS definition of lawful presence for purposes of applying for Social Security benefits under 8 CFR 1.3. We are not finalizing a definition for purposes of Medicaid or CHIP under the CHIPRA 214 option at this time, for the reasons detailed in section I.

DHS issued a proposed rule, ''Deferred Action for Childhood Arrivals,'' on September 28, 2021 (86 FR 53736), and the DHS DACA final rule on August 30, 2022 (87 FR 53152).[27] Among other things, the DHS DACA final rule reiterated USCIS's longstanding policy that a noncitizen who has been granted deferred action is deemed ''lawfully present''—a specialized term of art that the Congress has used in other statutes, including in 8 U.S.C. 1611(b)(2) with respect to receipt of certain Social Security benefits. We are aware that DHS received public comments about the ''HHS exclusion of DACA recipients from participation in Medicaid, the Children's Health Insurance Program (CHIP), and the ACA health insurance marketplace'' (87 FR 53210). In response, DHS noted that it did not have the authority to make changes to the definitions of ''lawfully present'' used to determine eligibility for insurance affordability programs and affirmed that such authority rests with HHS (87 FR 53212). While review of the DHS DACA final rule in part prompted HHS to revisit its own interpretation of ''lawfully present,'' HHS' administration of insurance affordability programs implicates separate statutory authority and policy considerations. HHS has independently decided that these changes reflect the best policy for the insurance affordability programs addressed in this rule, and also determined that the changes finalized in this rule align with longstanding DHS policy predating the DHS DACA final rule, under which deferred action recipients have been considered lawfully present for purposes of certain Social Security benefits under 8 CFR 1.3.

Further, since HHS first interpreted ''lawfully present'' to exclude DACA recipients in 2012, new information regarding DACA recipients' access to health insurance coverage has emerged. In the proposed rule, we cited a 2021 survey of DACA recipients that found while DACA may facilitate access to health insurance through employer-based plans, 34 percent of DACA recipient respondents reported that they were not covered by health insurance.[28] Since the proposed rule was published, an updated version of this survey has become available. According to 2022 survey data, 27 percent of DACA recipients are not covered by health insurance.[29] While this represents a modest improvement in the uninsured rate among DACA recipients, it is important to note that DACA recipients are still more than three times more likely to be uninsured than the general U.S. population, which had a national uninsured rate of 7.7 percent.[30] [31]

[26] *See* ''Deferred Action for Childhood Arrivals'' (87 FR 53152). Specifically, see 87 FR 53206 for DHS's discussion of the rule's provisions regarding lawful presence. *https://www.federalregister.gov/d/2022-18401/p-744*

[27] Current court orders prohibit DHS from fully administering the DACA final rule. However, a partial stay permits DHS to continue processing DACA renewal requests and related applications for employment authorization documents. *See* USCIS, DACA Litigation Information and Frequently Asked Questions (Nov. 3, 2022), *https://www.uscis.gov/humanitarian/consideration-of-deferred-action-for-childhood-arrivals-daca/daca-litigation-information-and-frequently-asked-questions.*

[28] National Immigration Law Center. *Tracking DACA Recipients' Access to Health Care* (2022). *https://www.nilc.org/wp-content/uploads/2022/06/NILC_DACA-Report_060122.pdf.*

[29] National Immigration Law Center. *Tracking DACA Recipients' Access to Health Care* (2023). *https://www.nilc.org/wp-content/uploads/2023/05/NILC_DACA-Report_2023.pdf.*

[30] National Immigration Law Center. *Tracking DACA Recipients' Access to Health Care* (2023). *https://www.nilc.org/wp-content/uploads/2023/05/NILC_DACA-Report_2023.pdf.*

[31] U.S. Department of Health and Human Services. New HHS Report Shows National Uninsured Rate Reached All-Time Low in 2023 After Record-Breaking ACA Enrollment Period (2023). *https://www.hhs.gov/about/news/2023/08/03/new-hhs-report-shows-national-uninsured-rate-reached-all-time-low-2023-after-record-breaking-aca-enrollment-period.html.*

Individuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts.[32] In the proposed rule, we noted that the 2021 survey of DACA recipients also found that 47 percent of respondents attested to having experienced a delay in medical care due to their immigration status and 67 percent of respondents stated that they or a family member were unable to pay medical bills or expenses.[33] According to newly available 2022 survey data, both of these rates have increased, with 48 percent of respondents experiencing a delay in medical care due to their immigration status, and 71 percent of respondents unable to pay medical bills or expenses.[34] These outcomes can have downstream impacts that further disrupt individuals' health and financial stability, and therefore their ability to work or study. Delays in care can lead to negative health outcomes including longer hospital stays and increased mortality, whereas being unable to pay medical bills puts individuals at higher risk of food and housing insecurity.[35] [36] [37]

The COVID–19 PHE also highlighted the need for this population to have access to high quality, affordable health coverage. According to a demographic estimate by the Center for Migration Studies, over 200,000 DACA recipients served as essential workers during the COVID–19 PHE.[38] This figure encompasses 43,500 DACA recipients who worked in health care and social assistance occupations, including 10,300 in hospitals and 2,000 in nursing care facilities.[39] During the height of the pandemic, essential workers were disproportionately likely to contract COVID–19.[40] [41] These factors emphasize how increasing access to health insurance would improve the health and well-being of many DACA recipients currently without coverage. In addition to improving health outcomes, these individuals could be even more productive and better economic contributors to their communities and society at large with improved access to health care, as evidenced by a 2016 study finding that a worker with health insurance is estimated to miss 77 percent fewer days than an uninsured worker.[42]

Our proposal to include DACA recipients in the definition of ''lawfully present'' for purposes of Exchange and BHP coverage aligns with the goals of the ACA—specifically, to lower the number of people who are uninsured in the United States and make affordable health insurance available to more people. In the proposed rule, we noted that DACA recipients represent a pool of relatively young, healthy adults; at an average age of 30 per U.S. Citizenship and Immigration Services (USCIS) data, they are younger than the general Exchange population.[43] Thus, there may be a slight positive effect on the Exchange or BHP risk pools as a result of this proposed change, discussed further in the Regulatory Impact Analysis in section V.C. of this final rule.

As discussed above, HHS sees no reason to treat DACA recipients differently from other noncitizens who have been granted deferred action for purposes of eligibility for health insurance coverage through an Exchange or BHP. Accordingly, we proposed to amend our regulations at 42 CFR 600.5 and 45 CFR 152.2 and 155.20 so that DACA recipients would be considered lawfully present for purposes of eligibility for health insurance coverage through an Exchange or a BHP, just like other individuals granted deferred action (88 FR 25313). Specifically, we proposed to amend QHP regulations at 45 CFR 155.20 to remove the current cross-reference to 45 CFR 152.2 and to instead add a definition of ''lawfully present'' for purposes of determining eligibility to enroll in a QHP through an Exchange. In section II.B of the preamble of the proposed rule, we explained the proposal to remove the definition of ''lawfully present'' currently in the PCIP regulations at 45 CFR 152.2 and add a cross reference to 45 CFR 155.20 to align the Exchange regulations. In section II.B of preamble of the proposed rule, we also explained the proposal to remove the existing exception in 45 CFR 152.2 that excludes DACA recipients from the definition of ''lawfully present,'' and to clarify that references to noncitizens who are granted deferred action who are lawfully present for purposes of this provision include DACA recipients. Finally, in section II.E of preamble of the proposed rule, we explained the proposal to amend BHP regulations at 42 CFR 600.5 to cross-reference the definition of ''lawfully present'' proposed at 45 CFR 155.20. Under these proposed changes, we estimated that approximately 124,000 DACA recipients would enroll in a QHP through an Exchange or a BHP. We received public comments on these proposals. The following is a summary of the comments we received and our responses.

General Support

Comment: Many commenters noted general support for CMS' proposal to include DACA recipients in the definition of ''lawfully present,'' such that DACA recipients may be eligible for CMS insurance affordability programs, including enrolling in a QHP and obtaining APTC and CSRs through an Exchange, or enrolling in a BHP.

Response: We appreciate comments that we received in support of this rule's change to no longer exclude DACA recipients from definitions of ''lawfully present'' used to determine eligibility to

[32] Kaiser Family Foundation. Key Facts About the Uninsured Population (2023). *https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.*

[33] National Immigration Law Center. *Tracking DACA Recipients' Access to Health Care* (2022). *https://www.nilc.org/wp-content/uploads/2022/06/NILC_DACA-Report_060122.pdf.*

[34] National Immigration Law Center. *Tracking DACA Recipients' Access to Health Care* (2023). *https://www.nilc.org/wp-content/uploads/2023/05/NILC_DACA-Report_2023.pdf.*

[35] Weissman JS, Stern R, Fielding SL, Epstein AM. (1991). Delayed access to health care: risk factors, reasons, and consequences. *Ann Intern Med. 1991 Feb 15;114(4):325–31. https://doi.org/10.7326/0003-4819-114-4-325.*

[36] Hanna, T.P., King, W.D., Thibodeau, S., Jalink, M., Paulin, G.A., Harvey-Jones, E., O'Sullivan, D.E., Booth, C.M., Sullivan, R., & Aggarwal, A. (2020). Mortality due to cancer treatment delay: systematic review and meta-analysis. *BMJ (Clinical research ed.), 371, m4087. https://doi.org/10.1136/bmj.m4087.*

[37] Himmelstein, D. U., Dickman, S. L., McCormick, D., Bor, D. H., Gaffney, A., & Woolhandler, S. (2022). Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US. *JAMA network open, 5(9), e2231898. https://doi.org/10.1001/jamanetworkopen.2022.31898.*

[38] Center for Migration Studies. *DACA Recipients are Essential Workers and Part of the Front-line Response to the COVID–19 Pandemic, as Supreme Court Decision Looms* (2020). *https://cmsny.org/daca-essential-workers-covid/.*

[39] Center for Migration Studies. *DACA Recipients are Essential Workers and Part of the Front-line Response to the COVID–19 Pandemic, as Supreme Court Decision Looms* (2020). *https://cmsny.org/daca-essential-workers-covid/.*

[40] Nguyen, L.H., Drew, D.A., Graham, M.S., Joshi, A.D., Guo, C.-G., Ma, W., Mehta, R.S., Warner, E.T., Sikavi, D.R., Lo, C.-H., Kwon, S., Song, M., Mucci, L.A., Stampfer, M.J., Willett, W.C., Eliassen, A.H., Hart, J.E., Chavarro, J. E., Rich-Edwards, J.W., . . . Zhang, F. (2020). Risk of COVID–19 among front-line health-care workers and the general community: A prospective cohort study. *The Lancet Public Health, 5*(9). *https://doi.org/10.1016/S2468-2667(20)30164-X.*

[41] Barrett, E.S., Horton, D.B., Roy, J., Gennaro, M.L., Brooks, A., Tischfield, J., Greenberg, P., Andrews, T., Jagpal, S., Reilly, N., Carson, J.L., Blaser, M.J., & Panettieri, R.A. (2020). Prevalence of SARS–COV–2 infection in previously undiagnosed health care workers in New Jersey, at the onset of the U.S. covid-19 pandemic. *BMC Infectious Diseases, 20*(1). *https://doi.org/10.1186/s12879-020-05587-2.*

[42] Dizioli, Allan and Pinheiro, Roberto. (2016). *Health Insurance as a Productive Factor.* Labour Economics. *https://doi.org/10.1016/j.labeco.2016.03.002.*

[43] Count of Active DACA Recipients by Month of Current DACA Expiration as of September 30, 2023. U.S. Citizenship and Immigration Services. *https://www.uscis.gov/sites/default/files/document/data/active_daca_recipients_fy23_q4.pdf.*

enroll in a QHP, for APTC and CSRs through an Exchange, and for a BHP.

Comment: Commenters noted support for CMS' clarification that the provisions in the proposed rule only pertained to the definitions of ''lawfully present'' to determine eligibility for certain health care benefits—including eligibility to enroll in a QHP or a BHP—and that nothing in the proposed rule provided any noncitizen relief or protection from removal, or conveyed any immigration status or other authority for a noncitizen to remain in the United States under existing immigration laws or to become eligible for any immigration benefit available under the DHS' or DOJ's purview.

Response: We reiterate that the provisions in this final rule, only apply to eligibility to enroll in a QHP and a BHP.

Comment: Some commenters stated that the proposed rule was a lawful exercise of the Department's authority under the ACA to define ''lawfully present'' for use in determining eligibility in HHS programs, and that the provisions in the proposed rule better effectuated the ACA's purposes than the current regulatory scheme. One commenter indicated that the rule corrects an error of CMS' 2012 regulation, which treated DACA recipients as a *sui generis* class of deferred action recipients, rather than what the commenter described as one in a long line of deferred action policies in the nation's history.

One commenter noted that the ACA uses the phrase ''lawfully present'' as an eligibility criterion in multiple provisions. The commenter believed that the Congress's policy directive, to consider individuals who are lawfully present, and only those lawfully present, as eligible for the ACA's benefits, was clear. The commenter noted that although the ACA did not define ''lawfully present,'' that this phrase was also used at 8 U.S.C. 1611(b)(2), which predates the ACA, as an eligibility criterion for Title II Social Security benefits. The commenter noted that 8 U.S.C. 1611(b)(2) grants authority to the Attorney General (now the Secretary of Homeland Security) to define who is lawfully present for purposes of Title II Social Security benefits. The commenter noted that when we changed course after DACA was announced, DHS did not change the definition of ''lawfully present'' used in their regulations.

The commenter described the status quo as incongruous, particularly given how DHS treats DACA recipients for purposes of immigration law. The commenter noted that although DACA, and deferred action generally, is not a form of ''lawful status,'' DHS does not consider deferred action recipients to be unlawfully present in the United States as long as their deferred action is in effect. The commenter further noted that unlawful presence has serious ramifications, including inadmissibility to the United States. The commenter stated that DACA recipients are, due to decades-old DHS regulations, eligible for work authorization. As a result of CMS' prior rulemaking, this meant that although DACA recipients have been eligible to live and work in the United States and have been eligible to receive benefits like Social Security, they are barred from accessing crucial aspects of the health care system. The commenter supported the elimination of this inconsistency, which would ''thereby harmonize the definition of a single statutory phrase across agencies and applications, following the lead of the Federal agency best suited to make immigration determinations—DHS.''

Response: We agree that this rule is a lawful exercise of CMS' authority to interpret the statutes it is charged with implementing, as described in detail throughout this rule. We agree with commenters that the changes proposed in this rule better effectuate the goals of the ACA by expanding access to affordable health insurance coverage and are consistent with DHS' rules for Social Security defining ''lawfully present'' at 8 CFR 1.3. We further acknowledge that this rule will eliminate the discrepancy by which DACA recipients are currently treated differently from other recipients of deferred action for purposes of eligibility for enrollment in a QHP or a BHP.

Because we are not finalizing a definition of ''lawfully present'' for purposes of Medicaid and CHIP eligibility under the CHIPRA 214 option at this time, there will be differences between who is considered ''lawfully present'' for Medicaid and CHIP and who is considered ''lawfully present'' for Exchange coverage and the BHP. We acknowledge commenters' interest in having a uniform definition across our insurance affordability programs, as uniformity was a factor we considered in our proposals. However, we are not finalizing a definition of ''lawfully present'' for purposes of Medicaid and CHIP eligibility at this time due to the reasons detailed in section I. Accordingly, we will consider, along with the comments we received on the proposed amendments to the definitions for purposes of Medicaid and CHIP, the potential benefits of such uniformity in any future rulemaking on this topic.

Comment: Many commenters stated that they agreed that DACA recipients should be treated the same as other recipients of deferred action, and that there is no reason for CMS to treat DACA recipients differently from other recipients of deferred action. One commenter stated that they believed deferred action recipients were eligible for QHP and BHP per the ACA, and that CMS' prior policy ''undermined this statutory eligibility'' and appreciated CMS updating the current policy of exclusion.

A comment submitted by some State attorneys general referred to the current exclusion as a ''discrepancy in the current regulatory scheme.'' This commenter also noted that the Federal Government has a long history of granting deferred action, including 17 different deferred action policies prior to DACA, and that none of the deferred action recipients under any of these other policies were categorically denied access to health insurance affordability programs. The commenter noted that the current exclusion bars DACA recipients from health insurance affordability programs that their tax contributions help fund. Another commenter stated this would bring greater consistency to Federal policy in this area and would advance the goals of the ACA.

Response: We agree with the commenters that DACA recipients should be treated the same as other recipients of deferred action for purposes of eligibility for Exchanges and the BHP. Commenters are correct that, up until now, DACA recipients have been the only category of deferred action recipients excluded from eligibility for these insurance affordability programs. We acknowledge that this policy did not best effectuate the ACA's directive to consider individuals who are ''lawfully present'' to be otherwise eligible for coverage. We agree with the commenter who characterized this exclusion of DACA recipients as a ''discrepancy in the regulatory scheme.'' When this final rule is effective on November 1, 2024, this discrepancy between DACA recipients, who are deferred action recipients, and other deferred action recipients will be corrected with respect to Exchange and BHP coverage, and all noncitizens granted deferred action by DHS will be considered as lawfully present for the purposes of eligibility for these programs. We will consider the impacts of eliminating this discrepancy for purposes of Medicaid and CHIP eligibility under the CHIPRA 214 option in future rulemaking.

Comment: Some commenters questioned whether the ACA provided an adequate legal basis for CMS to treat DACA recipients differently from other recipients of deferred action. Commenters further stated that they believed that CMS' 2012 IFR excluding DACA recipients from the definition of ''lawfully present'' was not aligned with the ACA's goal to expand access to affordable health coverage to the uninsured.

Response: The ACA does not define the term ''lawfully present,'' but our regulations implementing the ACA have recognized that noncitizens with a currently valid period of deferred action were lawfully present. For the reasons stated above, we believe that the ACA supports our proposed change in policy for DACA recipients as these individuals will be treated as lawfully present just like other individuals granted deferred action for the purposes of eligibility for health insurance through an Exchange or a BHP.

We agree with the comment that our prior policy did not fully align with the ACA's goal to expand access to affordable health coverage for the uninsured. We agree with commenters that the changes in this rule better effectuate the congressional intent in the ACA, given the ACA's broad aims to expand access to affordable health insurance coverage. As mentioned throughout this rule, new information regarding DACA recipients' difficulty in accessing health insurance coverage has become available since we adopted our prior policy. As mentioned previously in this rule, despite some DACA recipients being able to access health insurance coverage through their employers as a result of the employment authorization provided under the DACA policy, DACA recipients are still more than three times more likely to be uninsured than the general U.S. population, which had a national uninsured rate of 7.7 percent.[44] [45]

Comment: Some commenters noted that the current exclusion of DACA recipients from CMS definitions of ''lawfully present'' is inconsistent with other rules pertaining to public benefits eligibility for individuals with deferred action, including DHS regulations at 8 CFR 1.3 for the purposes of eligibility for Title II Social Security benefits. Commenters supported CMS' proposal to better align with DHS' policies.

Response: This rule would bring eligibility for health insurance through an Exchange and a BHP into alignment with DACA recipients' treatment under rules used by the Social Security Administration for Title II Social Security Benefits, as articulated in DHS regulations at 8 CFR 1.3. As we are not finalizing a definition of ''lawfully present'' for purposes of eligibility for Medicaid or CHIP under the CHIPRA 214 option at this time, due to the reasons detailed in section I, the definition used for purposes of those programs will continue to differ from DHS regulations at 8 CFR 1.3 with respect to DACA recipients. We will consider the impacts of updating the Medicaid and CHIP definition of ''lawfully present'' in future rulemaking.

Comment: Some commenters, including nonprofit advocacy organizations and State government agencies, stated the belief that no longer excluding DACA recipients from Exchange coverage could have a positive impact on Exchange risk pools. One government agency noted that improving the risk pool in this way will benefit insurers, and commenters further noted that improving risk pools in this way is expected to exert downward pressure on QHP premiums and to improve market stability. In support of the argument that allowing DACA recipients to access Exchange coverage could improve individual market risk pools, multiple commenters cited a study that found that DACA recipients had similar self-reported health status to U.S. born individuals, with 92 percent of survey respondents eligible for DACA reporting excellent, very good, or good health.[46] Commenters noted that DACA recipients are also younger, on average, than current Exchange enrollees, with an average age of 30.[47]

Response: While we are unable to quantify the potential impacts of this policy on Exchange risk pools, we believe it is reasonable to predict that allowing DACA recipients to enroll in Exchange coverage may have a positive impact. DACA recipients, whose average age is now 30, are younger than the existing population of Exchange enrollees, of whom 64 percent are age 35 or older.[48] [49] As commenters noted, DACA recipients are also generally in good health, due in part to the fact that DACA recipients are a relatively young population. However, we note that there does exist a slight gap between DACA recipients who report they are in excellent or very good health (64 percent) as compared to U.S. citizens (71 percent).[50] We are not able to assess how DACA recipients' health status compares to that of the existing population of Exchange enrollees, or to predict any downstream impacts on Exchange risk pools as a result. However, we are hopeful that allowing DACA recipients to access Exchange coverage may help address these existing disparities due to the positive health impacts of having health insurance, which are detailed later in this section.

Comment: One State government agency noted that extending QHP eligibility for DACA recipients is particularly important because DACA recipients may lose access to State-funded Medi-Cal during unwinding. Another commenter noted that extending QHP eligibility for DACA recipients is particularly important because even in the State of California, where DACA recipients may qualify for State-funded Medi-Cal if they are income-eligible, 57 percent of individuals likely eligible for DACA have incomes above 200 percent of the FPL. Allowing these DACA recipients to enroll in health coverage through a QHP provides an important source for affordable health insurance coverage that is not currently available.

Response: We appreciate a commenter pointing out the importance of making Exchange coverage available to DACA recipients who may not be eligible for, or who may be losing, State-funded health coverage during unwinding. While we are not finalizing a definition for purposes of Medicaid and CHIP eligibility at this time, due to the reasons detailed in section I, we will take this comment into consideration as part of any future rulemaking on this topic.

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[44] National Immigration Law Center. *Tracking DACA Recipients' Access to Health Care* (2023). *https://www.nilc.org/wp-content/uploads/2023/05/NILC_DACA-Report_2023.pdf.*

[45] U.S. Department of Health and Human Services. *New HHS Report Shows National Uninsured Rate Reached All-Time Low in 2023 After Record-Breaking ACA Enrollment Period* (2023). *https://www.hhs.gov/about/news/2023/08/03/new-hhs-report-shows-national-uninsured-rate-reached-all-time-low-2023-after-record-breaking-aca-enrollment-period.html.*

[46] Key Facts on Deferred Action for Childhood Arrivals (DACA) (2023), *https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.*

[47] Count of Active DACA Recipients by Month of Current DACA Expiration as of September 30, 2023. U.S. Citizenship and Immigration Services. *https://www.uscis.gov/sites/default/files/document/data/active_daca_recipients_fy23_q4.pdf.*

[48] Count of Active DACA Recipients by Month of Current DACA Expiration as of September 30, 2023. U.S. Citizenship and Immigration Services. *https://www.uscis.gov/sites/default/files/document/data/active_daca_recipients_fy23_q4.pdf.*

[49] Centers for Medicare and Medicaid Services. 2024 Open Enrollment Report. *https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf.*

[50] Key Facts on Deferred Action for Childhood Arrivals (DACA) (2023), *https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.*

General Opposition

Comment: Some commenters noted general opposition to CMS' proposal to consider DACA recipients lawfully present for purposes of insurance affordability programs. Some commenters urged CMS to withdraw the rule, or alternatively, to remove the proposed changes that would no longer exclude DACA recipients from the definitions of ''lawfully present'' used to determine eligibility for CMS insurance affordability programs.

Some commenters noted opposition to this rule on the basis that they believe DACA recipients entered the United States unlawfully, that they believe DACA recipients are undocumented, or that they believe DACA recipients have broken the law. Commenters stated that rules such as the one that CMS has proposed further incentivize illegal immigration, increase fraud and abuse of government systems, and encourage dependency on Federal programs.

Response: We recognize that some of the public commenters are opposed to the change this rule would make, and there is significant public debate concerning the availability of some public benefits for noncitizens. Although we recognize that the Congress has made a general statement of the immigration policy of the United States at 8 U.S.C. 1601, the Congress has provided some express exceptions that enable certain noncitizens to obtain certain public benefits under other authorities. For example, as noted in the proposed rule, individuals who are either U.S. citizens or nationals or lawfully present in the United States are eligible to enroll in a QHP and are eligible for PTCs, APTCs, and CSRs (88 FR 25313). We submit that our rule is consistent with the relevant statutory authorities.

In addition, DHS has recognized that even individuals who did not enter the United States legally could become ''lawfully present'' under the statutes governing particular benefit programs (87 FR 53152, 53156). DHS notes that ''the term 'lawful presence' historically has been applied to some persons who are subject to removal (and who may in fact have no ''lawful status''), and whose immigration status affords no protection from removal, but whose temporary presence in the United States the Government has chosen to tolerate for reasons of resource allocation, administrability, humanitarian concern, agency convenience, and other factors. Lawful presence also encompasses situations in which the Secretary, under express statutory authorization, designates certain categories of noncitizens as lawfully present for particular statutory purposes, such as receipt of Social Security benefits'' (87 FR 53152). As discussed throughout this rule, we have the authority to modify our definition of ''lawfully present'' used as an eligibility criterion for the programs we administer and for which we have oversight responsibilities.

We reiterate in response to the public comments that this rule aims to establish eligibility criteria only for Exchanges and a BHP and does not address or revise immigration policy, including DHS' DACA policy. We also reiterate that other recipients of deferred action have long been considered lawfully present under our regulations and policies, and this rule is removing the exception for DACA recipients for the purposes of eligibility for Exchanges and a BHP. We note that while we are not addressing the definition of ''lawfully present'' for purposes of Medicaid and CHIP eligibility in this final rule, we will consider commenters' concerns about negative impacts of DACA recipients being considered eligible for Medicaid or CHIP under the CHIPRA 214 option in future rulemaking. The rulemaking process with regard to that portion of the proposal is ongoing.

We also do not believe that this rule will encourage irregular migration, fraud or abuse of government systems, or encourage dependency on Federal programs. While the factors contributing to irregular migration are complex and multifaceted, DHS has clearly indicated from the beginning of the DACA policy that only certain noncitizens continuously residing in the United States since June 15, 2007 can be considered for deferred action under DACA.[51] We do not believe it is reasonable to conclude that no longer excluding DACA recipients from eligibility for insurance through an Exchange or a BHP will have any material impact on rates of illegal immigration. Individuals must have their lawful presence electronically verified by DHS to enroll in our insurance affordability programs, which ensures that noncitizens who are not lawfully present, as defined in this final rule, will not be able to enroll in health insurance through an Exchange and a BHP.

Comment: A few commenters stated their belief that DACA recipients should not be able to access the insurance affordability programs discussed in this rule because they do not pay into the U.S. health care system via taxes.

Response: Contrary to the commenter's assertion, we note that DACA recipients do pay Federal, State, and local taxes. One analysis estimated that DACA recipients contribute $6.2 billion in Federal taxes and $3.3 billion in State and local taxes each year.[52] In addition, we note that only DACA recipients who attest that they will file a Federal income tax return will be eligible for APTCs for Exchange coverage.

Comment: A few commenters stated their belief that DACA recipients should not be able to access the insurance affordability programs addressed in this rule unless they become U.S. citizens, or that DACA recipients and other noncitizens should not be able to access more benefits than U.S. citizens. A few commenters expressed their belief that DACA recipients should use employer sponsored coverage or other private coverage. One commenter indicated that they would be in favor of making subsidized health insurance coverage available to DACA recipients only if they are employed.

Response: Limiting access to the insurance affordability programs addressed in this rule to U.S. citizens, as some commenters suggested, is beyond our authority under the ACA. Further, the changes in this rule result in DACA recipients becoming potentially eligible for health insurance through an Exchange or a BHP for which U.S. citizens, U.S. nationals, and other noncitizens determined to be lawfully present are already considered eligible. Nothing in this rule restricts or changes the insurance affordability programs available to U.S. citizens, U.S. nationals, or other such lawfully present noncitizens.

Finally, we do not have authority under the ACA to limit the availability of coverage to individuals who are employed, although there is evidence that the majority of DACA recipients are employed.[53]

Comment: One nonprofit organization opposed the proposal stating that by expanding the definition of ''lawfully present,'' DACA recipients would rely

[51] *See* U.S. Department of Homeland Security. (2012) *Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children. https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf, and 8 CFR 236.22(b)(2).*

[52] Center for American Progress. The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition. (2022). *https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/.*

[53] Center for American Progress. Results from Tom K. Wong et al., 2022 National DACA Study. *https://www.americanprogress.org/wp-content/uploads/sites/2/2023/04/DACA-Survey-2022-Toplines.pdf.*

on Federal and State benefits that might be taken away if a court rules against DHS' DACA policy as codified in its 2022 DACA final rule (87 FR 53152).

Response: An individual could cease to be ''lawfully present'' for a number of reasons, including because DHS terminates an individual's grant of deferred action on a case-by-case basis, because the Congress enacts a statute that makes changes to current law, or, as the commenter suggests, because of a judicial decision. Regardless of whether any of these situations may come to pass in the future, we see no compelling reason not to update our regulations, consistent with our statutory and regulatory authority, as we have found that our current regulations do not best effectuate the ACA. As is detailed throughout this rule, we believe there are significant physical health, mental health, and financial benefits associated with having access to health insurance coverage. For both DACA recipients and other noncitizens who may no longer be considered ''lawfully present'' under our regulations at some point in the future, we do not believe that the potential risk of losing coverage in the future outweighs the potential benefit of increasing access to coverage at present.

Comment: Some commenters noted general opposition to this proposed rule stating that they believe more resources should go towards ensuring that U.S. citizens have access to the health insurance coverage and health care services that they need, before directing funds towards DACA recipients and other noncitizens. A few commenters stated frustration that the cost of health insurance for U.S. citizens, especially those who work, who have families, who are low income, or who own small businesses is too high, and they are suffering without access to affordable health care. Commenters requested that more work should go to fixing the current health care system and that American citizens or those who entered the United States legally should be receiving better care.

Response: We are committed to ensuring access to quality, affordable health insurance coverage and health care for everyone who is eligible for programs we regulate or administer. The insurance affordability programs being made available to DACA recipients in this rule—Exchange coverage and the BHP, specifically—have been and will continue to be available to eligible U.S. citizens, U.S. nationals, and other lawfully present noncitizens. The purpose of this rule is to establish eligibility requirements for health insurance through an Exchange and a BHP rather than dictate where tax dollars are directed. We note that nothing in this rule will restrict or eliminate the availability of these insurance affordability programs to U.S. citizens. In fact, it is possible that allowing DACA recipients to enroll in QHPs through an Exchange could lower QHP premiums for all enrollees. Given that DACA recipients are, on average, younger than current Exchange enrollees, having DACA recipients in the QHP risk pools may lower the associated premiums of such plans.

Comment: Some commenters believe the policies in this proposed rule are outside of the President's purview, are not permitted under the ACA, and should be policies established by the Congress. Some commenters noted that the ACA was passed after extensive discussions within the Congress and specific statements were made regarding ''lawful presence'' and who would receive ACA benefits. A few commenters further noted that the DACA policy was implemented to prevent deportation, and to provide work permits for those individuals, not to extend government benefits to them. Additional commenters expressed their belief that whether to provide health insurance to individuals who are DACA recipients falls to the Congress, and the President has no legal authority. A few commenters also pointed out that a prior administration originally prevented DACA recipients from accessing ACA coverage.

Response: We do not agree with the suggestion that the proposed rule exceeds our legal authority. We have identified the relevant statutory authority that supports our proposed and final rule. Moreover, we have identified specific reasons for proposing a change of policy and have sought public comments consistent with the requirements of the Administrative Procedure Act (APA). We have demonstrated that the rule is consistent with our existing authority under the law.

Comment: Commenters stated their view that the DACA policy is unlawful, and that this rule runs counter to immigration laws including statute, case law, and ongoing litigation in the Fifth Circuit Court of Appeals. One commenter stated that CMS was correct in its initial judgment that there was good reason to treat DACA recipients differently from other recipients of deferred action. The commenter further asserted that unlike other forms of prosecutorial discretion, DACA was ''plainly unlawful,'' as it was not authorized by the Congress, conflicted with other statutes, and did not originally undergo notice and comment rulemaking.

One nonprofit organization cited the Fifth Circuit's ruling in which the court found that DHS does not have authority to ''broaden the categories of aliens who are entitled to lawful presence in the United States.'' [54] The commenter also cited the court's findings that the DACA Memorandum ''contradicts significant portions of the Immigration and Nationality Act (INA),'' and that the 2012 Memorandum by then-DHS Secretary Janet Napolitano which announced the DACA policy violated the procedural requirements of the APA. One commenter further stated that the Congress identified in the INA several discrete categories of noncitizens that may be eligible for deferred action, nowhere granting the executive branch authority to unilaterally expand on those categories. One nonprofit organization cited the court's finding that the DACA policy ''failed under step one of the Chevron framework.'' One nonprofit organization noted that the Supreme Court has consistently held that the Congress holds plenary authority over immigration. The commenter cited *Kleindienst* v. *Mandel*,[55] in which the Court noted that the Congress has ''plenary power to make rules for the admission of aliens and to exclude those who possess those characteristics which the Congress has forbidden.''

One commenter further stated that they believed that by including DACA recipients in CMS' definition of ''lawfully present,'' CMS was ''reinforcing'' DACA, which they viewed to be an ''unlawful program.'' One nonprofit research organization stated that because the DACA policy is not a lawful exercise of deferred action, and because the DACA policy violates procedural and substantive Federal law, that CMS must exclude DACA recipients from its definitions of ''lawfully present.''

Response: We believe that the DACA final rule is lawful. As DHS articulates in detail in their final rule, the DACA final rule represents a lawful exercise of the Secretary of Homeland Security's authority and discretion regarding deferred action (87 FR 53152).

Perhaps more importantly, this rule does not in any way change existing immigration policy, nor does it confer lawful immigration status. As we explained in the proposed rule, ''[t]hese proposed definitions are solely for the purposes of determining eligibility for

[54] *Texas et al.* v. *United States et al.,* 50 F.4th 498 (5th Cir. 2022).

[55] 408 U.S. 753, 766 (1972).

specific HHS health programs and are not intended to define lawful presence for purposes of any other law or program.'' We also noted that the proposed rule would not provide any noncitizen relief or protection from removal or convey any immigration status or other authority for a noncitizen to remain in the United States under existing immigration laws or to become eligible for any immigration benefit available under the DHS's or DOJ's purview.

The ACA uses the term ''lawfully present'' as an eligibility criterion for health insurance through an Exchange or a BHP. As noted previously in this final rule, those terms were not defined in the operative statute, and we have the authority to define these terms for the purposes of determining eligibility for health insurance through an Exchange and a BHP.

Comment: One commenter, a nonprofit research organization, stated that because CMS' proposed change in policy is not based on a reasonable rationale, that extending benefits to DACA recipients is *ultra vires* and violates the APA. The commenter further stated that it believed that CMS' rationale for changing its interpretation is not justified by the facts and is therefore unlawful under the APA. The commenter asserted that CMS has failed to meet the standards of the APA by proposing to consider DACA recipients as ''lawfully present'' despite the DACA policy's ''serious legal deficiencies.'' The commenter specifically stated that CMS' explanation that, upon further review, the DACA policy ''was intended to provide recipients with the stability and assurance that would allow them to obtain education and lawful employment, and to integrate as productive members of society'' is inconsistent with the inherent nature of deferred action, which DHS has specified can be ''terminated at any time, in its discretion.'' The commenter noted that if DACA is truly a form of prosecutorial discretion, then DACA grants must be case-by-case and based on prioritization of cases, rather than a class-based benefits program intended to provide stability to a specific class of beneficiaries in a manner similar to standard immigration benefits. The commenter stated that any stability DACA recipients may receive as a part of the policy is unwarranted, and that deferred action does not provide lawful status or a right to remain in the United States nor does it excuse past or future periods of unlawful presence.

Response: We have met our obligations under the APA to explain our proposed policy change to no longer exclude DACA recipients from the group of individuals with deferred action in our definitions of lawful presence for purposes of eligibility for health insurance through an Exchange and a BHP. As noted above, we have the authority to define the term ''lawfully present'' as an eligibility criterion for health insurance through an Exchange or a BHP as the term was previously not defined in the operative statute.

Additionally, as discussed in this final rule and in the proposed rule, new information regarding DACA recipients' difficulty accessing health insurance coverage and health care has become available since we first excluded DACA recipients from our definitions of ''lawfully present'' in 2012. In this rule, we are adopting a policy that better effectuates the goals of the ACA to promote access to affordable health insurance coverage through Exchanges and BHPs. Further, we disagree with the commenter's characterization that any stability that DACA recipients receive related to the DACA policy is unwarranted. While deferred action does not confer legal immigration status or a right to remain in the United States, it does provide a degree of stability to recipients, including through providing eligibility to request employment authorization.

Comment: One government agency stated that it is illogical to consider DACA recipients and other deferred action recipients to be ''lawfully present'' because the ''action'' that is deferred under DACA and other deferred action policies is action on their recipients' unlawful presence. In support of this argument, the commenter cited an Eleventh Circuit opinion, which has noted that DACA recipients are ''given a reprieve from potential removal; that does not mean they are in any way 'lawfully present' under the [INA].'' [56]

Response: As DHS explained in their DACA final rule, the concept of ''lawful presence'' is a term of art used in certain benefit statutes and without a single controlling statutory definition. Still, we acknowledge that lawful presence is not an immigration status and does not connote a ''lawful immigration status.'' As DHS states in its DACA final rule, ''[a]n individual's lawful presence can include situations in which the executive branch tolerates an individual being present in the United States at a certain, limited time or for a particular, well-defined period. The term is reasonably understood to include someone who is (under the law as enacted by the Congress) subject to removal, and whose immigration status affords no protection from removal, but whose temporary presence in the United States the Government has chosen to tolerate, including for reasons of resource allocation, administrability, humanitarian concern, agency convenience, and other factors.'' (87 FR 53152).

Deferred action recipients have been considered lawfully present under regulations for many years for purposes of eligibility for Social Security, the Exchange, BHP, and under existing CMS policy outlined in the 2010 SHO for Medicaid and CHIP under the CHIPRA 214 option, and thus may be receiving benefits if they meet all other eligibility requirements for those programs.

The INA does not include a definition of ''lawfully present.'' As noted by DHS in their DACA final rule, there is no singular definition of ''lawfully present'' for all purposes and the term is not a legal immigration status. Similar to how DHS considers deferred action recipients lawfully present for purposes of Title II Social Security benefits under 8 CFR 1.3, this rule only addresses eligibility for specific programs. Under the authority granted the HHS Secretary by the ACA, we are defining ''lawfully present'' for purposes of Exchanges and BHP programs and believe we have adopted a reasonable approach in doing so.

Comment: A few commenters stated that CMS' changes to consider DACA recipients as ''lawfully present'' for purposes of its programs should go through the Congress, and that this rule reaches beyond the jurisdiction of the Executive branch. Commenters further indicated that they believed that bypassing the Congress was inappropriate because of the Congress's role in appropriating funding.

Response: Where the Congress uses a term like ''lawfully present'' but does not define the term, the agency is required to interpret the statute, particularly where the Congress grants the agency broad rulemaking authority to implement the statute, as it has done in the ACA.[57] We do not agree with the commenters' suggestion that we have acted beyond our statutory authority by proposing to include DACA recipients within the term ''lawfully present'' for purposes of eligibility for health insurance through an Exchange or a BHP as addressed in this rule. After review, we believe that the revised definition of ''lawfully present'' for

[56] *Estrada* v. *Becker*, 917 F.3d 1298, 1305 (11th Cir. 2019) (citing Ga. Latino All. for Human Rights v. Governor of Ga., 691 F.3d 1250, 1258 n.2 (11th Cir. 2012).

[57] 42 U.S.C. 18041(a)(1).

purposes of eligibility for health insurance through an Exchange or BHP is the most accurate interpretation of the ACA's text and better effectuates the Congressional intent in the ACA.

Access to Care

Comment: Many advocacy organizations, government agencies, and health insurers noted that despite DACA recipients' relatively high rates of employment, DACA recipients continue to face barriers to accessing health insurance coverage and health care. Some commenters cited a 2021 study that found that over one-third of DACA recipients were uninsured, and others cited an analysis of 2022 Current Population Survey Annual Social and Economic Supplement data that found that nearly half of individuals likely eligible for DACA are uninsured. Commenters noted that high proportions of DACA recipients reported being unable to pay medical bills. Another commenter noted that while DACA recipients initially realized some health improvements when the 2012 DACA policy was established, that those improvements slowed as uncertainty surrounding the policy grew. Commenters stated that this rule was urgently necessary to help DACA recipients gain access to needed health insurance coverage and close the insurance gap, in line with the goals of the ACA.

One nonprofit organization noted that individuals who would benefit from this rule likely have limited incomes and it is very unlikely that these individuals can afford health insurance. Another commenter cited data showing that in the State of New York, approximately two-thirds of DACA recipients have incomes below 100 percent of the FPL. By gaining access to insurance affordability programs, the commenter noted that this population would have an opportunity to enroll that is currently not available.

Several commenters noted that a significant proportion of DACA recipients are parents, citing estimates ranging from 30 percent to 48 percent of DACA recipients, and noted that 250,000 to 300,000 U.S.-born children have a parent who is a DACA recipient. Commenters cited studies showing that children are more likely to be insured when their parents have health insurance, and that therefore, expanding the health insurance options available to DACA recipients through this rule would also likely improve access to insurance for their children. One commenter noted U.S. citizen children with at least one noncitizen parent are twice as likely to be uninsured as those with two U.S. citizen parents.

Response: We agree with commenters' view that DACA recipients face disproportionately high rates of uninsurance, which has negative downstream health and economic impacts, discussed in further detail below. We believe that no longer barring DACA recipients from accessing health insurance through an Exchange or a BHP will enable previously uninsured DACA recipients to enroll in affordable and quality health insurance coverage and ultimately improve health outcomes for communities that have faced historical inequities.

We note that, in line with 26 U.S.C. 36B(c)(1)(B) and 42 U.S.C. 18071(b)(2), under the policy outlined in this rule, DACA recipients would generally be considered eligible for APTC and CSRs even if their household income is below 100 percent of the FPL, as individuals who are lawfully present but are ineligible for Medicaid due to their ''alien status.'' Under the enhanced subsidies made available through the American Rescue Plan Act and the Inflation Reduction Act, DACA recipients with household incomes up to 150 percent of the FPL would be eligible for zero-dollar premium silver plans, if otherwise eligible for APTC.[58] While we are not finalizing a definition of ''lawfully present'' for purposes of eligibility for Medicaid or CHIP under the CHIPRA 214 option at this time, we believe that most DACA recipients who may have been eligible for Medicaid or CHIP under the CHIPRA 214 option under our proposed rule will be eligible to enroll in a QHP with generous APTC and CSRs, or in the BHP, under this final rule. Because of this, we believe that this final rule will still decrease rates of uninsurance among DACA recipients.

Finally, we appreciate commenters' illustrations of how this rule may not only increase access to insurance coverage for DACA recipients and other individuals who would be newly considered lawfully present as a result of the final rule, hereinafter ''impacted noncitizens,'' but also for their children. We agree with commenters who noted that addressing the needs of DACA recipients and their families' need for access to affordable health insurance coverage through an Exchange or a BHP is in line with the goals of the ACA.

[58] See Section 9661 of the American Rescue Plan Act of 2021, Public Law 117–2 (March 11, 2021), and Section 12001 of the Inflation Reduction Act of 2022, Public Law 117–169 (August 16, 2022), which established enhanced premium tax credits for Exchange coverage through 2025.

Comment: Some commenters noted the negative impacts of the COVID–19 pandemic on DACA recipients. Commenters provided a range of estimates of the number of DACA recipients working as essential employees during the COVID–19 pandemic. One nonprofit organization cited a study by the Center for American Progress that found that more than three quarters of DACA recipients in the workforce worked in ''essential'' occupations during the public health emergency, and other commenters cited estimates ranging from around 200,000 to 343,000 workers at the height of the pandemic. Commenters further cited a range of estimates of the number of DACA recipients who worked in health care occupations during the pandemic, ranging from 30,000 to about 45,000. As essential workers, these DACA recipients often put their own and their families' health at risk.

One commenter noted that the COVID–19 pandemic exacerbated deep-seated disparities in health equity, particularly among communities of color, and that systemic barriers have amplified high uninsurance rates and the frequency of postponed medical care among communities of color. Commenters noted that DACA recipients are much more likely than the general population to have coverage through an employer or union. Commenters stated that of those with health insurance, 80 percent of DACA recipients had coverage through an employer or union, as compared to about 50 percent of the general population. As a result, DACA recipients' access to health insurance coverage was very directly tied to their employment status, and losing their job likely meant losing access to health insurance coverage. Commenters cited a 2021 survey of DACA recipients that found that nearly one in five had lost employer health coverage during the COVID–19 pandemic and noted that DACA recipients who lose employer coverage had very limited alternative options for obtaining health insurance coverage.

Response: We agree with the commenters' perspectives on the negative impacts that the COVID–19 pandemic had on DACA recipients, especially as essential workers. Additionally, we recognize the burden that DACA recipients faced when they lost employer-sponsored coverage in the midst of a pandemic. We believe that this rule's change to no longer exclude DACA recipients from the definition of ''lawfully present'' will enable this population to access health insurance through an Exchange or a BHP, options

that were previously unavailable. We believe that by updating the eligibility requirements for DACA recipients to enroll in a QHP through an Exchange or a BHP, some of the deep-seated disparities in health equity that commenters referenced may be reduced.

Comment: Several commenters encouraged CMS to invest in outreach and to create and maintain partnerships with assisters, who are certified and trusted community partners who provide free and impartial enrollment assistance to consumers (hereinafter ''assisters''), and community-based organizations to spread awareness about DACA recipients' access to care. One commenter suggested considering the geographic density of DACA recipients when determining the allocation of marketing resources in media markets.

Some commenters also urged CMS to provide adequate funding to community-based organizations so that they are able to contribute to the important work required to implement this rule. Commenters articulated how community-based organizations have worked for years to build relationships with DACA recipients and urged CMS to leverage these organizations' expertise when implementing this rule to ensure the maximum benefit for consumers. Commenters noted the importance of multilingual materials when conducting outreach and education related to this rule.

A few commenters further noted that targeted outreach is necessary to address DACA recipients' fears that accessing health care coverage and services could negatively affect their immigration status, given persistent fears related to the DHS 2019 public charge rule (84 FR 41292).[59]

Response: We are committed to conducting outreach and education to reach individuals impacted by this rule. We plan to analyze the population impacted by this rule and build strategies and tactics to educate them that they may be eligible for health insurance through an Exchange or a BHP. As noted previously in this final rule, we also plan to leverage existing channels for outreach and education utilized during the individual market Exchange Open Enrollment Period, including multilingual channels, to ensure that impacted noncitizens are aware that they may be newly eligible for coverage. We agree with commenters' view that to ensure maximization of DACA recipients' ability to access coverage, we should partner with assisters and community-based organizations.

Comment: Many commenters detailed how increasing access to health insurance coverage has positive impacts on individual and population health. Many commenters stated that they expected the provisions in the proposed rule would result in increased health and well-being for DACA recipients and other impacted noncitizens and would provide more equitable access to sources of health care on an individual level. Commenters noted that individuals who are insured are more likely to have a regular source of care, to receive timely and appropriate preventive care, and are less likely to experience certain health complications than those who are uninsured. A medical society noted that when uninsurance rates increase, worse health outcomes result at a population level, including reduced prescription adherence and increased prevalence of obesity and malnutrition, especially for pregnant or breastfeeding women, infants, or children. Similarly, one commenter noted that in States where health benefits are extended to all individuals regardless of immigration status, there are lower rates of foregoing medical, dental, and preventive care at a population level. One commenter noted that expanding access to health insurance coverage is particularly critical as the DACA population ages and faces new and different health challenges.

Response: We appreciate commenters' recognition of the many ways that this rule has the potential to improve health and decrease mortality for impacted noncitizens. While we are unable to quantify these potential impacts, we are hopeful that the coverage gains facilitated by this rule will positively impact the health and wellbeing of DACA recipients and other impacted noncitizens who will be newly considered ''lawfully present'' as a result of this rule's changes to the ''lawfully present'' definition for the purposes of eligibility for health insurance through an Exchange or a BHP.

Comment: Some commenters provided detailed analysis of the ways in which increased access to health insurance can contribute to individuals' financial stability. One commenter cited a study that found that when an uninsured individual becomes hospitalized, negative financial outcomes, including reduced access to credit and higher risk of filing for bankruptcy, persist for the following four years. Another commenter mentioned that without consistent access to care, costs of treatment are higher not only for the individual, but for society as a whole.

Some commenters expected that increased access to health insurance would help reduce medical debt for DACA recipients. Commenters noted that individuals with medical debt often have to cut spending on basic necessities. Because medical debt can threaten individuals' food and housing security, it has detrimental effects on social determinants of health associated with adverse health outcomes. Some commenters also noted that medical debt can have significant financial consequences, including having bills going to collections, lower credit scores, bankruptcy, home foreclosures, or evictions. Commenters cited a 2022 survey in which 71 percent of DACA recipient respondents reported being unable to pay medical bills or expenses in the past. Commenters further noted that the financial stability provided by the provisions in this rule may enable DACA recipients to seek education and employment opportunities they may not have otherwise been able to access.

Response: We appreciate commenters' analysis of the many ways that this rule has the potential to improve economic stability for impacted noncitizens. While we are unable to quantify these potential impacts, we are hopeful that the coverage gains facilitated by this rule, via the Exchange or a BHP, will positively impact the financial stability of DACA recipients, other impacted noncitizens and their families.

Comment: Several commenters further outlined how increasing access to health insurance coverage, or extending it to those who are uninsured, has positive impacts not only on individual financial well-being, but also on community-level economic health. One commenter stated that increasing access to affordable health coverage is expected to benefit communities, workforce, education systems, arts and culture, and many sectors of the economy. One commenter noted agreement with CMS' discussion in the proposed rule preamble of the positive impacts that the rule is expected to have on the workforce, given that insured individuals miss 77 percent fewer workdays than those who are uninsured. One nonprofit organization cited studies illustrating that access to affordable coverage allows individuals to spend more disposable income on essential goods and services, which increases tax revenues and produces a ''multiplier effect'' where increased business revenues benefit both suppliers

[59] In 2022, DHS issued the rule ''Public Charge Ground of Inadmissibility'' (87 FR 55472), which is applicable to applications for adjustment of status postmarked or electronically filed on or after December 23, 2022; DHS' 2019 Public Charge final rule (84 FR 41292) is no longer applicable.

and employees. This study found that the ''multiplier effect'' of Medicaid expansion was as much as 1.5 to 2 times as great as the amount of new Federal Medicaid spending. Similarly, one commenter cited a study finding that every $100,000 of additional Medicaid spending resulted in 3.8 net job-years (that is, one job that lasts one year), demonstrating that expanding health benefits creates jobs. One nonprofit organization stated that expanding eligibility for DACA recipients will continue to pay dividends for years to come at the community and national level.

Some members of the Congress, in their public comment, noted that a large portion of DACA recipients are medical and health professional students who will play a critical role in the U.S. health care system in the future, and they deserve the same access to health care. They noted that DACA recipients' access to health care during their education is vital to growing the health care workforce.

Response: We appreciate commenters' analysis of the many ways that this rule has the potential to benefit the economies and other social systems and institutions in impacted noncitizens' communities. We also appreciate the point that ensuring that DACA recipients who are medical and health professional students have access to health insurance coverage during their training is crucial to growing the health care workforce, which benefits communities' health and helps drive down health care costs. While we are unable to quantify these potential benefits, we believe it is reasonable to predict that the improvements in access to health insurance coverage through Exchanges and the BHP that will be facilitated by this rule would produce similar positive impacts to those we have seen with other expansion efforts.

Comment: Many commenters noted that excluding DACA recipients from definitions of ''lawfully present'' used to determine eligibility for CMS programs contributed to health disparities. Commenters further noted that because more than 90 percent of DACA recipients are Latino, it is likely that the current exclusion of DACA recipients from CMS definitions of ''lawfully present'' has contributed to disproportionately high uninsurance rates among Latino individuals. Specifically, the commenter cited that Latinos have an uninsurance rate of 18 percent, as compared to 8.4 percent for non-Hispanic whites. Commenters similarly noted persistent disparities in insurance rates between immigrants as compared to U.S. citizens. Commenters noted that while the ACA resulted in larger reductions in the uninsurance rate among Latinos than among any other racial or ethnic population, that DACA recipients have been excluded from these gains. Commenters stated that they expected that this rule would help mitigate these disparities and increase health equity and economic outcomes in the United States. One commenter noted that health disparities related to lack of insurance coverage were highlighted by recent infectious disease outbreaks including COVID–19 and Mpox. In the context of these outbreaks, lack of insurance often resulted in delays in seeking care, which can exacerbate outbreaks and hobble response efforts.

Response: We appreciate commenters' assessments of the ways the current exclusion of DACA recipients from definitions of ''lawfully present'' can contribute to health disparities, particularly for and within the Latino population. Studies have long demonstrated the impact of health coverage on health outcomes,[60] [61] [62] [63] [64] and the negative health consequences of even relatively short gaps in coverage.[65] Moreover, DACA recipients, with an uninsurance rate of 27 percent, are more than three times more likely to be uninsured than the general U.S. population, which had a national uninsured rate of 7.7 percent.[66] [67]

By including DACA recipients in the definition of ''lawfully present'' for the purposes of eligibility for health insurance through an Exchange or a BHP, we anticipate DACA recipients will have improved access to coverage through a QHP or BHP which should, in turn, improve consumers' ability to access a range of important health services, thereby improving health outcomes and reducing health disparities for this population.

Comment: Some commenters noted that while DACA recipients who are uninsured face barriers to accessing care that are similar to other uninsured individuals, DACA recipients face additional barriers due to concern that using health care services could negatively affect their own or their family's immigration status. Commenters cited a survey conducted in 2022 that found that nearly half (48 percent) of DACA recipient respondents reported delaying getting needed medical care because of their immigration status. One commenter stated that over 20 percent of DACA recipients were concerned that using health care services would negatively affect their or their family members' immigration status.

One commenter cited polling conducted in 2018 that found one in four Latino voters surveyed (24 percent) had a close family member or friend delay or avoid health care because of fear related to immigration policies, and one in five (19 percent) stated the same about reproductive health care.

Some commenters urged CMS to clarify in this rule and in outreach and education materials that accessing the programs discussed in this rule does not make someone a public charge.

Response: We recognize that some previous governmental policies may have caused people to not seek certain benefits. We note, however, that the DHS public charge policy has now been significantly changed with the publication of the 2022 Public Charge final rule (87 FR 55472). DHS' public charge policy from 2019 (84 FR 41292) has been vacated and is no longer in effect. When developing outreach and education materials related to this rule, we are committed to including content making it clear to DACA recipients and other noncitizens that accessing coverage through an Exchange or a BHP will not impact their grant of DACA, immigration status, or their future ability to adjust their status. Enrolling in

[60] Institute of Medicine (U.S.) Committee on Health Insurance Status and Its Consequences. (2009). *America's uninsured crisis: Consequences for health and health care. https://www.ncbi.nlm.nih.gov/books/NBK214966/* National Academies Press.

[61] Barker AR, Li L. *The cumulative impact of health insurance on health status.* Health Serv Res. 2020 Oct;55 Suppl 2(Suppl 2):815–822. doi: 10.1111/1475–6773.13325.

[62] American Hospital Association. *Report: The Importance of Health Coverage. https://www.aha.org/guidesreports/report-importance-health-coverage#:~:text=Impact%20of%20Coverage&text=Studies%20confirm%20that%20coverage%20improves,on%20individuals%2C%20families%20and%20communities.*

[63] Woolhandler S, Himmelstein, D. 2017, Sept. *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly*? Annals of Internal Medicine. *https://doi.org/10.7326/M17-1403.*

[64] Kaiser Family Foundation. *Key Facts About the Uninsured Population.* (2023). *https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.*

[65] Gabrielle H, Amber G, Dmitry T. 2022; 25:3, 399–406. Short- and Long-Term Health Consequences of Gaps in Health Insurance Coverage among Young Adults. Population Health Management. doi: 10.1089/pop.2021.0211.

[66] National Immigration Law Center. *Tracking DACA Recipients' Access to Health Care* (2023). *https://www.nilc.org/wp-content/uploads/2023/05/NILC_DACA-Report_2023.pdf.*

[67] U.S. Department of Health and Human Services. *New HHS Report Shows National Uninsured Rate Reached All-Time Low in 2023 After Record-Breaking ACA Enrollment Period* (2023). *https://www.hhs.gov/about/news/2023/08/03/new-hhs-report-shows-national-uninsured-rate-reached-all-time-low-2023-after-record-breaking-aca-enrollment-period.html.*

health insurance through the Exchanges, receipt of APTC or PTC, and CSRs are not considered in a public charge determination in any circumstance.

Comment: One commenter noted that the provisions in this rule will expand access to care for those DACA recipients who may be victims of child abuse, domestic violence, sexual assault, and human trafficking. The commenter noted that DACA recipients who are survivors of family violence and sexual assault may qualify for certain types of immigration relief as survivors of crime and abuse, and that ensuring that these individuals have access to health care providers who can screen for such abuse is critical for both their health and wellbeing and for ensuring that they have access to appropriate immigration relief.

Response: We appreciate this commenter's illustration of how access to health insurance coverage through an Exchange or a BHP may help ensure that DACA recipients and other impacted noncitizens who may have been victims of child abuse, domestic violence, sexual assault, and human trafficking are able to access the immigration benefits for which they may be eligible. We agree that this is yet another illustration supporting the goal of ensuring access to health insurance coverage and health care through an Exchange or a BHP for the underserved and vulnerable noncitizen populations.

Comment: One commenter noted that despite recent expansions of health insurance coverage, low-income Americans still have poor life expectancy outcomes.

Response: We do not agree that disparities in life expectancy rates between low-income and high-income Americans demonstrate that increasing access to health insurance coverage is not a worthwhile endeavor, or that it does not improve health outcomes for low-income populations. On the contrary, as other commenters have pointed out, increasing access to health insurance coverage is associated with improved health outcomes at both the individual and population levels.

Preventive Care

Comment: Many commenters stated that allowing DACA recipients to access QHPs, Medicaid, and CHIP would improve access to preventive care. Commenters noted that QHPs are required to cover certain essential health benefits, which include preventive services such as maternity and newborn care, contraception, and certain cancer screenings. Commenters cited studies finding that insured individuals are more likely to access preventive care for major health conditions and chronic diseases, including cancer.

One commenter noted that while DACA recipients may be able to access certain safety-net health care providers if they do not have insurance, expanding access to comprehensive health insurance coverage will result in better individual and community health outcomes. Commenters further noted that many of the safety net providers that uninsured DACA recipients may rely on often have limited resources and capacity.

Response: We appreciate commenters' detailed analysis of the many ways in which this rule will, by increasing access to health insurance through an Exchange or a BHP, improve impacted noncitizens' ability to access critical preventive care. We agree with commenters' perspectives that having health insurance coverage should improve consumers' ability to access a range of important health services and, in turn, improve health outcomes and reduce health disparities for this population. While we acknowledge that some of the studies that commenters cited referred specifically to the benefits of Medicaid coverage, many of the studies cited pertained to the benefits of QHP coverage or health insurance coverage more generally, and we expect that this rule will result in increased access to preventive care for DACA recipients and other impacted noncitizens through Exchanges and the BHP. Comments pertaining to the potential health benefits of Medicaid and CHIP coverage specifically will be addressed in future rulemaking.

We also appreciate commenters' illustration of how lack of access to preventive care can increase strain on the health care system. While safety net providers are an important source of care for uninsured individuals, helping more people access coverage that enables them to utilize a fuller range of providers both improves health outcomes and reduces the strain on safety-net provider resources.

Comment: Some commenters stated that the provisions in this rule will expand access to sexual and reproductive health care and women's health care services for DACA recipients. Commenters noted that the need for such services is high among DACA recipients, 53 percent of whom are women and the majority of whom are of reproductive age. Commenters detailed gaps in access to sexual and reproductive health care for noncitizens; one commenter cited a study that found that one in five noncitizens had not seen sexual and reproductive health services provider in the past year and that 30 percent had not had a Papanicolaou (Pap) test in the past 3 years. One commenter noted that uninsured pregnant individuals receive fewer prenatal care visits and have increased rates of harmful maternal and fetal outcomes.

A few commenters noted that women who are immigrants experience higher breast and cervical cancer incidence and mortality rates and lower screening rates compared to U.S.-born women, and that lack of health insurance coverage is associated with more advanced-stage cancer diagnoses. Commenters stated that they expected this rule would help mitigate existing racial and ethnic disparities related to sexual and reproductive health care outcomes.

A few commenters further noted that QHPs are required to cover a range of sexual and reproductive health care services without cost-sharing, including well-woman visits, contraceptive services, and breast and cervical cancer screenings.

A few commenters noted the importance of expanding access to sexual and reproductive health care services in light of the Supreme Court's ruling in *Dobbs* v. *Jackson Women's Health Organization,* 597 U.S. 215 (2022), which overturned *Roe* v. *Wade, 410 U.S. 113 (1973)* and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey 505 U.S. 833 (1992).* One commenter noted that in 2022, nearly 40 percent of the Latina women who lived in States that were likely to ban abortion were born outside of the United States, and that this group likely includes many DACA recipients.

Response: We acknowledge commenters' notes on the importance of expanding access to sexual and reproductive health care services, and we agree that it is critically important to close gaps in access to insurance coverage and care and to drive down existing disparities in sexual and reproductive health and improve maternal and child health outcomes.

We agree with commenters' perspectives that insurance coverage provides enrollees with access to a range of reproductive health services to the benefit of their own and their families' health and financial security. We believe this rule will result in increased access to sexual and reproductive health care for previously uninsured DACA recipients and other impacted noncitizens by increasing coverage through Exchanges and the BHP.

Comment: Some commenters noted that the rule would meaningfully expand access to mental and behavioral

health care services for DACA recipients. Commenters stated that the need for mental health care services is high among DACA recipients, who may experience feelings of depression, anxiety, and fear related to the future of their immigration status. Commenters cited a 2022 survey in which 48 percent of DACA recipient respondents indicated they were not receiving any health care services for their mental or behavioral health issues. Commenters stated that expanding access to health insurance coverage for DACA recipients would likely improve DACA recipients' mental and behavioral health outcomes. One nonprofit organization noted that access to behavioral health services is protective against intimate partner violence, child abuse and neglect, and suicidality. Another commenter mentioned that a 2022 survey found that half of DACA recipients who were uninsured wanted to access mental health services but were not doing so because of the associated cost.

Response: We appreciate commenters' description of the many ways in which allowing DACA recipients and other impacted noncitizens to access health insurance is expected to promote access to mental and behavioral health care services and to improve health care outcomes. We expect that this rule will result in increased access to mental and behavioral health services for DACA recipients and other impacted noncitizens by increasing coverage through Exchanges and the BHP.

Emergency Care

Comment: Several commenters suggested that the final rule will help shift health care visits made by noncitizens from emergency department (ED) care to preventive care. Commenters noted that uninsured individuals may delay or avoid seeking vital care, which can result in needing to utilize a hospital ED. Commenters further noted that uninsured individuals are more likely to seek care both non-emergency care and emergency care in a hospital ED, where they often receive more costly care, fewer services, and have higher mortality rates compared to individuals with insurance or individuals who routinely seek preventive care. Additionally, commenters noted that routine ED visits have the potential to divert resources from patients with more urgent health needs. A few commenters noted that visits to the ED by uninsured individuals are often more costly than preventive care visits and institutions often absorb the cost for uninsured individuals. Commenters suggested that by providing DACA recipients with more health insurance options, ED costs can shift from institutions to insured individuals, which can ultimately reduce costs to taxpayers. Commenters expressed their belief that expanding coverage to DACA recipients would promote a more efficient health care system. Commenters further suggested that the proposed rule would help decrease the amount of uncompensated care that EDs provide and would help maintain the emergency care safety net by mitigating existing financial risks. One commenter noted that emergency care providers face unique costs related to staffing EDs 24 hours per day, 7 days per week. The commenter further stated that by lessening barriers to enrollment in health insurance programs, uncompensated care costs could decline, leading to better financial sustainability for emergency care safety net providers.

Response: We appreciate commenters' analysis of the many ways in which this rule will shift the opportunity for impacted noncitizens to seek health care from EDs to more comprehensive health care that includes preventive care. Uninsured populations are more likely than those who are insured to postpone seeking care due to cost, which can increase the complexity and cost of care that they eventually require.[68] We agree with commenters' analysis that emergency care tends to be more costly and complex and that this rule could help decrease the amount of uncompensated care that EDs provide which could lead to better financial sustainability for emergency care safety net providers.[69] [70]

We agree with commenters who pointed out that uninsured individuals might delay seeking vital care, which can result in ED use. We are hopeful that expanding access to QHPs and the BHP to previously uninsured DACA recipients and other impacted noncitizens may similarly drive down emergency department use. As noted by commenters, we believe this rule could promote a lower cost and more efficient health care system by reducing high-cost emergency care, increasing lower-cost preventive care, and ultimately decreasing the number of DACA recipients and other impacted noncitizens who qualify only for the treatment of an emergency medical condition under Medicaid due to their immigration status, rather than more comprehensive coverage that may be available through the Exchange or a BHP.

After thorough consideration of public comments, we are finalizing the inclusion of DACA recipients in the definition of ''lawfully present'' at 45 CFR 155.20(9) as proposed.

Out of Scope

Comment: Several commenters stated general opposition to the current administration for its handling of both immigration and health care policy and reform, but without referring to the proposed rule at all. Some commenters stated direct opposition to specific political parties, and some stated they believe that this rule is a political maneuver to garner votes.

Response: We appreciate these comments but note that these comments are out of scope as related to the provisions laid out in this rule and no response is required.

Comment: Some commenters shared perspectives on DACA recipients' contributions to the workforce and economy and requests to create pathways for citizenship.

Response: We appreciate these comments. This rule does not address the DACA policy itself, only the eligibility of DACA recipients for coverage under an Exchange or BHP. While these comments are related to the DACA policy broadly, they do not seek to support or change specific provisions set forth in the proposed rule and no response is required.

Comment: Multiple commenters shared the challenges they faced seeking affordable health insurance, including as small business owners or low-income families, without referring to the substance of this rulemaking. Many commenters proposed other changes to the United States health care system or to other benefit programs such as the Supplemental Nutrition Assistance Program (SNAP).

Response: We appreciate these comments and note commenter concerns and requests, but these topics are out of scope for this final rule.

Comment: One public health system provider stated that they supported the rule's measures to enhance consumer protections, such as establishing an appeals process and extending the grace period for premium payments,

[68] Kaiser Family Foundation. *Key Facts About the Uninsured Population* (2023) *https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.*

[69] United Health Group. *18 Million Avoidable Hospital Emergency Department Visits Add $32 Billion in Costs to the Health Care System Each Year.* (2019) *https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2019/UHG-Avoidable-ED-Visits.pdf.*

[70] Center on Budget and Policy Priorities. *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect.* (2018) *https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage.*

safeguarding the rights of consumers who face unforeseen circumstances.

Response: We appreciate this comment but there were no specific proposals about an appeals process, grace periods for premium payments, or rights of consumers in unforeseen circumstances, so the comment is outside the scope of this rulemaking and no response is required.

2. Other Changes to the ''Lawfully Present'' Definition

In addition to including DACA recipients in the definition of ''lawfully present'' for the purposes of eligibility to enroll in a QHP through an Exchange and a BHP, we proposed several other clarifications and technical adjustments to the definition proposed at 45 CFR 155.20, as compared to the definition currently at 45 CFR 152.2.

First, in paragraph (1) of the proposed definition of ''lawfully present'' at 45 CFR 155.20, we proposed some revisions as compared to paragraph (1) of the definition currently at 45 CFR 152.2. In the current regulations at 45 CFR 152.2, paragraph (1) provides that qualified aliens, as defined in the PRWORA at 8 U.S.C. 1641, are lawfully present. Throughout the proposed definition at 45 CFR 155.20, we proposed a nomenclature change to use the term ''noncitizen'' instead of ''alien'' when appropriate to align with more modern terminology. Additionally, in paragraph (1) of the proposed definition at 45 CFR 155.20, we proposed to cite the definition of ''qualified noncitizen'' at 42 CFR 435.4, rather than the definition of ''qualified alien'' in PRWORA. The definition of ''qualified noncitizen'' currently at 42 CFR 435.4 includes the term ''qualified alien'' as defined at 8 U.S.C. 1641(b) and (c).

We noted in the preamble of the proposed rule that for purposes of Exchange coverage and APTC eligibility, citizens of the Freely Associated States (FAS) living in the United States under the Compacts of Free Association (COFA), commonly referred to as COFA migrants, were not considered qualified noncitizens because the statutory provision at 8 U.S.C. 1641(b)(8) making such individuals qualified noncitizens only applied with respect to the Medicaid program (88 FR 25317). Instead, COFA migrants were considered lawfully present under a different category, 45 CFR 152.2(2), that applied to noncitizens in a valid nonimmigrant status. After the proposed rule was issued, the Congress amended 8 U.S.C. 1641(b)(8) to eliminate the language restricting COFA migrants as qualified noncitizens only for purposes of the Medicaid program. The CAA, 2024,[71] effective March 9, 2024, recognizes that COFA migrants would be qualified noncitizens, and, therefore, lawfully present for the purposes of our regulation as qualified noncitizens at 45 CFR 152.2(1). COFA migrants will be considered lawfully present based on both sections 155.20(1) and 155.20(2) of this final rule.

In section II.D.2 of the proposed rule, we discussed whether to provide a more detailed definition of ''qualified noncitizen'' at 42 CFR 435.4. Pending such comments, and to ensure alignment across our programs, we proposed that the Exchange regulations at 45 CFR 155.20 define ''qualified noncitizen'' by including a citation to the Medicaid regulations at 42 CFR 435.4, rather than to PRWORA.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Commenters supported this proposal, noting that it aligned with CMS' effort to replace instances of ''alien'' in its current regulatory definition of ''lawfully present'' with ''noncitizen.''

Response: We appreciate commenters' support for this proposal and note that no comments opposed this proposal. We understand that the term ''alien'' is outdated and has been ascribed with a negative, dehumanizing connotation, and we agree with commenters that the proposal to cross-reference the definition of ''qualified noncitizen'' at 42 CFR 435.4 aligns with our efforts to replace the term ''alien'' with ''noncitizen'' in our regulations. This is also consistent with DHS' replacement of the term ''alien'' with ''noncitizen'' wherever possible. Given that we are finalizing a more detailed definition of ''qualified noncitizen'' at 42 CFR 435.4, CMS also believes that providing this cross-reference helps to promote transparency and maintain consistency across programs.

Comment: One commenter noted that they supported cross-referencing to DHS regulations to the extent that it clarifies definitions and verifications but did not support cross-referencing if there is potential that the cross-reference changes the HHS definition of ''lawfully present.'' The commenter stated that it should be made clear in any phrasing surrounding the cross-reference that DHS defines and regulates immigration statuses, which HHS uses and references, but that ''lawful presence'' for the purpose of HHS regulation is determined by HHS, not DHS.

Response: We generally agree with the commenter. We wish to clarify that we are not cross-referencing DHS' definition of ''lawfully present'' at 8 CFR 1.3 in the final rule. After considering public comments, we are adopting our own regulatory definition of ''lawfully present'' for purposes of eligibility to enroll in a QHP through an Exchange and the BHP.

After consideration of public comments, we are finalizing 45 CFR 155.20(1), which cross-references the definition of ''qualified noncitizen'' at 42 CFR 435.4, as proposed.

In the current definition of ''lawfully present'' at 45 CFR 152.2, we include in paragraph (2), a noncitizen in a nonimmigrant status who has not violated the terms of the status under which they were admitted or the status to which they have changed since their admission. In the proposed rule, we proposed, in paragraph (2) of 45 CFR 155.20, to modify this language such that a noncitizen in a valid nonimmigrant status would be deemed lawfully present. We noted that determining whether an individual has violated the terms of their status is a responsibility of DHS, not CMS or States. Accordingly, as proposed, the change would ensure coverage of noncitizens in a nonimmigrant status that has not expired, as long as DHS has not determined those noncitizens have violated their status.

Under the proposed change, Exchanges and BHPs would continue to submit requests to verify an applicant's nonimmigrant status through a data match with DHS via the Hub using DHS' Systematic Alien Verification for Entitlements (SAVE) system. If SAVE indicated that the applicant did not have an eligible immigration status, the applicant would not be eligible for coverage. This modification will simplify the eligibility verification process, so that a nonimmigrant's immigration status can be verified solely using the existing SAVE process, which can often provide verification in real time when an application is submitted and reduce the number of individuals for whom an Exchange or a BHP may need to request additional information. We note that this change will promote simplicity, consistency in program administration, and program integrity given the reliance on a Federal trusted data source, while eliminating the agency's responsibility to understand and evaluate the complexities of the various immigration statuses and regulations.

We received public comments on this proposal. The following is a summary of

[71] Div G, Title II, sec. 209(f), Public Law 118–42 (March 9, 2024).

the comments we received and our responses.

Comment: We received several comments in support of this change, with commenters noting that the existing language regarding whether a nonimmigrant has violated the terms of their status is confusing and that the changes proposed to this regulation will promote efficiency and consistency in eligibility determinations and verification processes. Commenters further noted that this would clarify that an individual's nonimmigrant status can be verified through DHS SAVE, streamlining eligibility verification processes and promoting program administration and integrity through alignment with DHS processes.

Response: We appreciate commenters' perspectives on this proposal and agree that the wording changes will promote more efficient and consistent eligibility determinations.

Comment: One commenter noted that CMS' proposal to adjust the language regarding nonimmigrant visa-holders to remove language relating to nonimmigrants not having violated the terms of their status would streamline eligibility determinations and verifications for COFA migrants who are otherwise eligible for Exchange coverage. Commenters stated that they supported proposed changes that would enable migrants under the COFA who are lawfully present as ''nonimmigrants'' to enroll in Exchange coverage.

Response: We appreciate commenters' feedback on how this change may streamline immigration status verifications and benefit eligibility determinations for COFA migrants, who are and will continue to be considered ''lawfully present'' for purposes of health insurance coverage through an Exchange or a BHP as addressed in this rule, as COFA migrants are nonimmigrants under current regulations at 42 CFR 152.2(2), and are both qualified noncitizens and nonimmigrants under the provisions finalized in this rule at 45 CFR 155.20(1) and (2), respectively. We agree that the change to remove language regarding whether a nonimmigrant has violated the terms of their status will streamline the eligibility and enrollment process for COFA migrants and other nonimmigrants, increasing access to health insurance through an Exchange or a BHP.

We wish to further clarify that under our existing regulations, COFA migrants are considered ''lawfully present'' by virtue of their nonimmigrant status and are therefore currently eligible to enroll in a QHP or BHP. While the changes in this rule may provide additional clarity for COFA migrants and streamline the ability of CMS to verify their immigration status and determine benefit eligibility, nothing in this rule changes whether COFA migrants are considered eligible for the insurance affordability programs addressed in this rule.

After consideration of public comments, we are finalizing 45 CFR 155.20(2), pertaining to noncitizens in a valid nonimmigrant status, as proposed.

We proposed a minor technical change in paragraph (4) of the proposed definition of ''lawfully present'' at 45 CFR 155.20, as compared to the definition of ''lawfully present'' currently in paragraph (4)(i) of 45 CFR 152.2, to refer to individuals who are ''granted,'' rather than ''currently in'' temporary resident status, as this language more accurately refers to how this status is conferred. We similarly proposed a minor technical change in paragraph (5) of the proposed definition of ''lawfully present'' at 45 CFR 155.20, as compared to the definition of ''lawfully present'' currently in paragraph (4)(ii) of 45 CFR 152.2, to refer to individuals who are ''granted,'' rather than ''currently under'' Temporary Protected Status (TPS), as this language more accurately refers to how DHS confers this temporary status upon individuals.

We did not receive public comments on these provisions, and therefore, we are finalizing 45 CFR 155.20(4) and 45 CFR 155.20(5) as proposed.

Paragraph (4)(iii) of the current definition at 45 CFR 152.2 provides that noncitizens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24) are considered lawfully present. In paragraph (6) of the proposed definition of ''lawfully present'' at 45 CFR 155.20, we proposed to cross reference 8 CFR 274a.12(c) in its entirety to simplify the regulatory definition and verification process. We proposed this modification to the regulatory text to include all noncitizens who have been granted employment authorization under 8 CFR 274a.12(c), as USCIS has authorized these noncitizens to accept employment in the United States. USCIS may grant noncitizens employment authorization under this regulatory provision based on the noncitizen's underlying immigration status or category, an application for such status or other immigration relief, or other basis. Almost all noncitizens granted employment authorization under 8 CFR 274a.12(c) are already considered lawfully present under existing regulations, either in paragraph (4)(iii) of the definition at 45 CFR 152.2 or within 45 CFR 152.2 more broadly. We noted in the proposed rule that this modification would add two minor categories to the proposed definition: noncitizens granted employment authorization under 8 CFR 274a.12(c)(35) and (36). Individuals covered under 8 CFR 274a.12(c)(35) and (36) are noncitizens with certain approved employment-based immigrant visa petitions who are transitioning from an employment-based nonimmigrant status to lawful permanent resident (LPR) status and their spouses and children, for whom immigrant visa numbers are not yet available. These categories act as a ''bridge'' to allow these noncitizens to maintain employment authorization after their nonimmigrant status expires while they await an immigrant visa to become available. Because these individuals were previously eligible for insurance programs by virtue of their nonimmigrant status, the proposed rule would simply allow their eligibility to continue until they are eligible to apply to adjust to LPR status.

This change to consider ''lawfully present'' all individuals with employment authorization under 8 CFR 274a.12(c) is beneficial because Exchanges and BHPs can verify that an individual has been granted employment authorization under 8 CFR 274a.12(c) in real time through SAVE, at the initial step of the verification process. Thus, the proposed revision to the definition will help to streamline and expedite verification of status for individuals who have been granted employment authorization under this regulatory provision.

Further, to reduce duplication and confusion, we proposed to remove the clause currently in paragraph (4)(ii) of the definition at 45 CFR 152.2, referring to ''pending applicants for TPS who have been granted employment authorization,'' as these individuals would be covered under proposed paragraph (6) of the definition of ''lawfully present'' at 45 CFR 155.20.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: We received several comments in support of this change, with commenters agreeing that all individuals granted employment authorization under 8 CFR 274a.12(c) should be considered lawfully present, and that this change should simplify verification of lawful presence for impacted consumers.

Response: We appreciate commenters' feedback and agree that this

modification will simplify the agency's benefit eligibility determinations and verification of lawful presence for individuals granted employment authorization.

Comment: One commenter encouraged CMS to consider all individuals who are eligible to apply for employment authorization as ''lawfully present'' for the purposes of the programs addressed in this rule. The commenter suggested that a noncitizen's lawful presence should not depend on whether they have been granted employment authorization, as eligibility for employment authorization should signify lawful presence regardless of whether employment authorization has actually been granted. The commenter noted that considering individuals who are eligible for employment authorization would reduce administrative burden on eligibility determination agencies by no longer requiring agencies to determine whether an individual had applied for employment authorization and how long their application had been pending. The commenter noted that the current requirement to obtain employment authorization imposes burdens on individuals who may not otherwise need employment authorization, such as children and individuals with disabilities, who may also face accessibility barriers when applying for employment authorization. The commenter also pointed out that low-income noncitizens may not be able to afford the fees required to apply for and obtain employment authorization, and that the waiting periods required before certain noncitizens can obtain employment authorization result in coverage and care delays.

Response: We believe that the authority to determine whether an individual is eligible to apply for employment authorization rests with DHS, not CMS, Exchanges, or BHP agencies. We do not believe that it is appropriate or possible for Exchanges or BHP agencies to evaluate whether someone may be eligible to apply for employment authorization. We outline elsewhere in the rule why it is not appropriate for CMS, Exchanges, or BHP agencies to evaluate whether a nonimmigrant has violated the terms of their status, and that this is within DHS' purview. We believe that evaluating an individual's eligibility to apply for employment authorization is similarly within DHS' purview.

Additionally, we do not agree that including individuals who are eligible to apply for employment authorization, but have not been granted employment authorization, in our definitions of ''lawfully present'' would reduce administrative burden. Requestors are not able to verify through SAVE whether an individual is eligible to apply for employment authorization in the same way that they can verify that an individual has been granted employment authorization through the SAVE system, which can be provided as a real-time step 1 response. Therefore, verifying that an individual is eligible to apply for employment authorization would require CMS, Exchanges, and BHP agencies to develop complex manual processes to evaluate eligibility on this basis.

Furthermore, while having employment authorization can help facilitate verification, as we discussed above, virtually all noncitizens eligible for employment authorization under 8 CFR 274a.12(c) are already lawfully present because of their underlying immigration category (*e.g.,* deferred action), whether or not they obtain employment authorization. That underlying category can be determined for purposes of eligibility for the CMS programs, without the additional significant complexity of further trying to determine whether the noncitizen's category authorized them to apply for employment authorization on a case-by-case basis, and then trying to verify that. Therefore, this suggestion would add little substantive value in terms of actual expanded access to these programs, compared to the significant burden of trying to implement it by revising our definitions of ''lawfully present'' for purposes of health insurance through an Exchange or a BHP. While we have the authority to define ''lawfully present'' for the purposes of our programs, we also intend to codify a definition of ''lawfully present'' that is aligned with DHS' conceptions of lawful presence as articulated at 8 CFR 1.3 to the extent practicable and appropriate for our programs, given DHS' deep expertise in this area.

For these reasons, we are not finalizing a provision to include individuals who are eligible to apply for employment authorization in CMS definitions of ''lawfully present.''

Comment: One commenter stated that CMS' proposal ran counter to the Congress's statutory scheme because the proposal considers noncitizens who are granted employment authorization under 8 CFR 274a.12(c) to be ''lawfully present.'' The commenter noted that the Congress's definition of a ''qualified alien'' does not depend on whether an individual has been granted employment authorization by DHS. The commenter further noted that a grant of employment authorization does not confer lawful presence under either the INA or PRWORA, and that CMS' proposal is therefore contrary to law and should be withdrawn.

Response: As previously stated, we are required under the ACA to consider individuals who are ''lawfully present'' as eligible to enroll in a QHP or a BHP, and the ACA, like the INA and PRWORA, does not provide a definition of ''lawfully present.''

We agree that a grant of employment authorization does not result in an individual being considered a ''qualified alien'' under 8 U.S.C. 1641(b) or (c). However, we are not proposing in this rule that an individual should be considered a ''qualified alien'' if they are granted employment authorization under 8 CFR 274a.12(c). Eligibility for enrollment in a QHP and for APTC and CSRs as well as BHP does not depend entirely on whether an individual is a ''qualified alien'' under PRWORA. This issue is discussed in further detail later in this section.

We are acting consistent with our statutory authority by codifying a regulatory definition of ''lawfully present''' for use in determining eligibility for QHP and BHP coverage. We note that individuals granted employment authorization under 8 CFR 274a.12(c) are permitted to accept employment because DHS has determined that the individual has an immigration status or category that qualifies them for employment authorization under this subsection. Thus, we believe it is appropriate to include all individuals with such employment authorization because DHS has made an affirmative determination that the individual has an underlying immigration status or category that authorizes them to work legally in the United States.

After consideration of public comments, we are finalizing the proposal at 45 CFR 155.20(6) to consider individuals granted employment authorization under 8 CFR 274a.12(c) as lawfully present, as proposed.

We proposed a minor technical modification to the citation in paragraph (7) of the definition of ''lawfully present'' to describe Family Unity beneficiaries more accurately. Family Unity beneficiaries are individuals who entered the United States, have been continuously residing in the United States since May 1988, and who have a family relationship (spouse or child) to a noncitizen with ''legalized status.'' [72]

[72] See USCIS Form I–817 (Application for Family Unity Benefits) and Instructions available at *https://*

Continued

The current definition of ''lawfully present'' at 45 CFR 152.2 includes Family Unity beneficiaries eligible under section 301 of the Immigration Act of 1990 (Pub. L. 101–649, enacted November 29, 1990), as amended. However, DHS also considers as Family Unity beneficiaries individuals who are granted benefits under section 1504 of the Legal Immigration and Family Equity (LIFE) Act Amendments of 2000 (enacted by reference in Pub. L. 106–554, enacted December 21, 2000, referred to hereinafter as the LIFE Act Amendments). In the proposed rule, we proposed to amend the ''lawfully present'' definition to include individuals who are granted benefits under section 1504 of the LIFE Act Amendments for consistency with DHS' policy to consider such individuals Family Unity beneficiaries.

We did not receive public comments on this provision, and therefore, we are finalizing 45 CFR 155.20(7) as proposed.

As discussed previously, in paragraph (9) of the proposed definition of ''lawfully present'' at 45 CFR 155.20, we proposed an additional clause clarifying that all recipients of deferred action, including DACA recipients, are lawfully present for purposes of 45 CFR part 155, which concerns eligibility to enroll in a QHP through an Exchange, and by cross-reference at 42 CFR 600.5, eligibility for a BHP. Please see section II.B.1 for a detailed discussion of the comments we received on this proposal.

In paragraph (10) of the proposed definition of ''lawfully present'' at 45 CFR 155.20, we proposed to clarify that individuals with a pending application for adjustment of status to LPR are not required to have an approved immigrant visa petition to be considered lawfully present. We proposed this change because in some circumstances, DHS does not require a noncitizen to have an approved immigrant visa petition to apply for adjustment of status. For example, USCIS allows noncitizens in some employment-based categories, as well as immediate relatives of U.S. citizens, to concurrently file a visa petition with an application for adjustment of status. Further, there are some scenarios where individuals need not have an approved visa petition at all, such as individuals applying for adjustment of status under the Cuban Adjustment Act. In addition, the SAVE verification system generally does not currently return information to requestors on the status of underlying immigrant visa petitions associated with the adjustment of status response. As proposed, the modification would simplify verification for these noncitizens, reduce the burden on States and individual applicants, and align with current DHS procedures.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: We received several comments in support of this change, with commenters noting that the existing requirement that individuals with a pending application for adjustment of status also have an approved visa petition unnecessarily includes family-based and other immigrants who are not required to have an approved visa petition when they apply to adjust their status. Commenters also noted that the proposed simplification will simplify eligibility verification processes, reduce administrative burden, and align with DHS procedures.

Response: We agree that the current requirement that individuals with a pending application for adjustment of status also have an approved visa petition does not align with DHS policy or practice and believe that lifting this requirement will simplify verification of lawful presence for these consumers. We received no comments opposing this proposal.

After consideration of public comments, we are finalizing 45 CFR 155.20(10) as proposed.

Paragraph (5) of the current definition of ''lawfully present'' pertains to applicants for asylum, withholding of removal, or protection under the regulations implementing U.S. obligations under the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (hereinafter ''CAT''). In the proposed rule, we proposed to move this text to paragraph (12) of the definition of ''lawfully present'' at 45 CFR 155.20, and remove the portion of the text pertaining to noncitizens age 14 and older who have been granted employment authorization, as these individuals are noncitizens granted employment authorization under 8 CFR 274a.12(c)(8), and as such, are included in paragraph (6) of our proposed definition of ''lawfully present'' at 45 CFR 155.20. We noted that the proposed change was intended to reduce duplication and would not have a substantive impact on the definition of ''lawfully present.''

We further proposed to remove the requirement in the current definition that individuals under age 14 who have filed an application for asylum, withholding of removal, or protection under CAT have had their application pending for 180 days to be deemed lawfully present. We originally included this 180-day waiting period for children under 14 in our definition of ''lawfully present'' to align with the statutory waiting period before applicants for asylum and other related forms of protection can be granted employment authorization. We proposed to change this so that children under 14 are considered lawfully present without linking their eligibility to the 180-day waiting period for employment authorization. We noted in the proposed rule that children under age 14 generally are not permitted to work in the United States under the Fair Labor Standards Act,[73] and therefore, the employment authorization waiting period has no direct nexus to their eligibility for coverage. Under the proposed rule, Exchanges and States would continue to verify that a child has the relevant pending application or is listed as a dependent on a parent's[74] pending application for asylum or related protection using DHS' SAVE system. As proposed, the modification captures the same population of children that was previously covered as lawfully present, without respect to how long their applications have been pending.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: We received several comments in support of this change, with commenters supporting CMS' proposal to no longer require children under the age of 14 who are applicants for asylum, withholding of removal, or protection under CAT, to have had their application pending for 180 days before they can be considered ''lawfully present'' under CMS regulations. Commenters agreed with CMS' reasoning that while this waiting period was initially meant to parallel the amount of time an applicant must wait before pursuing employment authorization based on a pending asylum application, the waiting period held little significance for children who generally are not legally able to work and presented an unnecessary barrier to health coverage access.

Commenters further cited significant physical and mental health care needs faced by children seeking asylum or humanitarian protection. Commenters cited studies finding that as many as 64 percent of child asylum seekers are

www.uscis.gov/sites/default/files/document/forms/i-817.pdf and *https://www.uscis.gov/sites/default/files/document/forms/i-817instr.pdf.*

[73] See 29 CFR 570.2.

[74] See 8 U.S.C. 1101(b)(2) (definition of ''parent'').

diagnosed with post-traumatic stress disorder (PTSD), as many as 75 percent of child asylum applicants are suspected or diagnosed to have at least one significant mental health diagnosis, and children seeking asylum experience delays in obtaining basic preventive medical care like vaccines.

Response: We agree with commenters that, in the context of eligibility for Exchange and BHP coverage, the 180-day waiting period for individuals who are lawfully present based on an application for asylum, withholding of removal, or protection under CAT, is not significant for children under the age of 14 because they would generally not be permitted to work in the United States. We agree with commenters that the 180-day waiting period could delay access to health coverage and care for this population.

Comment: Some commenters further urged CMS to eliminate the requirement that applicants for asylum, withholding of removal, or protection under CAT who are age 14 and older obtain employment authorization to be considered lawfully present. Commenters noted that these applicants for humanitarian relief often have significant physical and mental health needs, and that eliminating this requirement would have a positive impact on access to health care, primarily for children and pregnant individuals. Commenters noted that this change could help reduce barriers for individuals who already may have limited access to Exchange coverage due to requirements to commit to filing a Federal income tax return and to project their income based on limited or no work experience.

Response: We understand that some individuals who are age 14 and older obtain employment authorization for purposes beyond employment, such as for identification purposes. We are taking more time to evaluate and consider comments suggesting that the age at which applicants for these forms of humanitarian protection are required to have employment authorization be raised or eliminated. Specifically, we are evaluating the potential impacts of a change to the age 14 requirement—as raised by commenters—on these applicants and on program integrity. The rulemaking process with regard to that portion of the proposal is ongoing. As a result, we are not finalizing any change to the age 14 requirement at this time.

After consideration of public comments, we are finalizing the proposal at 45 CFR 155.20(12) to no longer require children under the age of 14 who are applicants for asylum, withholding of removal, or protection under CAT to have had their application pending for 180 days before they can be considered ''lawfully present,'' as proposed.

In paragraph (13) of the proposed definition of ''lawfully present'' at 45 CFR 155.20, we proposed to include individuals with an approved petition for Special Immigrant Juvenile (SIJ) classification. The definition currently at paragraph (7) of 45 CFR 152.2 refers imprecisely to noncitizens with a ''pending application for [SIJ] status'' and therefore unintentionally excludes from the definition of ''lawfully present,'' children whose petitions for SIJ classification have been approved but who cannot yet apply for adjustment of status due to lack of an available visa number.[75] Due to high demand for visas in this category, for many SIJ-classified noncitizens, it can take several years for a visa number to become available. SIJs are an extremely vulnerable population and as such, we proposed to close this unintentional gap so that all children with an approved petition for SIJ classification are deemed lawfully present.

In May 2022, USCIS began considering granting deferred action to noncitizens with approved petitions for SIJ classification but who are unable to apply for adjustment of status solely due to unavailable immigrant visa numbers.[76] Accordingly, based on the proposed changes at 45 CFR 155.20, SIJs could be considered ''lawfully present'' under three possible categories, as applicable: paragraph (9), deferred action; paragraph (10), a pending adjustment of status application; or paragraph (13), a pending or approved SIJ petition. While proposed paragraph (9) would cover individuals with approved SIJ petitions who cannot yet apply for adjustment of status, there may be a small number of SIJs with approved petitions who have not yet been considered for deferred action or for whom USCIS has declined to defer action. The proposed modification to paragraph (13) of the definition of ''lawfully present'' at 45 CFR 155.20 would capture individuals who have petitioned for or established eligibility for SIJ classification but do not qualify under paragraph (9) or (10) of the proposed definition of ''lawfully present'' at 45 CFR 155.20 and eliminate an unintentional gap in the definition.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: CMS received several comments in support of this change, with commenters noting that SIJs are extremely vulnerable children and that updating this policy will correct the unintentional exclusion of individuals with an approved SIJ petition who have not yet been able to adjust to lawful permanent resident status and who are not otherwise covered under CMS definitions of lawfully present. Commenters noted that these children tend to have profound mental health needs. Commenters further noted that this change will streamline eligibility verifications for impacted individuals.

Response: We agree with commenters that the current exclusion of certain individuals with an approved SIJ petition from our regulatory definitions is unintentional, and that this change will ensure that vulnerable children do not face unnecessary barriers to accessing health insurance coverage.

After consideration of public comments, we are finalizing 45 CFR 155.20(13) as proposed.

We also proposed a nomenclature change to the definitions currently at 45 CFR 152.2 to use the term ''noncitizen,'' rather than ''alien'' in the definition proposed at 45 CFR 155.20 to align with more modern terminology. Public comments on this proposal are discussed earlier in this section. After consideration of public comments, we are finalizing these nomenclature changes as proposed.

We received general comments on the clarifications and technical adjustments to the definition of ''lawfully present'' at 45 CFR 155.20. The following is a summary of the comments we received and our response.

Comment: Many commenters stated general support for CMS' proposals to make technical corrections further clarifying the definition of ''lawfully present'' for other noncitizens, for purposes of these programs.

[75] Moreover, SIJ classification is not itself a status and should not be described as such in the regulation. The current regulatory reference to a ''pending application for SIJ status'' has been construed to encompass noncitizens with a pending SIJ petition. It is not limited to noncitizens with a pending application for adjustment of status based on an approved SIJ petition. Therefore, the proposed regulatory change does not modify the current practice of determining lawful presence for noncitizens in the SIJ process based on a pending petition, rather than based on a pending adjustment application (as with other categories of noncitizens seeking LPR status). The modification we proposed instead clarifies the language so that both pending and approved SIJ petitions convey lawful presence for the purposes of eligibility for health insurance coverage through an Exchange or BHP, whether or not an individual with an approved SIJ petition has an adjustment application pending.

[76] U.S. Citizenship and Immigration Services. *Policy Alert: Special Immigrant Juvenile Classification and Deferred Action.* (2022). *https://www.uscis.gov/sites/default/files/document/policy-manual-updates/20220307-SIJAndDeferredAction.pdf.*

Commenters stated that the proposed technical changes would decrease operational burden on CMS programs. Commenters noted that these changes would be easier for noncitizen consumers to understand and would also make it easier for individuals and entities conducting outreach and enrollment assistance to assist immigrant consumers.

Response: We appreciate commenters' support for making technical clarifications to our definition of ''lawfully present.'' We agree that these changes will result in simplifications to lawful presence verification operations that will have a positive impact on Exchanges, BHP agencies, and consumers. We also believe that these new policies will be easier for both consumers and consumer advocates to navigate, and we are committed to providing high-quality education and technical assistance on the policy changes in this rule for the many interested parties who assist immigrant communities with health coverage enrollment. We intend to begin providing such education and technical assistance after the publication date of this rule, in advance of the rule's November 1, 2024 effective date.

We received several comments recommending additional modifications or clarifications to the definition of ''lawfully present'' in this rule. The following is a summary of the comments we received and our responses.

Comment: One commenter recommended that CMS expand access to other noncitizen populations, such as nonelderly nonimmigrants, who make up one third of the nation's projected uninsured.

Response: Our proposed definition of ''lawfully present'' included all nonimmigrants in a valid status or category regardless of age. These individuals would be eligible for Exchange or BHP coverage if they meet all other eligibility requirements for these programs.

Comment: One commenter noted that immigrant crime victims who are permanently residing under color of law (PRUCOL) should be considered lawfully present and have the same extended ACA coverage.

Response: Victims of qualifying crimes and certain family members who have been granted U nonimmigrant status under 8 U.S.C. 1101(a)(15)(U)[77] are already considered to be lawfully present for HHS insurance affordability programs as nonimmigrants. The classification of PRUCOL—describing any noncitizen living in the United States with the knowledge and consent of DHS, and whose departure DHS does not contemplate enforcing—is not used under the current law. Noncitizens under PRUCOL were previously eligible for certain public benefits, such as Medicaid, if they met all other eligibility requirements in the State plan. However, the PRWORA further limited eligibility so that noncitizens and individuals under PRUCOL could no longer be eligible for such benefits. Such individuals are not considered to be ''lawfully present'' under HHS health programs, unless they have another immigration status that is considered to be ''lawfully present.'' Unlike the other categories of lawful presence discussed in this rule, PRUCOL is not an immigration classification recognized or verifiable by DHS, or otherwise supported by current Federal law. We are not expanding the definition of lawful presence to include PRUCOL in this final rule.

Comment: One commenter encouraged CMS to amend the proposed definitions of ''lawfully present'' to consider individuals who have petitioned for a U visa as nonimmigrants to be lawfully present. The commenter noted that the U visa program provides immigration protections to victims of certain serious crimes, and that victims must submit a statement from a law enforcement official certifying that they have been helpful to the investigation of criminal activity to be eligible. The commenter further noted that there are currently years-long delays for U visa petitioners to receive visas, employment authorization, or decisions relating to deferred action, and that these delays impact both principal U visa petitioners and their children.

The commenter stated that such U visa petitioners are unlikely to be priorities for immigration enforcement and should therefore be considered ''lawfully present'' for purposes of the CMS programs addressed in this rule. The commenter noted that such a modification to CMS' definitions of ''lawfully present'' would align with Congressional intent to protect survivors of domestic violence, sexual assault, and human trafficking as stated in legislation including the Violence Against Women Act (VAWA), the Family Violence Prevention and Services Act (FVPSA) and the Victims of Crime Act (VOCA).

The commenter further detailed the severe physical and mental health needs of U visa petitioners, who are likely to be survivors of domestic violence, sexual assault, human trafficking, and other forms of gender-based violence. The commenter cited adverse physical health effects of abuse including chronic pain, migraines and frequent headaches, sexually transmitted infections, and stomach ulcers. The commenter also noted that survivors of domestic and sexual violence tend to face chronic health issues including depression, alcohol and substance abuse, and HIV/AIDS, which can limit the ability of survivors to manage other chronic conditions like diabetes or hypertension. Given that U visa petitioners are likely to have many severe and complex health needs, the commenter stated that it is particularly important to ensure that this population has access to health insurance coverage.

Response: We appreciate commenters' concern for U nonimmigrant status petitioners, and we recognize that such petitioners are a vulnerable population often with profound health care needs. Generally, applicants and petitioners for statuses or categories who do not have an underlying approved status or category are not considered to be lawfully present, except in very limited circumstances. We note that once an individual has deferred action, including under DHS policy or regulations providing deferred action to certain U nonimmigrant status petitioners in the United States with a pending bona fide petition,[78] has been placed on the U nonimmigrant status waiting list,[79] or has U nonimmigrant status, they are considered lawfully present under the deferred action or valid nonimmigrant part of the definition of ''lawfully present'' at paragraphs (9) and (2), respectively.

Comment: One commenter urged HHS to consider expanding its definition of ''lawfully present'' to include all individuals regardless of their immigration status. The commenter noted that undocumented immigrants are typically barred from accessing

[77] Victims of Trafficking and Violence Protection Act of 2000, div. B., Violence Against Women Act of 2000 (VTVPA 2000), tit. V, Battered Immigrant Women Protection Act of 2000, Public Law 106–386, sec. 1513, 114 Stat. 1464, 1533–37 (2000), *amended by* Violence Against Women Department of Justice Reauthorization Act of 2005, tit. VIII, Public Law 109–162, 119 Stat. 2960 (Jan. 5, 2006), *amended by* Violence Against Women and Department of Justice Reauthorization Act—Technical Corrections, Public Law 109–271, 120 Stat. 750 (Aug. 12, 2006), *amended by* TVPRA 2008, Public Law 110–147, 122 Stat. 5044 (Dec. 23, 2008), *amended by* VAWA 2013, Public Law 113–4, 127 Stat. 110, 111–118, 140, 144, 156–159 (Mar. 7, 2013).

[78] USCIS Policy Manual, Vol. 3, Part C, Chap. 5, available at *https://www.uscis.gov/policy-manual/volume-3-part-c-chapter-5* (last visited July 27, 2023).

[79] 8 CFR 214.14(d)(2).

health coverage and health care despite performing essential jobs and services in their communities.

Response: The ACA states that if an individual is not considered ''lawfully present,'' the individual will not be treated as a qualified individual and may not be covered under a QHP. We believe that including all individuals regardless of their immigration status in the definition of ''lawfully present'' is beyond our regulatory authority without further legislative clarification.

Comment: A few commenters encouraged CMS to include language in the final rule, or to release additional guidance, that supports States that are interested in pursuing section 1332 waivers to allow individuals who are not ''lawfully present'' to enroll in Exchange coverage or a BHP and access State-funded subsidies. Commenters noted that thus far only Washington State has pursued a section 1332 waiver to waive section 1312(f)(3) of the ACA to the extent it would otherwise require excluding certain State residents from enrolling in QHPs and qualified dental plans (QDPs) through the State Exchange and that other States may be interested in adopting similar policies.

Response: We appreciate the commenters' suggestions regarding section 1332 waivers and will consider releasing additional guidance on the subject in the future. We note that BHP-eligible individuals must be lawfully present in the United States under section 1331(e)(1) of the ACA. Therefore, BHP Trust Funds may not be used toward BHP coverage for individuals who are not lawfully present. Additionally, section 1331(e)(1) of the ACA is not a waivable provision under section 1332(a)(2) of the ACA, and BHP Trust Funds may not be used to finance activities under a section 1332 waiver. We note, however, that there is no prohibition on using section 1332 waiver pass-through funding to fund State affordability programs (such as State subsidies) under the waiver plan for health insurance coverage for individuals not lawfully present, so long as the waiver plan meets the section 1332 statutory guardrails and other applicable requirements.

Comment: One commenter stated that premium tax credits and cost-sharing reductions to lower the cost of a QHP purchased through an Exchange constitute a ''Federal public benefit'' under PRWORA, and that such financial assistance may only be made available to individuals who are ''qualified aliens'' as defined under PRWORA.

Response: We do not believe PRWORA's restriction on ''Federal public benefits'' to ''qualified aliens'' at 8 U.S.C. 1611(a) applies to the ACA. The ACA, enacted after PRWORA, directly addresses the question of which noncitizens are entitled to benefits or subsidies, and it does so through a framework that irreconcilably conflicts with the earlier statute's approach. In particular, the ACA restricts benefits and subsidies to noncitizens who are ''lawfully present''—a group that is, and was understood to be, more expansive than the group of ''qualified aliens.'' The specific approach that the Congress chose to apply to the particular benefits and subsidies created by the ACA overtakes the broader approach to ''public benefits'' in general in the earlier-enacted PRWORA.

The ACA departed from PRWORA's restriction that only ''qualified aliens'' could receive covered benefits. Instead, in multiple provisions related to Exchanges, the Congress allowed various benefits or subsidies for individuals who were ''lawfully present in the United States.'' [80] In fact, the ''lawfully present'' language is similar to the exceptions that the Congress used in 8 U.S.C. 1611(b)(2), (3), and (4) to permit certain non-qualified aliens to obtain Social Security, Medicare, and Railroad Retirement benefits.

The ACA did not expressly define ''lawfully present,'' but the legislative history supports that the ACA Exchanges and subsidies were intended to allow immigrants who are lawfully present in the United States, who are otherwise ineligible for Medicaid, to be eligible to receive tax credits and purchase coverage through Exchanges.[81] In particular, the Congress was aware of the intersection and intended to depart from the PRWORA framework when enacting the ACA. The Congressional Research Service (CRS) has recognized that the ''lawful presence'' framework the Congress adopted in the ACA irreconcilably conflicts with PRWORA, stating:

> It is rather clear, for instance, that PRWORA does not restrict alien eligibility for the health benefits authorized in the Patient Protection and Affordable Care Act (ACA) of 2010. The ACA does not override PRWORA expressly but does extend eligibility to ''lawfully present'' aliens, a more expansive category than ''qualified aliens'' under PRWORA.[82]

In a separate report, the CRS identified the ACA as an example of the establishment of ''clear rules for alien eligibility in the new legislation that conflict irreconcilably with PRWORA.'' [83]

The ACA also expressly provides that noncitizens who are lawfully present but who are ineligible for Medicaid ''by reason of such alien status'' are considered eligible for PTCs [84] and CSRs [85] even if their household income is below the otherwise applicable threshold of 100 percent of the FPL. This clearly demonstrates that the Congress intended and understood that the ''lawfully present'' standard applicable to APTC and CSRs was broader than the ''qualified alien'' standard applicable to Medicaid programs.

We previously issued regulations defining ''lawfully present'' for various ACA programs, specifically PCIP, Exchanges, and the BHP, that differed from the PRWORA restrictions and extended eligibility to a more expansive category than ''qualified aliens'' under PRWORA. As previously discussed in this rule, CMS first defined ''lawfully present'' as an eligibility criterion for purposes of PCIP shortly after the ACA's enactment, with regulations published in 2010 (75 FR 45013). This definition of ''lawfully present,'' was later applied to eligibility for other ACA programs; regulations pertaining to Exchanges were issued in 2012 (77 FR 18309) and regulations pertaining to the BHP were issued in 2014 (79 FR 14111). In all of these regulations, consistent with direction from the Congress, CMS provided a definition of ''lawfully present'' that was more expansive than the definition of ''qualified aliens'' under PRWORA. We are modifying these regulatory definitions of ''lawfully present'' for Exchanges and the BHP as described in this final rule.

Comment: One commenter urged HHS to amend its regulatory definition of ''lawfully present'' for purposes of enrollment in a QHP through an Exchange, APTC, CSRs, and a BHP to exclude immigrants who do not have ''lawful immigration status'' and who therefore ''may not be reasonably expected to be lawfully present in the United States for the duration of enrollment,'' as required by the ACA at 42 U.S.C. 18032(f)(3) and 42 U.S.C. 18071(e)(2). The commenter further

[80] *See* 42 U.S.C. 18001(d)(1), 18032(f)(3), 18071(e), 18081(a)(1), and 18082(d).

[81] See 156 Cong. Rec. S2079 (2010) *https://www.congress.gov/crec/2010/03/25/CREC-2010-03-25-senate.pdf.*

[82] See CRS Report R46510, *PRWORA's Restrictions on Noncitizen Eligibility for Federal Public Benefits: Legal Issues,* by Ben Harrington (Sept. 3, 2020) *https://crsreports.congress.gov/product/pdf/R/R46510.*

[83] CRS Report LSB10526, *PRWORA and the CARES Act: What's the Prospective Power of a ''Notwithstanding'' Clause?* by Ben Harrington (July 27, 2020). *https://crsreports.congress.gov/product/pdf/LSB/LSB10526.*

[84] 26 U.S.C. 36B(c)(1)(B).

[85] 42 U.S.C. 18071(b)(2).

specified that because recipients of deferred action, TPS, Deferred Enforced Departure (DED), and parole do not have a legal right to remain in the United States, CMS does not have a reasonable basis to assume that such individuals will remain lawfully present for the duration of their potential enrollment.

One commenter agreed with CMS that ''lawful presence'' is a statutory term of art that is distinct from ''lawful status,'' and that it is a statutory prerequisite for receipt of certain benefits. The commenter suggested that *DHS* v. *Regents* found that lawful presence ''is not the same as forbearance nor does it flow inexorably from forbearance. Thus, while deferred action recipients have been designated lawfully present for purposes of Social Security and Medicare eligibility . . . agencies can also exclude them from this designation.'' [86] The commenter stated that because lawful presence is ''context-dependent'' and ''there is no express definition of 'lawfully present' . . . for all purposes,'' that CMS should exclude all recipients of deferred action, TPS, and DED from its regulatory definition of ''lawfully present'' for purposes of ACA benefits eligibility. The commenter noted that even if such individuals are considered ''lawfully present'' for other purposes, that the ACA's requirement that noncitizens be ''reasonably expected'' to be lawfully present for the duration of their QHP enrollment means that they must be excluded from the definition of ''lawfully present'' used to determine eligibility to enroll in a QHP.

In arguing that TPS recipients cannot be reasonably expected to be lawfully present for the duration of their QHP enrollment, the commenter stated that TPS is a form of forbearance from removal proceedings. The commenter noted that under 8 U.S.C. 1254(a), the Secretary of Homeland Security is only authorized to designate a country for TPS for a period of up to 18 months. The commenter noted that while the Secretary is also authorized to extend a country's TPS designation, a country's TPS designation could end during the time period that a TPS recipient is enrolled in a QHP. The commenter further noted that DHS has authority to rescind prior TPS designations, and that TPS is not intended to provide long-term or permanent immigration status. In arguing that deferred action recipients, DED recipients, and parolees cannot be reasonably expected to be lawfully present for the duration of their QHP enrollment, the commenter noted that deferred action, DED, and parole do not provide legal immigration status or a right to remain in the United States, and such categories may be revoked or terminated at any time.

The commenter further noted that the INA stipulates that, for parolees, ''when the purposes of such parole shall . . . have been served the alien shall forthwith return or be returned to the custody from which he was paroled and thereafter his case shall continue to be dealt with in the same manner as that of any other applicant for admission to the United States.'' [87] The commenter acknowledged that the Congress did designate parolees who are paroled for periods of at least one year as ''qualified aliens'' for purposes of general Federal public benefits eligibility under 8 U.S.C. 1641(b), but noted that this standard does not apply to QHP eligibility, as the Congress specified the ''lawfully present'' standard in the ACA instead.

Response: We do not agree that deferred action, TPS, DED, and parole recipients cannot reasonably be expected to be lawfully present in the United States for the duration of enrollment as required by the ACA. More specifically, we do not agree with the assertion that we must exclude all recipients of deferred action, TPS, DED, and parole from our regulatory definition of ''lawfully present'' for purposes of ACA benefits eligibility to meet the ACA's requirement that individuals only be considered ''lawfully present'' as long as they are reasonably expected to be lawfully present for the duration of their enrollment. Our existing policy and operations, as well as the policies in this final rule, are in line with the ACA's statutory requirements.

As the commenter indicated, the ACA requires both that individuals who are lawfully present be considered eligible to enroll in a QHP, and that individuals only be considered lawfully present if they are expected to be lawfully present for the duration of enrollment.

As we noted in a 2012 rulemaking (77 FR 18309, 18350), we do not interpret the ACA's ''reasonably expected'' standard to mean that an applicant must be lawfully present for an entire coverage year. Rather, we noted that the lawful presence verification processes would address whether an applicant's lawful presence is time-limited, and if so, the Exchange would determine his or her eligibility for the period of time for which his or her lawful presence has been verified. We have verification processes in place for applicants whose immigration status or category is temporary and would be able to terminate enrollment for consumers in a hypothetical situation where their deferred action, TPS, DED, or parole designation expired, or was rescinded or terminated. Thus, Exchanges on the Federal platform currently balance these statutory directives by considering whether someone is lawfully present at the time of their application, and by generally requiring applicants whose immigration status or category is expiring within the next 90 days to submit additional information demonstrating their continuing lawful presence.

We note that many individuals in these categories have been in the United States for extended periods of time. For example, TPS recipients have been in the United States for 20 years, on average; we would be incorrect to assert that a TPS recipient was not ''reasonably expected'' to remain lawfully present during their Exchange enrollment solely on the basis of their receipt of TPS.[88] We also clarify that the Supreme Court in *DHS* v. *Regents* in no way suggested that agencies could not consider deferred action recipients to be ''lawfully present.'' [89] We note that we have considered recipients of deferred action under policies other than DACA—including TPS, DED, and parole—to be ''lawfully present'' for purposes of eligibility for Exchange coverage since 2012 (77 FR 18309). For the reasons discussed here, we do not believe it is necessary or appropriate to exclude recipients of deferred action, TPS, DED, and parole from our definitions of ''lawfully present.''

3. Severability

We proposed to add a new section at 45 CFR 155.30 addressing the severability of the provisions proposed in the proposed rule. In the event that any portion of a final rule is declared invalid, we intended that the various provisions of the definition of ''lawfully present'' be severable, and that the changes to the definition of ''lawfully present'' in 45 CFR 155.20 would continue even if some of the changes to any individual category are found invalid. The severability of these provisions, and the public comments we received on our proposal to add severability clauses, are discussed in detail in section III. of this rule.

[86] *Dep't of Homeland Sec.* v. *Regents of the Univ. of California,* 140 S. Ct. 1891, 1911 n.5 (2020).

[87] 8 U.S.C. 1182(a)(5)(A).

[88] Council on Foreign Relations. What is temporary protected status? (2023). *https://www.cfr.org/backgrounder/what-temporary-protected-status.*

[89] *Dep't of Homeland Sec.* v. *Regents of the Univ. of California,* 140 S. Ct. 1891, 1911 n.5 (2020).

C. Proposed Effective Date

In the proposed rule, we had targeted a potential effective date of November 1, 2023 to align with the Open Enrollment Period for most individual market Exchanges. We were not able to establish a final rule prior to that date. However, we continue to believe that Open Enrollment is a critical opportunity for consumers to shop for and enroll in insurance coverage, and implementation of these changes would be most effective during a period when there are many outreach and enrollment activities occurring from CMS, State Exchanges, assisters, and other interested parties.

We noted in the proposed rule that DACA recipients would qualify for the Special Enrollment Period (SEP) at 45 CFR 155.420(d)(3) for individuals who become newly eligible for enrollment in a QHP through an Exchange due to newly meeting the requirement at 45 CFR 155.305(a)(1) that an enrollee be lawfully present. Despite the availability of the SEP, we believed that proposing to align this rule's effective date with the individual market Exchange Open Enrollment Period would significantly increase the opportunity for individuals to enroll for coverage through the Exchange or a BHP due to the extensive outreach and enrollment activities occurring during this time and the longer period of time individuals have to enroll in a QHP through an Exchange during the individual market Exchange Open Enrollment Period (75 days from November 1 through January 15 for Exchanges on the Federal platform) compared with an SEP (60 days from the effective date of the rule). Further, even though the individual market Exchange Open Enrollment Period is, among CMS insurance affordability programs, currently only applicable to Exchanges, we expressed in the proposed rule that it was important to align effective dates between Exchanges, BHP, Medicaid, and CHIP to promote consistency, and because eligibility for these programs is typically evaluated through a single application.[90] [91]

While we are not finalizing a definition of ''lawfully present'' for purposes of Medicaid and CHIP eligibility at this time for the reasons detailed in section I, we believe that this rule will still have positive health and financial benefits for DACA recipients and other impacted noncitizens who may be eligible in an Exchange or a BHP, as detailed in section II.B.1 and II.B.2. While this final rule will result specifically in changes to the Exchange and BHP definitions of ''lawfully present,'' we believe that any negative effects of the resulting misalignment following the rule's effective date are outweighed by the expected positive impacts of the rule.

In the proposed rule, we sought comment on the feasibility of the November 1, 2023 proposed target effective date and whether to consider a different target effective date. We noted our commitment to working with State agencies and providing technical assistance regarding implementation of these proposed changes, if finalized. We also acknowledged, as outlined above, that State Medicaid and CHIP agencies were experiencing a significant increase in workload to ''unwind'' (*i.e.,* to return to regular eligibility renewal operations) following the expiration of the continuous enrollment condition in section 6008(b)(3) of the FFCRA on March 31, 2023.[92] We sought comment about the impact of this workload or any other operational barriers to implementation for State Exchanges, and State Medicaid, CHIP, and BHP agencies. While the proposed rule's target effective date of November 1, 2023 has passed, similar considerations regarding feasibility and State impacts are still relevant.

We received public comments on this proposed target effective date. The following is a summary of the comments we received and our responses.

Comment: The majority of comments that CMS received supported the November 1, 2023 effective date and noted the benefits of aligning with the individual market Exchange Open Enrollment Period and related education and outreach activities. One commenter, a State department of insurance, stated that aligning with such outreach would support ongoing efforts to lower rates of uninsurance.

Response: We agree that it is important for impacted noncitizens and other interested parties, such as enrollment assisters, that this rule be implemented in time to align with the individual market Exchange Open Enrollment period to maximize enrollment in health coverage for impacted noncitizens who will be affected by the final rule. Given that the initially proposed effective date of November 1, 2023 has now passed, we believe that aligning the effective date of this rule with the individual market Exchange Open Enrollment Period on November 1, 2024 will help ensure that the maximum number of newly eligible impacted noncitizens are able to seamlessly enroll in coverage through the Exchange or BHP. CMS plans to leverage existing channels for outreach and education utilized during the individual market Exchange Open Enrollment Period to ensure that impacted noncitizens are aware that they may be eligible for coverage. We appreciate commenters' perspectives on the feasibility of operationalizing the changes in this rule by the initially proposed effective date of November 1, 2023, and we are committed to assisting our partners and interested parties with their implementation efforts. CMS is finalizing an effective date of November 1, 2024, for Exchanges and the BHP and, as described in section I, is not finalizing the proposed definition of ''lawfully present'' for Medicaid and CHIP agencies at this time.

Comment: We received some comments urging the agency to adopt an earlier effective date than November 1, 2023. These comments varied in proposed effective date. Some commenters, including advocacy organizations, professional trade associations, and State government agencies, urged us to consider the rule effective upon publication in the **Federal Register**. Other commenters recommended that the rule take effect 30 days after publication in the **Federal Register**. Commenters that supported an earlier effective date noted the importance of making health insurance affordability programs available to impacted noncitizens as quickly as possible, and noted that they did not believe it was necessary to wait for the individual market Exchange Open Enrollment Period given that Exchange applicants would qualify for an SEP and that Medicaid, CHIP, and BHP currently allow for year-round enrollment.[93] One

[90] Pursuant to 42 CFR 600.320(d), a State operating a BHP must either offer open enrollment periods pursuant to Exchange regulations at 45 CFR 155.410 or follow Medicaid's continuous open enrollment process. As of April 1, 2024, only Minnesota currently operates a BHP, and it follows Medicaid's continuous open enrollment process.

[91] See 42 CFR 435.907, 42 CFR 457.330, and 45 CFR 155.405 for requirements related to a single streamlined application for all insurance affordability programs.

[92] *See* CMS, SHO # 23–002, ''Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023,'' January 27, 2023, available at *https://www.medicaid.gov/media/149291*; Additional guidance for State Medicaid and CHIP agencies is available at *https://www.medicaid.gov/unwinding*.

[93] See 42 CFR 600.320(d). Pursuant to 42 CFR 600.320(d), a State operating a BHP must either offer open enrollment periods pursuant to Exchange regulations at 45 CFR 155.410 or follow Medicaid's continuous open enrollment process. As of April 1, 2024, only Minnesota currently operates a BHP and it follows Medicaid's continuous open enrollment process.

health care organization emphasized the importance of finalizing the rule as soon as possible given the uncertain future of the DACA policy. One commenter urged CMS to implement the final rule as quickly as possible, ideally by the upcoming SEP.

Response: We note commenters' interest in seeing the rule implemented as soon as possible, and we agree that DACA recipients and other impacted noncitizens should be able to access the Exchange or BHP coverage for which they will be eligible as soon as possible. However, we also acknowledge the importance of giving Exchanges, including Exchanges on the Federal platform and State Exchanges operating their own platforms, BHPs, assisters, and other entities who support enrollment in Exchange and BHP coverage sufficient time to prepare for the changes in this rule. Given the time required for us to closely review and respond to all public comments received and to develop the operational changes required to implement the rule's provisions, we do not believe it is feasible for Exchanges on the Federal platform to implement this rule prior to its effective date on November 1, 2024. We acknowledge that some DACA recipients will be eligible under this final rule for a BHP (we estimate that 1,000 DACA recipients will enroll in BHP), to which the individual market Exchange Open Enrollment Period does not currently apply.[94] However, BHPs will also need to make operational changes as a result of this rule, and we believe that a November 1, 2024 effective date will allow BHPs sufficient time to implement the operational changes required.

CMS also acknowledges that DACA recipients and other impacted noncitizens who are newly considered to be lawfully present as a result of this rule will qualify for an SEP; however, as stated previously, we are not able to effectively implement the rule with an effective date earlier than November 1, 2024. We are committed to working with impacted State Exchanges operating their own platforms and BHP agencies to provide technical assistance and educational materials to facilitate successful implementation of this rule.

For the reasons detailed in section I., we are not finalizing a definition of ''lawfully present'' for purposes of Medicaid and CHIP eligibility at this time. We acknowledge that commenters urged us to ensure that DACA recipients and other impacted noncitizens would be able to access these programs as soon as possible. During this time, we believe that many DACA recipients and other impacted noncitizens who may have been eligible for Medicaid or CHIP under the policies in the proposed rule will instead be able to access coverage by enrolling in a QHP via the Exchange or BHP coverage.[95]

For the commenter who urged us to implement the rule by the upcoming SEP, we believe that the commenter may have been referring to the individual market Exchange Open Enrollment Period; the benefits of aligning with the Exchange Open Enrollment Period are addressed above. Alternatively, this commenter may be referring to the SEP for individuals who lose Medicaid or CHIP coverage due to the end of the continuous enrollment condition in Medicaid, also referred to as the ''Unwinding SEP.'' This SEP has been available on *HealthCare.gov* to consumers since March 31, 2023 and remains in effect.[96] As noted previously, this final rule will be effective for the 2024 individual market Exchange Open Enrollment Period which will begin on November 1, 2024.

Comment: Many commenters agreed with CMS that DACA recipients and other impacted noncitizens would qualify for the existing SEP for individuals who are newly considered to be lawfully present for the 60 days following the effective date of the rule. One nonprofit organization urged CMS to implement an SEP for DACA recipients that would last for 12 months after the effective date of the rule, to ensure that individuals have sufficient time to enroll.

Response: Commenters are correct that noncitizens who are newly considered lawfully present under the definition in the final rule will qualify for the existing 60-day SEP for individuals who are newly lawfully present under 45 CFR 155.420(d)(3) as of the applicability date of the final rule. We acknowledge the suggestion that we make an extended SEP, greater than 60 days, available for this population. However, we believe that the individual market Open Enrollment Period and the existing 60-day SEP should give impacted noncitizens sufficient time to apply for and enroll in coverage. In our prior experience implementing changes to Exchange eligibility rules that align with the individual market Open Enrollment Period, such as changes related to employer-sponsored coverage affordability and premium tax credit eligibility (87 FR 61979), we are not aware of significant issues related to consumers having sufficient time to enroll. In nearly all situations where consumers become newly eligible to enroll in a QHP or for APTC or CSRs, we provide a 60-day SEP, and we believe that is generally an appropriate approach. Additionally, as indicated above, pursuant to 42 CFR 600.320(d), Minnesota's BHP has elected to follow Medicaid's continuous enrollment process and therefore an extended SEP would not apply to this population.

We acknowledge that there may be unique challenges relevant to the consumers impacted by this rule, and we are committed to working with State Exchanges not on the Federal platform, BHPs, assisters, and community-based organizations to conduct targeted outreach to facilitate efficient enrollment processes for DACA recipients and other impacted noncitizens who may be eligible for coverage. We also note that some State Exchanges not on the Federal platform, including those in California and New Jersey, where an estimated 168,120 and 14,760 DACA recipients live, respectively, have individual market Open Enrollment Periods that are longer than the one provided in the Exchanges on the Federal platform, giving consumers up to 90 days to enroll in a QHP.

Comment: A minority of State Exchanges not on the Federal platform that commented on the rule raised concerns that the proposed effective date of November 1, 2023, may not be feasible. These commenters urged CMS to provide State Exchanges not on the Federal platform with flexibility on the timeframe for full implementation of the rule's provisions. Some of these commenters also stated concerns that changes would not be available for testing through the Federal Data Services Hub (hereinafter ''the Hub'') in a timely manner. Additionally, some commenters noted the importance of finalizing the rule as soon as possible, to give interested parties, including State Exchanges not on the Federal platform, assisters, and community-based organizations as much time as possible to prepare for the policy and operational changes in the rule prior to its effective date.

[94] Pursuant to 42 CFR 600.320(d), a State operating a BHP must either offer open enrollment periods pursuant to Exchange regulations at 45 CFR 155.410 or follow Medicaid's continuous open enrollment process. The one State that currently operates a BHP, Minnesota, follows Medicaid's continuous open enrollment process.

[95] DACA recipients who qualify to enroll in a QHP will generally be eligible for APTC and CSRs (subject to other eligibility requirements) even if their income is under 100 percent of FPL, as individuals who are lawfully present but ineligible for Medicaid due to their ''alien status'' may be eligible for APTC and CSRs. See 26 U.S.C. 36B(c)(1)(B) and 42 U.S.C. 18071(b)(2).

[96] *See https://www.medicaid.gov/resources-for-states/downloads/extn-sep-cnsmrs-lsg-chip-cvrg-adndm-faq.pdf.*

Response: We acknowledge commenters' concerns about challenges with implementation of the provisions of this rule. To address these concerns, we plan to release technical guidance to State Exchanges not on the Federal platform and to BHP agencies to assist those agencies with implementing provisions of the rule. We are committed to supporting readiness for State Exchanges not on the Federal platform and BHP agencies, while also removing barriers to coverage for eligible individuals and supporting their enrollment through the Exchange or a BHP for which they are eligible. We will be available to work with State Exchanges not on the Federal platform and BHP agencies individually to facilitate their compliance by November 1, 2024.

We also acknowledge the possibility that some State Exchanges not on the Federal platform may not be able to fully implement the provisions of this rule by the November 1, 2024 effective date. We further acknowledge that if State Exchanges are not able to implement by November 1, 2024, that there is a risk that DACA recipients and other impacted noncitizens could have limited opportunity to access QHP coverage through the SEP for which they are eligible under 45 CFR 155.420(d)(3), given that the trigger event for the SEP is the November 1, 2024 effective date of this rule and only provides 60 days after the triggering event to select a QHP. If a delay in State Exchange implementation results in newly eligible consumers being unable to enroll in coverage during their initial 60-day SEP window, State Exchanges could consider granting a pathway into QHP coverage for eligible applicants on a case-by-case basis under exceptional circumstances authority at 45 CFR 155.420(d)(9).

Comment: A few commenters urged CMS to consider a later effective date than November 1, 2023 due to ongoing litigation concerning a separate DHS final rule. One nonprofit organization urged CMS to refrain from finalizing the rule and setting an effective date until the challenge to DACA in *Texas* v. *United States,* 50 F.4th 498 (5th Cir. 2022), has reached a final disposition. The commenter further stated concern that pursuing this rulemaking while litigation continues could result in unnecessary expenditures and investment of staff time by DHS and HHS. A comment submitted by some State attorneys general urged CMS to postpone the effective date of the final rule pending judicial review.

Response: We do not believe it is necessary to delay this final rule in its entirety pending a resolution of litigation concerning DHS's final rule. We are not finalizing a definition of ''lawfully present'' for purposes of Medicaid and CHIP eligibility at this time, for the reasons detailed in section I. Moreover, this rule makes other changes to the definitions of ''lawfully present,'' in 45 CFR 155.20 and impacts other noncitizens in addition to DACA recipients.

We acknowledge that current court orders prohibit DHS from fully administering the DHS DACA final rule (87 FR 53152). Those orders, however, have been subject to judicial stays since their issuance and, as a result, the DACA policy has remained in effect with respect to current DACA recipients. Additionally, the policies in this rule solely address eligibility for specific HHS health programs and are separate from DHS regulations. As described in detail throughout this rule, this rule reflects our independent statutory authority under the ACA to define ''lawfully present'' for purposes of eligibility to enroll in a QHP or the BHP.

After careful consideration of public comments, we are finalizing November 1, 2024 as the effective date of this final rule. This means that, effective November 1, 2024, the definitions of ''lawfully present'' used to determine eligibility to enroll in a QHP, and for APTC and CSRs, as well as for the BHP, will no longer exclude DACA recipients and will also reflect the changes detailed in section II.B.2. The proposed definitions of ''lawfully present'' for Medicaid and CHIP are not being addressed in this final rule. For purposes of these programs, the definitions established in the 2010 SHO and 2012 SHO will continue to apply.

D. Eligibility in States, the District of Columbia, the Northern Mariana Islands, and American Samoa and Children's Health Insurance Programs (CHIPs) (42 CFR 435.4 and 457.320(c))

1. Lawfully Residing and Lawfully Present Definitions

We proposed to define the term ''lawfully present'' at 42 CFR 435.4 for Medicaid eligibility under the CHIPRA 214 option, consistent with the Exchange definitions described in the proposed rule at 45 CFR 155.20, including the minor technical changes and clarifications to the lawfully present definition described in preamble section II.B.2 of this final rule. We also proposed to add a cross-reference to this definition at 42 CFR 457.320(c) for purposes of determining eligibility for CHIP under the CHIPRA 214 option. We proposed a definition of ''lawfully residing'' in 42 CFR 435.4 to mirror the definition in the 2010 SHO, discussed previously in this rule—that an individual is ''lawfully residing'' if they are ''lawfully present'' in the United States and are a resident of the State in which they are applying under the State's Medicaid residency rules. For CHIP, we also proposed to add a cross-reference at 42 CFR 457.320(c) to the ''lawfully residing'' definition at 42 CFR 435.4, except that States must comply with CHIP residency requirements at 42 CFR 457.320(e).

Due to the reasons discussed in section I of this final rule, we are not finalizing a ''lawfully present'' definition for Medicaid and CHIP at this time. This means that for the definition of ''lawfully present'' used in determining eligibility for Medicaid and CHIP under the CHIPRA 214 option, the current policy, based on the 2010 SHO and the 2012 SHO, continues to apply.

We received comments regarding the proposals to define the term ''lawfully present'' for Medicaid and CHIP eligibility under the CHIPRA 214 option. As we are continuing to consider and evaluate these comments, we are not providing our responses to comments in the final rule at this time. Comments that expressed general support for or opposition to the policies in the proposed rule without reference to a specific insurance affordability program have been addressed above in sections II.B.1 and II.B.2 with respect to Exchange and BHP coverage.

2. Defining Qualified Noncitizen

Under our current Medicaid regulations, a ''qualified non-citizen'' is defined at 42 CFR 435.4, which includes an individual described in 8 U.S.C. 1641(b) and (c). Similarly, 42 CFR 457.320(b)(6) defines a ''qualified alien'' for CHIP with a cross-reference to section 431 of PRWORA, which is codified at 8 U.S.C. 1641. The definitions are currently used for determining Medicaid and CHIP eligibility under our regulations at 42 CFR 435.406 and 42 CFR 457.320, and the definition is also used when determining eligibility of individuals under the CHIPRA 214 option. In the proposed rule, we considered whether the current definition of ''qualified noncitizen'' at 42 CFR 435.4 should be modified to provide greater clarity and increase transparency for the public. Specifically, we noted that we were considering whether the definition should be modified to expressly include all of the categories of noncitizens covered by 8 U.S.C. 1641(b) and (c), as well as additional categories of

noncitizens that Medicaid agencies are required to cover (if they meet all eligibility requirements in the State) as a result of subsequently enacted legislation that was not codified in 8 U.S.C. 1641(b) or (c). For example, Federal law requires certain populations to be treated as ''refugees'' for certain purposes of eligibility for certain means tested benefit programs, including Medicaid and CHIP. Because refugees are listed in 8 U.S.C. 1641(b)(3) as a category of noncitizens who are ''qualified aliens'' and are also exempt from the 5-year waiting period under 8 U.S.C. 1613, these noncitizens also are treated as qualified noncitizens for purposes of Medicaid and CHIP and are exempt from the 5-year waiting period. In the proposed rule, we indicated that we were considering including these additional categories of noncitizens who are treated as refugees under other Federal statutes as specifically included in the definition of ''qualified noncitizen'' in 42 CFR 435.4, and we sought comment on this possibility. Examples of such noncitizens include victims of trafficking and certain Afghan and Ukrainian parolees.[97] A full list can be found below in section II.D.2. of this rule. Because noncitizens who are treated as refugees for purposes of Medicaid eligibility are also treated as refugees for purposes of CHIP eligibility, these categories of noncitizens (discussed previously in the proposed rule) were considered for the definition of qualified noncitizen for purposes of CHIP.

We also noted in the proposed rule that there was at least one difference in how the term ''qualified noncitizen'' applies to Medicaid compared to the other programs discussed in the proposed rule. Specifically, we noted that COFA migrants were only considered ''qualified aliens'' for purposes of the Medicaid program, under the Consolidated Appropriations Act, 2021.[98] However, after the proposed rule was issued, Congress amended 8 U.S.C. 1641(b)(8) through CAA, 2024 [99] to remove the language that limited COFA migrants as qualified noncitizens only for purposes of the Medicaid program. Since CHIP is identified as a Federal public benefit as defined at 8 U.S.C. 1611(c),[100] COFA migrants are now considered qualified noncitizens for the purposes of CHIP eligibility. Further, CAA, 2024 amended 8 U.S.C. 1613(b)(3) to expand the exception for COFA migrants from the 5-year waiting period for all Federal means-tested public benefits, allowing immediate eligibility for CHIP effective March 9, 2024, if the individual meets all other eligibility requirements in the State plan. Since the new legislation supersedes our proposed rule, we will remove the proposed limitations considering COFA migrants from the definition of qualified noncitizen in this final rule.

We solicited comments on our proposal to add more detailed information to the definition of qualified noncitizen under Medicaid and CHIP to promote clarity, transparency, and administrative ease.

We also proposed a nomenclature change to the definition of ''citizenship,'' ''noncitizen,'' and ''qualified noncitizen'' in 42 CFR 435.4 to remove the hyphen in the term ''non-citizen'' and use the term ''noncitizen'' throughout those definitions. We proposed this change to ensure alignment with terminology used by DHS. We noted that these changes do not affect eligibility for Medicaid and CHIP programs and only streamline the use of terminology for clarity and administrative ease. We did not receive any public comments regarding those changes. We are finalizing the changes as proposed in 42 CFR 435.4.

We received several public comments on our request to provide additional detail to the definition of qualified noncitizen used for Medicaid and CHIP at 42 CFR 435.4 and 42 CFR 457.320(c). No commenters opposed our proposal.

Comment: Some commenters supported CMS' proposal to include a detailed definition of ''qualified noncitizen'' at 42 CFR 435.4 and to expressly list all the categories of noncitizens that Medicaid and CHIP agencies are required to cover. One commenter supported a definition that includes categories of noncitizens covered by 8 U.S.C. 1641(b) and (c), any additional categories that Medicaid agencies are required to cover as a result of subsequently enacted legislation not currently codified in Title 8, as well as a ''residual category that encompasses any statuses created by subsequent legislation or other changes to the statute after the proposed rule is finalized.''

These commenters noted that codifying a clear definition of ''qualified noncitizen'' would reduce confusion among individuals applying for Medicaid coverage, those helping them apply for coverage, and for Medicaid agencies.

Response: We agree with commenters that including a detailed definition of ''qualified noncitizen'' in our regulations will help clarify our policy for beneficiaries, State Medicaid agencies, and other partners and interested parties, and we are including a definition of ''qualified noncitizen'' in the final rule at 42 CFR 435.4, which is incorporated by cross reference in the CHIP regulations at 42 CFR 457.320(c).

We are declining the commenter's suggestion to include a broad catchall category that would include future changes in statute. Adding a provision to accommodate potential future legislation would add ambiguity and uncertainty to the final rule that may be confusing for States that may be applying the regulation once it is effective. Should the Congress make further changes to the definition of qualified noncitizen, we will provide additional guidance.

Comment: One nonprofit organization stated that CMS should include petitioners for U-visas in the definition of qualified noncitizen.

Response: We do not have the statutory authority to include U nonimmigrant status petitioners in our definition of ''qualified noncitizen,'' because the definition of qualified noncitizen is based on PRWORA's definition of ''qualified alien'' at 8 U.S.C. 1641 and other specific statutory changes authorizing treatment of certain noncitizens as a ''refugee'' for purposes of Medicaid and CHIP eligibility, among other purposes. Neither the statutory definition at 8 U.S.C. 1641 nor any other Federal statute expressly addresses U nonimmigrant status petitioners' treatment as a refugee or eligibility for Federal public benefits, nor is there a statute that includes nonimmigrants more broadly. Thus, we are not adopting the commenter's suggestion to include U visa petitioners in the definition of qualified noncitizen. See preamble section II.B.2 for additional information on the use of deferred action for certain U nonimmigrant status petitioners.

[97] To date, these other Federal laws include the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7105(b)), relating to certain victims of trafficking; section 602(b)(8) of the Afghan Allies Protection Act of 2009, Public Law. 111–8 (8 U.S.C. 1101 note), relating to certain Afghan special immigrants; section 1244(g) of the Refugee Crisis in Iraq Act of 2007 (8 U.S.C. 1157 note), relating to certain Iraqi special immigrants; section 584(c) of Public Law. 100–202 (8 U.S.C. 1101 note), relating to Amerasian immigrants; section 2502(b) of the Extending Government Funding and Delivering Emergency Assistance Act of 2021, Public Law. 117–43, relating to certain Afghan parolees; and section 401 of the Additional Ukraine Supplemental Appropriations Act of 2022, Public Law. 117–128, relating to certain Ukrainian parolees.

[98] Div. CC, Title II, sec. 208, Public Law. 116–260.

[99] Div. G, Title II, sec. 209(f), Public Law. 118–42.

[100] For a list of HHS programs that provide ''Federal public benefits,'' see 63 FR 41658 (Aug. 4, 1998).

Comment: A few commenters noted that they supported the proposed changes to expand eligibility for noncitizens who are treated as refugees, such as certain Afghan and Ukrainian parolees,[101] which would enable these individuals to enroll in an Exchange plan, Medicaid and CHIP.

Response: We appreciate the support for including in the regulatory definition of ''qualified noncitizen'' both the noncitizens who are included in the definition of ''qualified alien'' under 8 U.S.C. 1641(b) and (c) as well as the noncitizens who are treated as refugees for purposes of eligibility for Medicaid and CHIP under other Federal statutes, and we are including both groups of noncitizens in the definition at 42 CFR 435.4 and 42 CFR 457.320(c) of the final rule. We wish to clarify that the final rule does not expand eligibility for these noncitizens but merely expressly reflects in our regulations individuals who may be eligible for Medicaid and CHIP under existing statutes, including the expansion of CHIP eligibility for COFA migrants as authorized by CAA, 2024. Individuals who are treated as refugees under other Federal laws are already required by statute to be covered by State Medicaid and CHIP programs if the individual meets all other eligibility requirements in the State plan. Additionally, these individuals are included in the existing Exchange definition of ''lawfully present'' as qualified noncitizens at 45 CFR 152.2(1), cross-referenced in our current regulation at 45 CFR 155.20 and 42 CFR 600.5, and are therefore eligible for QHP and BHP coverage if they meet other eligibility requirements.

Comment: One commenter requested that we include within the definition of ''qualified noncitizen'' a list of each category of human trafficking victims separately, while explaining that the list of subsections included is not exclusive. The commenter mentioned that Afghans, Ukrainians, and Iraqis should be specifically listed. The commenter further specified that CMS' definition of ''qualified noncitizen'' should include T visa holders, ''T visa applicants with bona fide determinations'' and HHS Office of Trafficking in Persons (OTIP) certifications, human trafficking victims who have been granted continued presence by DHS and receive OTIP certifications, and noncitizen child victims of human trafficking (sex or labor) with eligibility letters from OTIP.

Response: We wish to clarify that victims of a severe form of trafficking in persons under the Trafficking Victims Protection Act of 2000, Public Law 106–386 and family members of trafficking victims granted derivative T nonimmigrant status are considered qualified noncitizens because they are eligible for benefits and services to the same extent as refugees. 22 U.S.C. 7105(b). This statutory provision includes individuals who received a certification from HHS under 22 U.S.C. 7105(b)(1)(E). A victim of a severe form of trafficking in persons may receive an HHS certification if they have complied with any reasonable request for assistance in the detection, investigation, or prosecution of the trafficking (or qualify for an exemption due to their age or an exception due to physical or psychological trauma) and have made a bona fide application for T nonimmigrant status or were granted continued presence by DHS. Such individuals who receive an HHS certification are included as individuals treated as refugees when meeting the requirements of 22 U.S.C. 7105(b). Additionally, we note that T nonimmigrants and T nonimmigrant status applicants who have set forth a prima facie case for such nonimmigrant status are considered qualified noncitizens under 8 U.S.C. 1641(c)(4). We are including these classifications of victims of trafficking and applicants for T nonimmigrant status in our revised definition of qualified noncitizen at 42 CFR 435.4 of this final rule.

After consideration of public comments, we are including in our definition of ''qualified noncitizen'' in this final rule noncitizens who are considered ''qualified aliens'' under 8 U.S.C. 1641(b) and (c), and other immigration statuses and categories that are not included in the statutory definition of ''qualified aliens'' but whom the Congress has specifically authorized be treated as refugees for purposes of eligibility for certain benefits, including Medicaid and CHIP. Specifically, we are including the following noncitizens in the definition of ''qualified noncitizen'' in 42 CFR 435.4 of the final rule:

- Noncitizens who are victims of a severe form of trafficking in persons, who are eligible for Medicaid and CHIP to the same extent as refugees under section 107 of the Victims of Trafficking and Violence Protection Act of 2000 and the members of a trafficking victim's family who are granted derivative T nonimmigrant status, in accordance with 22 U.S.C. 7105(b)(1)(A);
- Iraqi and Afghan special immigrants, who are eligible for Medicaid and CHIP to the same extent as refugees under the National Defense Authorization Act for Fiscal Year 2008 (Pub. L. 110–181, enacted January 28, 2008); the Omnibus Appropriations Act, 2009 (Pub. L. 111–8, enacted March 11, 2009); the Department of Defense Appropriations Act, 2010 (Pub. L. 111–118, enacted December 19, 2009); and the National Defense Authorization Act for Fiscal Year 2015 (Pub. L. 113–291, enacted December 19, 2014);
- Amerasian immigrants, who are treated the same as refugees for purposes of Medicaid and CHIP eligibility in accordance with a joint resolution making further continuing appropriations for the fiscal year 1988, and for other purposes (Pub. L. 100–202, enacted December 22, 1987);
- Certain Afghan parolees who are eligible for Medicaid and CHIP to the same extent as refugees in accordance with section 2502 of the Extending Government Funding and Delivering Emergency Assistance Act (Pub. L. 117–43 as amended, enacted September 30, 2021); and
- Certain Ukrainian parolees who are also eligible for Medicaid and CHIP to the same extent as refugees under section 401 of the Additional Ukraine Supplemental Appropriations Act (Pub. L. 117–128 as amended, enacted May 21, 2022).

We are also making a conforming technical change to 42 CFR 435.406(2)(i) to replace the current cross-reference to ''qualified noncitizens'' as defined in section 431 of PRWORA (8 U.S.C. 1641) to the modified definition of ''qualified noncitizen'' at 42 CFR 435.4 that is being finalized in this rule. Likewise, in response to public comments and to align CHIP with Medicaid and to include COFA migrants as qualified noncitizens for the purposes of CHIP eligibility as authorized by CAA, 2024, we have finalized a definition of ''qualified noncitizen'' for purposes of CHIP eligibility at 42 CFR 457.320(c), which cross references to the definition of ''qualified noncitizen'' at 42 CFR 435.4. We are also finalizing an amendment at 42 CFR 457.320(b)(6) to replace ''qualified aliens'' with ''qualified noncitizens'' and to replace the reference to section 431 of PRWORA with the new definition of ''qualified noncitizen'' at 42 CFR 457.320(c).

Comment: One commenter recommended that we include in the definition of ''qualified noncitizen'' other individuals who are required to be covered in Medicaid under the Federal statute at 8 U.S.C. 1612(b) but are not considered qualified aliens under 8 U.S.C. 1641 or treated as refugees under other Federal statutes (for example,

[101] See Section 2502 of the Extending Government Funding and Delivering Emergency Assistance Act, Public Law. 117–43 (Sept. 30, 2021), as amended, and Section 401 of the Additional Ukraine Supplemental Appropriations Act, 2022, Public Law. 117–128 (May 21, 2022).

American Indians born in Canada or members of a Federally-recognized tribe, 8 U.S.C. 1612(b)(2)(E); 8 U.S.C. 1613(d)(1)). This commenter recommended that CMS include these additional individuals required to be covered by Medicaid in our revised definition of ''qualified noncitizen'' to promote clarity and transparency to the public specifying those individuals who must be covered in Medicaid, if meeting all other eligibility requirements.

Response: We agree with the commenter that there are additional groups of noncitizens who are required to be covered in Medicaid under 8 U.S.C. 1612(b)(2), but do not agree that these individuals are considered qualified noncitizens under 8 U.S.C. 1641. We also appreciate that there is some confusion regarding the noncitizens for whom coverage under Medicaid and CHIP is required. States are required to provide full Medicaid benefits to certain noncitizens under 8 U.S.C. 1612(b)(2) if they meet all other eligibility requirements in the State plan. We are not adopting the commenter's suggestion to include these individuals in the definition of ''qualified noncitizen'' in 42 CFR 435.4, as they are not qualified aliens under 8 U.S.C. 1641 or based on other Federal statutes. Moreover, we did not propose a rule that would identify all the individuals required to be covered in Medicaid under 8 U.S.C. 1612(b).

While we are not adopting a final rule, pursuant to the request for clarification, we are identifying in this preamble the individuals that States are required by statute to cover in Medicaid under 8 U.S.C. 1612(b) and are exempt from the 5-year bar under 8 U.S.C. 1613.

Under 8 U.S.C. 1612(b)(2)(A), States must cover for at least 7 years refugees; asylees; noncitizens whose deportation is withheld under specified sections of the INA; Cuban and Haitian entrants; Amerasian immigrants; and other noncitizens treated as if they were refugees for purposes of Medicaid eligibility.

Under 8 U.S.C. 1612(b)(2)(B), States are required to cover lawful permanent residents who have worked or can be credited with 40 qualifying quarters, as defined under title II of the Social Security Act. Quarters worked either by the individual or his or her spouse or parents may be counted if certain conditions, described in 8 U.S.C. 1612(b)(2)(B) and 8 U.S.C. 1645, are met. Under 8 U.S.C. 1612(b)(2)(C), States must provide full Medicaid coverage to all lawfully residing noncitizens who are an honorably discharged veteran or an active-duty service member in the United States Armed Forced as well as to spouses and dependent children of such individuals who meet all other eligibility requirements under the State plan.

In accordance with 8 U.S.C. 1612(b)(2)(E) and (F), States must provide full Medicaid benefits to certain American Indians and noncitizens receiving SSI. Finally, in accordance with 8 U.S.C. 1612(b)(2)(G), States must provide full Medicaid benefits to COFA migrants who live in one of the 50 States or the District of Columbia. Covering COFA migrants in the U.S. territories, including Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa is at the territory's option. All such individuals described in 8 U.S.C. 1612(b)(2) must meet all other eligibility requirements in the State to be eligible for Medicaid coverage.

Since CHIP is not a ''designated Federal program'' under 8 U.S.C. 1612(b)(3), none of the individuals described in 8 U.S.C. 1612 are eligible for separate CHIP based on this statute, though some of these individuals may be eligible for CHIP under other statutes.

E. Administration, Eligibility, Essential Health Benefits, Performance Standards, Service Delivery Requirements, Premium and Cost Sharing, Allotments, and Reconciliation (42 CFR Part 600)

Section 1331 of the ACA provides States with an option to establish a BHP.[102] In States that elect to implement a BHP, the program makes affordable health benefits coverage available for lawfully present individuals under age 65 with household incomes between 133 percent and 200 percent of the FPL (or in the case of lawfully present noncitizens who are ineligible for Medicaid or CHIP due to immigration status, with household incomes between zero and 200 percent of the FPL) who are not otherwise eligible for other minimum essential coverage including Medicaid, CHIP, or affordable employer-sponsored coverage. As of April 1, 2024, there is one State that operates a BHP—Minnesota.[103]

In the proposed rule, we proposed conforming amendments to the BHP regulations to remove the current cross-reference to 45 CFR 152.2 in the definition of ''lawfully present'' at 42 CFR 600.5. We proposed to amend the definition of ''lawfully present'' in the BHP regulations at 42 CFR 600.5 to instead cross-reference the definition of ''lawfully present'' proposed at 45 CFR 155.20. We noted that this proposal, if finalized, would result in DACA recipients being considered lawfully present for purposes of eligibility to enroll in a BHP in a State that elects to implement such a program, if otherwise eligible. We also noted that, if the proposals were finalized, the modification would ensure that the definition of ''lawfully present'' used to determine eligibility for coverage under a BHP is aligned with the definition of ''lawfully present'' used for the other insurance affordability programs. While we are not finalizing a lawfully present definition for Medicaid or CHIP in this final rule for the reasons detailed in section I, we are finalizing a definition of ''lawfully present'' for purposes of BHP eligibility that will align the definitions used for Exchanges and for BHP.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: One nonprofit organization commenter noted that in Minnesota, a bill was recently passed to expand the State's BHP to all individuals who are otherwise eligible, regardless of immigration status, using State funds. The commenter notes that CMS' rule aligns with Minnesota's ongoing efforts to reduce uncompensated care costs and improve population health.

Response: We appreciate this commenter's support for the rule's provisions to no longer exclude DACA recipients from eligibility for a BHP.

Comment: Commenters noted and appreciated CMS' foresight to ensure that DACA recipients will be able to enroll in a BHP should other States choose this option in the future.

Response: We agree that, should any other States elect to operate a BHP in the future, that DACA recipients in the State would be considered lawfully present for purposes of eligibility for the BHP. Since the proposed rule was published, Oregon has indicated that they intend to begin operating a BHP effective July 1, 2024, and the definition of ''lawfully present'' finalized in this rule will apply to Oregon's BHP which is currently pending approval with CMS.

After consideration of public comments, we are finalizing the proposal to include a cross-reference to

[102] See 42 U.S.C. 18051. *See also* 42 CFR part 600.

[103] Minnesota's program began January 1, 2015. New York's BHP program began April 1, 2015 and was suspended effective April 1, 2024. For more information, see *https://www.medicaid.gov/basic-health-program/index.html.* Also see, for example, 87 FR 77722, available at *https://www.govinfo.gov/content/pkg/FR-2022-12-20/pdf/2022-27211.pdf.* Oregon is proposing to implement a BHP effective July 1, 2024, and it is currently pending approval with CMS.

45 CFR 155.20 at 42 CFR 600.5 as proposed.

III. Severability

As described in the background section of this rule, the ACA generally [104] requires that to enroll in a QHP through an Exchange, an individual must be either a citizen or national of the United States or be ''lawfully present'' in the United States.[105] The ACA also generally requires that individuals be ''lawfully present'' to be eligible for insurance affordability programs such as PTC,[106] APTC,[107] and CSRs [108] for their Exchange coverage. Additionally, enrollees in a BHP are required to meet the same citizenship and immigration requirements as QHP enrollees.[109] The ACA does not define ''lawfully present'' beyond specifying that an individual is only considered lawfully present if they are reasonably expected to be lawfully present for the period of their enrollment,[110] and that CMS is required to verify that Exchange applicants are lawfully present in the United States.[111]

Since 1996, when the DOJ's Immigration and Naturalization Service issued an interim final rule defining the term ''lawfully present'' as used in the then-recently enacted PRWORA, Federal agencies have considered deferred action recipients to be ''lawfully present'' for purposes of certain Social Security benefits (see *Definition of the Term Lawfully Present in the United States for Purposes of Applying for Title II Benefits Under Section 401(b)(2) of Public Law 104–193,* interim final rule, 61 FR 47039). Given the lack of a statutory definition of ''lawfully present'' in the ACA and given the rulemaking authority granted to CMS under 42 U.S.C. 18051 and 42 U.S.C. 18041, HHS has discretion to determine the best legal interpretations of these terms for purposes of administering its programs. As previously described, CMS' authority to remove the exclusion that treated DACA recipients differently from other noncitizens with deferred action under the definition of ''lawfully present'' for purposes of eligibility for health insurance through an Exchange and a BHP is supported by law and should be upheld in any legal challenge.

Similarly, we are finalizing technical changes to the definition of ''lawfully present'' for the purposes of eligibility for a QHP through an Exchange or a BHP, and we believe those changes are also well-supported in law and practice and should be upheld in any legal challenge. We also believe that our exercise of our authority reflects sound policy.

However, in the event that any portion of this final rule is declared invalid, we intend that the other changes to the definition of ''lawfully present'' would be severable. For example, if a court were to stay or invalidate the inclusion of one provision in the definition of ''lawfully present,'' for purposes of eligibility for the Exchanges or the BHP, we intended the remaining features in sections II.B.1 and II.B.2 of this rule to stand. Likewise, CMS intends that if one provision of the changes to the definition of ''lawfully present'' is stayed or invalidated, that other provisions within this regulation be severable to the extent possible. For example, if one of the provisions discussed in section II.B.2 (Other Changes to the ''Lawfully Present'' Definition) of the proposed rule is stayed or invalidated, CMS intends that the other provisions discussed in that section be severable.

Additionally, individual portions of this final rule have significant benefits and would be worthwhile in themselves. For example, a rule consisting only of the technical and clarifying changes in section II.B.2 of this final rule, applied through cross-reference to Exchanges and BHPs, would allow CMS and Exchanges to more effectively verify the lawful presence of noncitizens for purposes of eligibility for health insurance affordability programs. A rule consisting solely of the changes in section II.B.1 of this rule would have significant benefits because it would increase access to health coverage for DACA recipients. These reasons alone would justify the continued implementation of these policies.

In the proposed rule, we proposed a severability provision at 45 CFR 155.30 indicating that the provisions regarding the definition of ''lawfully present'' proposed at 45 CFR 155.20 were intended to be severable from each other, as well as from the definitions of ''lawfully present'' and ''lawfully residing'' proposed at 42 CFR 435.4. We also proposed a provision at 42 CFR 435.12 regarding the severability of the definitions of ''lawfully present'' and ''lawfully residing'' that were proposed at 42 CFR 435.4.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters stated support for CMS' inclusion of severability clauses in the rule. Commenters stated that they agreed with HHS that the proposed changes are well-supported in law and practice and that they reflect sound policy, but that they also recognized that the rule's changes are not dependent on each other and could be implemented independently.

Response: We appreciate commenters' agreement that the changes in this rule are well-supported in law and practice. We further appreciate commenters' recognition that the provisions of this rule are not dependent on each other and could be implemented independently.

After consideration of public comments, we are finalizing the severability clause at 45 CFR 155.30 as proposed, with one modification to no longer reference the definitions of ''lawfully present'' and ''lawfully residing'' proposed at 42 CFR 435.4, given that we are not finalizing those definitions at this time. Because we are not finalizing definitions of ''lawfully present'' or ''lawfully residing'' at 42 CFR 435.4 at this time, we are also not finalizing the proposed severability clause that references those definitions at 42 CFR 435.12 at this time. The rulemaking process with regard to these portions of the proposal is ongoing.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*),

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[104] States may pursue a waiver under section 1332 of the ACA that could waive the ''lawfully present'' framework in section 1312(f)(3) of the ACA. See 42 U.S.C. 18052(a)(2)(B). There is currently one State (Washington) with an approved section 1332 waiver that includes a waiver of the ''lawfully present'' framework to the extent necessary to permit all State residents, regardless of immigration status, to enroll in a QHP and QDP through the State's Exchange, as well as to apply for State subsidies to defray the costs of enrolling in such coverage. Consumers who are newly eligible for Exchange coverage under the waiver remain ineligible for PTC for their Exchange coverage. While neither Colorado nor New York requested a waiver of the ''lawfully present'' framework, both States are permitted to use pass-through funding based on Federal savings from their 1332 waivers to support programs covering immigrants who are ineligible for PTC. Colorado provides premium and cost-sharing subsidies to individuals earning up to 300 percent of FPL who are otherwise ineligible for Federal premium subsidies, including undocumented individuals. Under New York's section 1332 waiver, some immigrants with household incomes up to 200 percent of FPL, including DACA recipients, will be eligible for coverage under the State's EP Expansion plan. Beginning August 1, 2024, DACA recipients with incomes up to 250 percent of FPL will also be eligible for coverage under the State's EP Expansion. For more information on the Colorado, Washington, and New York section 1332 waivers, see *https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-*.

[105] 42 U.S.C. 18032(f)(3).

[106] 26 U.S.C. 36B(e)(2).

[107] 42 U.S.C. 18082(d).

[108] 42 U.S.C. 18071(e).

[109] 42 U.S.C. 18051(e).

[110] 42 U.S.C. 18032(f)(3), 42 U.S.C. 18071(e)(2).

[111] 42 U.S.C. 18081(c)(2)(B).

we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We solicited public comment on each of these issues for the following sections of this document that contain information collection requirements.

A. Wage Estimates

To derive average costs in the proposed rule, we used data from the U.S. Department of Labor's Bureau of Labor Statistics' (BLS's) May 2021 National Occupational Employment and Wage Estimates for all salary estimates (*https://www.bls.gov/oes/current/oes_nat.htm*).[112] Since publishing the proposed rule, more recent data has become available, so we are modifying all salary estimates in this final rule to use BLS's May 2023 National Occupational Employment and Wage Estimates (*https://www.bls.gov/oes/current/oes_nat.htm*). In this regard, Table 1 presents BLS's median hourly wage, our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupational Code	Median Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Computer Programmer	15-1251	47.94	47.94	95.88
Database and Network Administrator & Architect	15-1240	50.83	50.83	101.66
General and Operations Manager	11-1021	48.69	48.69	97.38
Business Operations Specialist	13-1000	37.74	37.74	75.48
Eligibility Interviewers, Govt Programs	43-4061	24.17	24.17	48.34

For States and the private sector, employee hourly wage estimates have been adjusted by a factor of 100 percent to account for fringe benefits and other indirect costs. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

We adopt an hourly value of time based on after-tax wages to quantify the opportunity cost of changes in time use for unpaid activities. This approach matches the default assumptions for valuing changes in time use for individuals undertaking administrative and other tasks on their own time, which are outlined in an Assistant Secretary for Planning and Evaluation (ASPE) report on ''Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices.'' [113] We started with a measurement of the usual weekly earnings of wage and salary workers of $1,117.[114] We divided this weekly rate by 40 hours to calculate an hourly pre-tax wage rate of $27.93. We adjusted this hourly rate downwards by an estimate of the effective tax rate for median income households of about 17 percent, resulting in a post-tax hourly wage rate of $23.18. We adopt this as our estimate of the hourly value of time for changes in time use for unpaid activities.

B. Information Collection Requirements (ICRs)

1. ICRs Regarding Medicaid and CHIP

a. Medicaid and CHIP and the CHIPRA 214 Option (42 CFR 435.4 and 457.320(c))

Changes related to our Medicaid and CHIP proposals related to the CHIPRA 214 option were submitted to OMB for review under OMB Control Number 0938–1147 (CMS–10410). We are not finalizing these provisions at this time and as such, are not updating PRA burden estimates.

We continue to consider the public comments on the Medicaid and CHIP proposals that we received; thus, we are not responding to these comments in the final rule at this time.

b. CHIP Changes Related to the CAA, 2024 (42 CFR 435.4 and 457.320(b))

Since the time of the proposed rule, and as discussed earlier in this final rule, under the CAA, 2024 COFA migrants are now considered qualified noncitizens for the purposes of eligibility for CHIP, effective March 9, 2024, if they meet all other eligibility requirements for CHIP. This change does not impact Medicaid, Exchanges, or BHP. Therefore, we have updated our regulations to reflect the statutory change extending eligibility for CHIP to COFA migrants.

[112] *See* 88 FR 25322 through 25323 for more information on the wage estimates used in the proposed rule.

[113] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. ''Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices.'' (2017) *https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework.*

[114] U.S. Bureau of Labor Statistics. Employed full time: Median usual weekly nominal earnings (second quartile): Wage and salary workers: 16 years and over [LEU0252881500A], retrieved from FRED, Federal Reserve Bank of St. Louis; *https://fred.stlouisfed.org/series/LEU0252881500A.* Annual Estimate, 2023.

The impact of this change will be very minimal and will impact only those States that have a separate CHIP, and that have not elected the CHIPRA 214 option for at least one population of pregnant individuals or children in their separate CHIPs. Since COFA migrants are already eligible for CHIP in States that have elected the CHIPRA 214 option, as reflected in a 2021 SHO letter,[115] we only estimate impact for States with a separate CHIP that have not elected the CHIPRA 214 option. Using data from the GAO for the most recent year we could obtain,[116] which estimated that the total US population of COFA migrants was 94,000, and then estimating how many may be living in States under the previously described conditions, we estimate approximately 12,225 COFA migrants live in States impacted by this change, primarily within six of those States. Accounting further for how many would actually be eligible under the remaining CHIP eligibility criteria, and then would seek to enroll, we believe the impact of this change to be very minimal. Therefore, and because this change is based on a statutory change and not the result of a policy in this final rule, we are not including more extensive burden estimates in this or section V. of this final rule.

2. ICRs Regarding the BHP (42 CFR 600.5)

The following changes were submitted to OMB for review under OMB Control Number 0938–1218 (CMS–10510).

In the proposed rule, we estimated a one-time burden of 200 hours at a cost of $18,863 for completing the necessary updates to a BHP application. We are modifying the estimates in this final rule to reflect the updated wage estimates as outlined in section IV.A of this final rule. We did not receive public comments on the method of deriving these burden estimates in the proposed rule, and we are therefore finalizing them using the proposed methodology with the updated wage estimates.

The impact of completing the necessary changes to the BHP application is with regards to the two States that will operate BHPs as of the effective date of this rule—Minnesota and Oregon.[117] Although Oregon's BHP is still pending CMS approval, we are including it in our estimate in order to best reflect which States we anticipate may be impacted when this rule becomes effective. We estimate that it will take each State 100 hours to develop and code the changes to its BHP eligibility and verification system to correctly evaluate eligibility under the revised definition of ''lawfully present'' to include DACA recipients and certain other limited groups of noncitizens as outlined in section II.B.2 of this final rule. This estimate is based on past experience with similar system changes. To be conservative in our estimates, we assume 100 hours per State, but it is important to note that it may take each State less than 100 hours given the overlap in State eligibility and verification systems, as work completed for the State Exchange system may be the same for its BHP.

Of those 100 hours, we estimate it would take a database and network administrator and architect 25 hours at $101.66 per hour and a computer programmer 75 hours at $95.88 per hour. In the aggregate, we estimate a one-time burden of 200 hours (2 States × 100 hours) at a cost of $19,465 (2 States × [(25 hours × $101.66 per hour) + (75 hours × $95.88 per hour)]) for completing the necessary updates to a BHP application.

We note that the policies in this final rule will impose additional costs on BHP agencies to process the applications for individuals impacted by these policies. Those impacts are accounted for under OMB Control Number 0938–1191 (Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Insurance Marketplaces, Medicaid and Children's Health Insurance Program Agencies (CMS–10440)), discussed in section IV.B.3 of this final rule, which pertains to the streamlined application.

3. ICRs Regarding the Exchanges and Processing Streamlined Applications (45 CFR 152.2 and 155.20, and 42 CFR 600.5)

The following changes were submitted to OMB for review under OMB Control Number 0938–1191 (CMS–10440).

In the proposed rule, we estimated a one-time burden of 1,900 hours at a cost of $179,199 for completing the necessary updates to eligibility and enrollment platforms. We are modifying the estimates in this final rule to reflect the updated wage estimates as outlined in section IV.A of this final rule. As discussed previously, the changes to the definition of ''lawfully present'' will impact eligibility to enroll in a QHP through an Exchange and for APTC and CSRs. This change applies to the 18 State Exchanges not on the Federal platform, as well as the Federal Government, which will make changes to the Federal eligibility and enrollment platform for the States with Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal platform (SBE–FPs). We estimate that it will take the Federal Government and each of the State Exchanges not on the Federal platform 100 hours in 2024 to develop and code the changes to their eligibility systems to correctly evaluate and verify eligibility under the definition of ''lawfully present'' that is revised to include DACA recipients and certain other limited groups of noncitizens as outlined in section II.B.2 of this final rule. We do not expect States operating SBE–FPs to incur any implementation costs related to Exchange eligibility and enrollment platform changes. These estimates are based on past experience with similar system changes.

Of those 100 hours, we estimate it would take a database and network administrator and architect 25 hours at $101.66 per hour and a computer programmer 75 hours at $95.88 per hour. In aggregate for the State Exchanges not on the Federal platform, we estimate a one-time burden in 2024 of 1,800 hours (18 State Exchanges × 100 hours) at a cost of $175,185 (18 States × [(25 hours × $101.66 per hour) + (75 hours × $95.88 per hour)]) for completing the necessary updates to State Exchange systems. For the Federal Government, we estimate a one-time burden in 2024 of 100 hours at a cost of $9,733 ((25 hours × $101.66 per hour) + (75 hours × $95.88 per hour)). In total, the burden associated with all system updates will be 1,900 hours at a cost of $184,918.

''Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid and CHIP Agencies,'' OMB Control Number 0938–1191 (CMS–10440), accounts for burdens associated with the streamlined application for enrollment in the programs impacted by this rule. As such, the following information collection addresses the burden of processing applications and assisting enrollees with BHP and QHP enrollment, and those impacts are not reflected in the ICRs for BHPs,

[115] *See* SHO #21–005, available at *https://www.medicaid.gov/federal-policy-guidance/downloads/sho21005.pdf.*

[116] Compacts of Free Association: Populations in U.S. Areas Have Grown, with Varying Reported Effects, June 2020, available at *https://www.gao.gov/assets/gao-20-491.pdf.*

[117] Minnesota's BHP began January 1, 2015. Oregon's BHP is projected to begin July 1, 2024, and is pending CMS approval. New York suspended its BHP effective April 1, 2024. For more information, see *https://www.medicaid.gov/basic-health-program/index.html.*

discussed in section IV.B.2 of this final rule. In the proposed rule, we estimated that the total burden of application processing and assisting enrollees with Medicaid, CHIP, BHP, and QHP enrollment would be 34,000 hours for a total cost of $1,587,800, where the total burden on States would be 18,397 hours annually at a cost of $859,140, and the total burden on the Federal Government would be 15,603 hours annually at a cost of $728,660. We sought comment on these estimates and the methodology and assumptions used to calculate them. We are updating the estimates in this final rule to reflect that we are not finalizing the proposed changes for Medicaid and CHIP and that we have modified the estimates with the updated wage estimates as outlined in section IV.A of this final rule and the most recent available data on DACA recipients.

For assisting additional eligible enrollees and processing their applications, we estimate this will take a government programs eligibility interviewer 10 minutes (0.17 hours) per application at a rate of $48.34 per hour, for a cost of approximately $8.22 per application. This estimate is based on past experience with similar application changes. As outlined further in section IV.B.4 of this final rule, we anticipate that approximately 147,000 individuals impacted by this final rule will complete the application annually. Therefore, the total application processing burden associated with the policies in this final rule will be 24,990 hours (0.17 hours × 147,000 applications) for a total cost of $1,208,017 (24,990 hours × $48.34 per hour). As discussed further in this section, we anticipate that approximately 52 percent of the application processing burden will fall on States, while the remaining approximately 48 percent will be borne by the Federal Government. We estimate these proportions as follows.

To start, we estimate the percentage of applications that will be processed for the Exchanges and BHPs. We assume that the proportion of applications that will be processed for each program will be equivalent to the proportion of individuals impacted by the policies in this final rule that would enroll in each program. As outlined in section V.C. of this final rule, we estimate that of the 100,000 individuals impacted by the policies in this rule, 99,000 will enroll in the Exchanges (99 percent), and 1,000 (1 percent) in BHPs on average each year, including redeterminations and re-enrollments. Using these same proportions, out of the 147,000 applications anticipated to result from the policies in this final rule, we estimate 145,000 applications will be processed for the Exchanges, and 2,000 will be processed for BHPs on average each year.

Next, we calculate the proportion of each program's application processing costs that are borne by States compared to the Federal Government. The entire information collection burden associated with changes to BHPs falls on the two States with BHPs—Minnesota and Oregon.[118] As such, we assume 100 percent of the BHP application processing costs will fall on these two States. For the Exchanges, we use data from the 2024 Open Enrollment Period to estimate the proportion of applications that are processed by States compared to the Federal Government, and we determined that 49 percent of Exchange applications were submitted to FFEs/SBE–FPs, and are therefore processed by the Federal Government, while 51 percent were submitted to and processed by the 18 State Exchanges not on the Federal platform.[119] As such, we anticipate that 49 percent of Exchange application processing costs will fall on the Federal Government and 51 percent of Exchange application processing costs will fall on States using their own eligibility and enrollment platforms. We do not expect States operating SBE–FPs to incur any application processing costs as these applications, and the costs associated with them, will fall on the Federal Government.

Finally, we apply the proportion of applications we estimated for each program we discussed earlier to the State and Federal burden proportions. Using the per-application processing burden discussed earlier in this ICR (10 minutes, or 0.17 hours, per application at a rate of $48.34 per hour) for BHPs, if we estimate 2,000 applications will be processed, the burden for all of those will be borne by the States. Using the per-application processing burden of 10 minutes (0.17 hours) per application at a rate of $48.34 per hour, this results in a burden of 340 hours, or $16,436, for States to process BHP applications. For the Exchanges, if we estimate 145,000 applications will be processed, 51 percent of those (73,950) will be processed by State Exchanges not on the Federal platform and 49 percent (71,050) will be processed by the Federal Government. Using the per-application processing burden of 10 minutes (0.17 hours) per application at a rate of $48.34 per hour, this results in a burden of 12,572 hours, or $607,706, for State Exchanges not on the Federal platform and 12,079 hours, or $583,875, for the Federal Government.

Therefore, the total burden on State Exchanges not on the Federal platform to assist eligible beneficiaries and process their applications will be 12,912 hours annually (340 hours for BHP + 12,572 hours for State Exchanges not on the Federal platform) at a cost of $624,142, and the total burden on the Federal Government will be 12,079 hours annually (entirely for Exchanges) at a cost of $583,875.

We received public comments on the estimates outlined in the proposed rule. We are finalizing the proposed methodology of deriving these burden estimates with the updated wage estimates as outlined in section IV.A of this final rule and the most recent available data on DACA recipients and application processing. The following is a summary of the comments we received and our responses.

Comment: Some State Exchanges stated concerns about whether they would be able to implement the rule's provisions by the November 1, 2023 proposed effective date but did not express concern about the overall burden on State agencies of making systems changes or processing new applications for impacted populations.

Response: We understand that some State Exchanges not on the Federal platform will need to make changes to their eligibility and enrollment systems to correctly determine eligibility for DACA recipients and the other individuals impacted by the revised lawfully present definition. We are committed to providing State Exchanges with technical assistance and any additional support needed to ensure that States are able to correctly determine eligibility for DACA recipients and other impacted noncitizens by this final rule's November 1, 2024 effective date. We are also committed to working with State Exchanges not on the Federal platform and BHP agencies to identify any potential manual workarounds that may be needed to correctly determine eligibility prior to full systems changes being in place.

Comment: Commenters noted that they expected that the technical changes made to the definition of lawfully present discussed in section II.B.2 of this final rule would reduce application processing burdens for State Exchanges in the future, given that they are

[118] Minnesota's BHP began January 1, 2015. Oregon's BHP is projected to begin July 1, 2024, and is pending CMS approval. For more information, see *https://www.medicaid.gov/basic-health-program/index.html.*

[119] Centers for Medicare & Medicaid Services. (2024). 2024 Open Enrollment Report. *https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf.*

expected to make it easier for State Exchanges to verify applicants' lawful presence through DHS SAVE.

Response: We agree that including DACA recipients and making the technical changes discussed in this rule will streamline application processing and make electronic verification of immigration status through SAVE more efficient, by both decreasing DHS' workload in verifying immigration status at Steps Two and Three, which require manual intervention, and by no longer requiring eligibility caseworkers to resubmit a request for additional information or provide additional documentation.

After consideration of public comments, we are finalizing these burden estimates using the proposed methodology with the most recent available data as described above.

4. ICRs Regarding the Application Process for Applicants

The following changes were submitted to OMB for review under OMB Control Number 0938–1191 (CMS–10440).

As required by the ACA, there is one application through which individuals may apply for health coverage in a QHP through an Exchange and for other insurance affordability programs like Medicaid, CHIP, and a BHP.[120] In the proposed rule, we assumed the burden of completing an Exchange application was essentially the same as applying with a State Medicaid or CHIP agency, and therefore we did not distinguish between these populations. In the proposed rule, we estimated the total annual additional burden on all individuals impacted by the proposed changes by completing the application or submitting documentation to verify their lawful presence would be approximately 163,000 hours with an equivalent cost of approximately $3,375,730. We sought comment on these burden estimates. We are updating the estimates in this final rule to reflect that we are not finalizing the proposed changes for Medicaid and CHIP and to reflect the most recent available data, which includes the updated wage estimates in section IV.A of this rule, and the most recent available data on DACA recipients and open enrollment.

Based on the enrollment projections discussed in the Regulatory Impact Analysis section later in this rule, we anticipate that DACA recipients will represent the majority of individuals impacted by this final rule, and we are unable to quantify the number of non-DACA recipients impacted by the other changes in this rule, but we expect the number to be small. We estimate that there are 147,000 uninsured DACA recipients based on USCIS data on active DACA recipients (545,000 in 2023) [121] and a 2022 survey by the National Immigration Law Center stating that 27 percent of DACA recipients are uninsured,[122] and we assume that 100 percent of uninsured DACA recipients will apply for coverage.[123] As such, we anticipate that approximately 147,000 individuals impacted by the proposals in this rule will complete the application annually.

In the existing information collection request for this application OMB Control Number 0938–1191, we estimate that the application process will take an average of 30 minutes (0.5 hours) to complete for those applying for insurance affordability programs and 15 minutes (0.25 hours) for those applying without consideration for insurance affordability programs.[124] We estimate that of the 147,000 individuals impacted by the proposed changes, 98 percent will be applying for insurance affordability programs and 2 percent will be applying without consideration for insurance affordability programs. Using the hourly value of time for changes in time use for unpaid activities discussed in section IV.A of this final rule (at an hourly rate of $23.18), the average opportunity cost to an individual for completing this task is estimated to be approximately 0.495 hours ((0.5 hours × 98 percent) + (0.25 hours × 2 percent)) at a cost of $11.47. The total annual additional burden on the 147,000 individuals impacted by the changes in this final rule will be approximately 72,765 hours with an equivalent cost of approximately $1,686,693.

As stated earlier in this final rule, Exchanges and BHP agencies will require individuals completing the application to submit supporting documentation to confirm their lawful presence if they are unable to be verified electronically. An applicant's lawful presence may not be able to be verified electronically if, for example, the applicant opts to not include information about their immigration documentation, such as their alien number or Employment Authorization Document (EAD) number, when they fill out the application. We estimate that of the 147,000 individuals impacted by the changes as finalized, approximately 54 percent (or 79,380) of applicants will be able to have their lawful presence electronically verified, and the remaining 46 percent (or 67,620) of applicants will be unable to have their lawful presence electronically verified and will therefore have to submit supporting documentation to confirm their lawful presence.[125] We estimate that a consumer will, on average, spend approximately 1 hour gathering and submitting required documentation. Using the hourly value of time for changes in time use for unpaid activities discussed in section IV.A of this final rule (at an hourly rate of $23.18), the opportunity cost for an individual to complete this task is estimated to be approximately $23.18. The total annual additional burden on the 67,620 individuals impacted by the changes finalized in this rule who are unable to electronically verify their lawful presence and therefore need to submit supporting documentation will be approximately 67,620 hours with an equivalent cost of approximately $1,567,432.

As previously stated, for the 147,000 individuals impacted by this rule, the annual additional burden of completing the application will be 0.495 hours per individual on average, which totals to 72,765 hours at a cost of $1,686,693. For the 67,620 individuals who are unable to have their lawful presence electronically verified, the total annual burden of submitting documentation to verify their lawful presence will be 67,620 hours at a cost of $1,567,432. Therefore, the average annual burden per respondent will be 0.955 hours ((0.495 hours × 54 percent of individuals) + (1.495 hours × 46 percent of individuals)), and the total annual

[120] 42 U.S.C. 18083.

[121] Count of Active DACA Recipients by Month of Current DACA Expiration as of September 30, 2023. U.S. Citizenship and Immigration Services. *https://www.uscis.gov/sites/default/files/document/data/active_daca_recipients_fy23_q4.pdf.*

[122] National Immigration Law Center. DACA Recipients' Access to Health Care*: 2023 Report.* (2023) *https://www.nilc.org/wp-content/uploads/2023/05/NILC_DACA-Report_2023.pdf.*

[123] While some individuals impacted by the changes in this final rule may not apply for coverage, we are unable to quantify the proportion of uninsured DACA recipients who would choose not to apply. Because uninsured DACA recipients would likely benefit from becoming insured, we assume 100 percent of DACA recipients will apply for coverage.

[124] It is possible that some individuals impacted by the proposed changes to the definition of lawful presence in this rule would apply using the paper application, but internal CMS data show that this would be less than 1 percent of applications. Therefore, we are using estimates in this analysis to reflect that nearly all applicants would apply using the electronic application.

[125] This estimate is informed by recent data from the FFEs and SBE–FPs. While certain changes proposed in this rule may result in an increase in the proportion of applicants who are able to have their lawful presence electronically verified, we do not have a reliable way to quantify any potential increase.

burden on all of these individuals impacted by the proposed changes in this rule will be 140,385 hours at a cost of $3,254,124.

We received public comments on the estimates outlined in the proposed rule. As previously mentioned, we are updating the estimates in this final rule to reflect that we are not finalizing the proposed changes for Medicaid and CHIP and to reflect the most recent available data. The following is a summary of the comments we received and our responses.

Comment: One commenter agreed with CMS' assumption that regardless of where an individual applies, the burden of completing an application is essentially the same. The commenter further affirmed CMS' statement that, as required by the ACA, there is generally one application through which individuals may apply for health coverage in a QHP through an Exchange and for other insurance affordability programs like a BHP.

Response: We agree that the burden of completing an application is essentially the same regardless of whether the individual was to apply directly with their BHP agency or with an Exchange. As we are not finalizing our proposals related to Medicaid and CHIP at this time, there will not be a change in the application process for Medicaid and CHIP.

Comment: One commenter stated that the changes in the rule ''will not result in an increased application burden for impacted individuals.''

Response: We have considered this comment and continue to believe that the burden estimates associated with the policies in this final rule are reasonable and in line with the burden estimates in the currently approved PRA package OMB Control Number 0938–1191. However, we acknowledge that the actual application burden may vary depending on the applicant. We are hopeful that the changes in this rule will not overburden individuals in the application process. Additionally, we clarify that as discussed earlier in this ICR section, we submitted the burden changes associated with this ICR to OMB for review under OMB Control Number 0938–1191.

After consideration of public comments, we are finalizing these burden estimates using the methodology as proposed with the most recent available data.

C. Burden Estimate Summary

TABLE 2: Summary of Final Burden Estimates

Regulation Section(s)/ ICR Provision	OMB Control No./ CMS-ID	Year	Number of Respondents	Number of Responses	Time per Response (hrs)	Total Time (hr)	Hourly Labor Rate ($/hr)	Total Labor Cost ($)	State Share ($)	Total Beneficiary Cost ($)
42 CFR 600.5 BHP System Changes	0938–1218 (CMS-10510)	2024	2	2	100	200	Varies	$19,465	$19,465	N/A
45 CFR 152.2 and 155.20 Exchange System Changes	0938-1191 (CMS-10440)	2024	19	19	100	1,900	Varies	$184,918	$175,185	N/A
42 CFR 600.5, 45 CFR 152.2 and 155.20 Streamlined Application Processing	0938-1191 (CMS-10440)	**2025-**2028	147,000	147,000	0.17	24,990	$48.34	$1,208,017	$624,142	N/A
42 CFR 600.5, 45 CFR 152.2 and 155.20 Application Process for Applicants	0938-1191 (CMS-10440)	**2025-2028**	147,000	147,000	0.96	140,385	$23.18	$3,254,124	N/A	$3,254,124

V. Regulatory Impact Analysis

A. Statement of Need

This final rule updates the definition of ''lawfully present'' in our regulations for certain CMS programs. This definition is currently used to determine whether a consumer is eligible to enroll in a QHP through an Exchange and for APTC and CSRs, and whether a consumer is eligible to enroll in a BHP in States that elect to operate a BHP. In addition, we are removing the exception for DACA recipients from the definitions of ''lawfully present'' used to determine eligibility to enroll in a QHP through an Exchange or a BHP, and we are instead treating DACA recipients the same as other deferred action recipients. We are also finalizing some modifications to the ''lawfully present'' definition currently at 45 CFR 152.2 that incorporate additional detail, clarifications, and some technical modifications for the Exchanges and BHPs. We are not finalizing changes to the Medicaid and CHIP programs with respect to the definitions of ''lawfully present'' at this time.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Executive Order 14094 on Modernizing Regulatory Review (April

6, 2023), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866, as amended by Executive Order 14094, defines a ''significant regulatory action'' as an action that is likely to result in a rule that may: (1) have an annual effect on the economy of $200 million or more (adjusted every 3 years by the Administrator of OMB's Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product), or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impacts of entitlement, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or policy issues for which centralized review will meaningfully further the President's priorities or the principles set forth in the Executive order, as specifically authorized in a timely manner by the Administrator of OIRA.

Based on our estimates, OIRA has determined that this rulemaking is a significant regulatory action under section 3(f)(1) Executive Order 12866. Accordingly, we have prepared a regulatory impact analysis (RIA) that to the best of our ability presents the costs and benefits of the rulemaking. Therefore, OMB has reviewed these final regulations, and we have provided the following assessment of their impact.

Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act, 5 U.S.C 801 *et seq.*), OIRA has determined that this rule does meet the criteria set forth in 5 U.S.C. 804(2). Accordingly, this rule has been submitted to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information.

C. Detailed Economic Analysis

We prepared the economic impact estimates utilizing a baseline of ''no action,'' comparing the effect of the policies against not finalizing the rule at all.

This analysis reviews the amendments finalized under 42 CFR 600.5, and 45 CFR 152.2 and 155.20, which will add the following changes to the definition of lawfully present by making technical modifications to add the following new categories of noncitizens to this definition via this regulation:

- Those granted deferred action under DACA;
- Those granted employment authorization under 8 CFR 274a.12(c)(35) and (36);
- Additional Family Unity beneficiaries;
- Individuals with a pending application for adjustment of status, without regard to whether they have an approved visa petition;
- Children under 14 with a pending application for asylum, withholding of removal, or protection under CAT or children under 14 who are listed as a dependent on a parent's pending application, without regard to the length of time that the application has been pending; and
- Individuals with an approved petition for SIJ classification.

The amendments finalized under 42 CFR 600.5 and 45 CFR 152.2 and 155.20 will also:

- Revise the description of noncitizens who are nonimmigrants to include all nonimmigrants who have a valid and unexpired status;
- Remove individuals with a pending application for asylum, withholding of removal, or CAT protection who are over age 14 from the definition, as these individuals are covered elsewhere; and
- Simplify the definition of noncitizens with an EAD to include all individuals granted employment authorization under 8 CFR 274a.12(c), as these individuals are already covered elsewhere, with the exception of a modest expansion to those granted employment authorization under 8 CFR 274a.12(c)(35) and (36), discussed earlier in this final rule.

In these respects, the technical modifications that do not relate to DACA recipients contained in this rule are generally technical changes or revisions to simplify verification processes, and therefore, we anticipate a modest impact on individuals' eligibility as a result of these changes. We sought comment on estimates or data sources we could use to provide quantitative estimates for the benefit to these individuals. The proposed regulation also adds those granted deferred action under DACA to the definition. As noted further in this section, we estimate that 100,000 DACA recipients will enroll in health coverage and benefit from the proposals in this rule.[126] We are unable to quantify the number of additional Family Unity beneficiaries, individuals with a pending application for adjustment of status, children under age 14 with a pending application for asylum or related protection or children listed as dependents on a parent's application for asylum or related protection, and individuals with approved petition for SIJ classification, or individuals granted employment authorization under 8 CFR 274a.12(c)(35) or (36) that could enroll in health coverage and benefit from the proposals in this rule, but we expect this number to be small. We sought comment on estimates or data sources we could use to provide quantitative estimates for the benefit to these individuals.

The changes to 42 CFR 600.5 will no longer exclude DACA recipients from the definition of ''lawfully present'' used to determine eligibility for a BHP in those States that elect to operate the program, if otherwise eligible. The changes to 45 CFR 152.2 and 155.20 will make DACA recipients eligible to enroll in a QHP through an Exchange, and for APTC and CSRs, if otherwise eligible. We present enrollment estimates for these populations in Table 3.

[126] The estimates in this RIA are based on DHS' current implementation of the DHS DACA final rule, consistent with the court orders in *Texas* v. *United States,* 50 F.4th 498 (5th Cir. 2022) and *Texas* v. *United States,* 1:18–cv–0068 (S.D. Tex. Oct. 14, 2022), whereby DHS continues to accept the filing of both initial and renewal DACA requests and related applications for employment authorization but is only processing renewal requests.

TABLE 3: Enrollment Estimates by Program, Coverage Years 2024 – 2028

	2024	2025	2026	2027	2028
BHP Enrollment	0	1,000	1,000	1,000	1,000
Exchange Enrollment	0	99,000	85,000	85,000	85,000
Total Enrollment	0	100,000	86,000	86,000	86,000

In the proposed rule, we estimated an enrollment impact of about 129,000.[127] We sought comment on these estimates and the assumptions and methodology used to calculate them. We are modifying the estimates in this final rule to reflect that we are not finalizing the proposed changes for Medicaid and CHIP and to reflect the States that will operate BHPs as of the effective date of this rule and the most recent available data on DACA recipients.[128] [129] To estimate the enrollment impact on the Exchanges and the BHPs, we started with an estimate of the DACA population. USCIS has estimated this count to be 545,000 persons as of September 30, 2023.[130] Based on a 2022 survey from the National Immigration Law Center,[131] roughly 27 percent of DACA recipients were uninsured. In addition, we assume that approximately 70 percent of this group will opt to enroll in the Exchanges and BHPs. This results in an enrollment impact of about 100,000 persons for both the Exchanges and BHP.[132] Based on internal enrollment data, we estimate that 1,000 people will enroll in the BHPs in Minnesota and Oregon,[133] and the remaining 99,000 will enroll in the Exchanges.

The changes to 42 CFR 600.5 will no longer exclude DACA recipients from the definition of lawfully present used to determine eligibility for a BHP in those States that elect to operate the program, if otherwise eligible. There may be an effect on the BHP risk pool as a result of this change, as DACA recipients are relatively younger and healthier than the general population, based on USCIS data showing an average age of 30 years.[134] [135]

The changes to 45 CFR 152.2 and 155.20 will make DACA recipients eligible to enroll in a QHP through an Exchange, and for APTC and CSRs, if otherwise eligible. Similar to BHP eligibility, there may be a slight effect on the States' individual market risk pools. In addition, the modifications to the definition of ''lawfully present'' discussed in section II.B.2. of this rule will reduce burden on Exchanges and BHPs by allowing them to more frequently verify a noncitizen's status with a trusted source of data and to not have to request additional information from consumers. This change will promote simplicity and consistency in program administration, and further program integrity resulting from the increased reliance on a trusted Federal source of data. We sought comment on estimates or data sources we could use to provide quantitative estimates for this benefit.

In addition, increased access to health coverage for DACA recipients and other noncitizens impacted by the proposals in this rule will ensure increased access to health care services for these populations, which in turn may decrease costs for emergency medical expenditures. Further, the policies in this rule will improve the health and well-being of many individuals that are currently without coverage, as having health insurance makes individuals healthier. Individuals without insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts. In addition to the improvement of health outcomes, these individuals will be more productive and better able to contribute economically, as studies have found that workers with health insurance are estimated to miss 77 percent fewer workdays than uninsured workers.[136]

We sought comment on these effects and any other potential benefits that may result from the proposals in this rule.

We received public comments on these effects. The following is a summary of the comments we received and our responses.

Comment: Commenters provided comments related to CMS' estimates for the number of individuals who will newly enroll in health insurance coverage through an Exchange, Medicaid, CHIP, or a BHP. Commenters agreed with CMS' assumption that no longer excluding DACA recipients from eligibility for APTC and CSRs would make such individuals more likely to enroll in coverage.

Commenters also offered details specific to their States and localities. One State department of insurance cited an estimate that of the 40,000 uninsured DACA recipients in California with incomes above the Medi-Cal threshold, 30,000 would enroll in subsidized

[127] *See* 88 FR 25327 through 25329 for a discussion of the proposed enrollment estimates by program.

[128] The Exchange enrollment estimates in this final rule have been updated to account for the DACA recipients that would have enrolled in Medicaid under the policies in the proposed rule but will now enroll in a QHP through an Exchange based on the finalized policies.

[129] The BHP enrollment estimates in the proposed rule assumed that New York and Minnesota would be States impacted by the BHP changes in the proposed rule. The BHP enrollment estimates in this final rule reflect that Minnesota and Oregon will be States impacted by the finalized BHP changes. The data on the number of DACA recipients, as well as the average age of DACA recipients and the percent of DACA recipients that are uninsured has been updated since the proposed rule. *See* 88 FR 25327 through 25329 for more detail on the estimates in the proposed rule.

[130] Count of Active DACA Recipients by Month of Current DACA Expiration as of September 30, 2023. U.S. Citizenship and Immigration Services. *https://www.uscis.gov/sites/default/files/document/data/active_daca_recipients_fy23_q4.pdf.*

[131] National Immigration Law Center, 2023. DACA Recipients' Access to Health Care*: 2023 Report.* (2023). *https://www.nilc.org/wp-content/uploads/2023/05/NILC_DACA-Report_2023.pdf.*

[132] This enrollment estimate does not include DACA recipients who are now expected to be covered under New York's Essential Plan Expansion, effective April 1, 2024, as they will not be impacted by this final rule. For more information, see *https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers#To%20view%20New%20York's%20application%20materials,%20please%20visit%20the%20New%20York%20waiver%20section%20of%20this%20webpage%20below.*

[133] Minnesota's BHP began January 1, 2015. Oregon's BHP is projected to begin July 1, 2024, and is pending CMS approval. For more information, see *https://www.medicaid.gov/basic-health-program/index.html.*

[134] USCIS. Count of Active DACA Recipients by Month of Current DACA Expiration as of September 30, 2023. *https://www.uscis.gov/sites/default/files/document/data/active_daca_recipients_fy23_q4.pdf.*

[135] In the proposed rule, the available USCIS data at the time showed an average age of 29 years. We sought comment on any estimates or data sources we could use to provide quantitative estimates for the associated effects, including benefit to these individuals. *See* 88 FR 25328.

[136] Dizioli, Allan and Pinheiro, Roberto. (2016). *Health Insurance as a Productive Factor.* Labour Economics. *https://doi.org/10.1016/j.labeco.2016.03.002.*

coverage through Covered California.[137] One commenter agreed with CMS' assumption that none of the proposed technical changes to the definition of ''lawfully present'' would result in a significant number of individuals gaining coverage. Nevertheless, the commenter believed that such changes were still important given their potential to significantly benefit impacted individuals and their families, often at very vulnerable points in their lives.

Response: These enrollment projections align with our projections as presented in the proposed rule and in this final rule. As previously stated, we are not finalizing the proposed changes for Medicaid and CHIP at this time, and therefore the enrollment projections in this final rule only reflect the BHP and Exchange enrollment impact. Additionally, we agree that the technical changes to the definition of ''lawfully present'' are important due to the potential benefit to the individuals and families impacted by these changes.

Comment: Commenters provided detailed analysis of the benefits they expected this rule would convey. These benefits, discussed in detail in section II.B.1., include increased access to care, improved health outcomes, reduced disparities, decreased reliance on uncompensated care and emergency department care, and strengthened workforce, education systems, and local economies. Many commenters pointed out how the provisions of this rule will benefit not only DACA recipients and other impacted noncitizens, but their families and communities as well. Commenters further noted that they believed this rule would improve individual market Exchange risk pools, due to DACA recipients' age and health status as compared to current Exchange enrollees, and that improvements to the risk pool could result in cost savings for health insurance issuers in the form of lower claims costs and for individuals in the form of lower health insurance premiums. One commenter, a nonprofit organization, noted that after New York and California established State-funded Medicaid options for DACA recipients, DACA-eligible individuals were 4 percent more likely to report having health insurance in those States as compared to other States that did not expand eligibility, implying that expanding the insurance affordability programs available to DACA recipients will result in further coverage gains.

Response: We agree that these are potential benefits of the policies finalized in this rule. We appreciate the insight from commenters that the policies in this rule will also benefit the families and communities of the DACA recipients impacted by the rule. We agree that it is possible that this rule could improve the Exchange risk pools, which could result in cost savings for issuers and individuals due to lower claims costs and premiums. We further appreciate the supporting data regarding potential coverage gains in Exchange programs in specific States.

Comment: Commenters, including State government agencies, noted that the proposed changes would result in the more efficient operation of CMS programs. Some commenters specifically stated that changes to the definition of ''lawfully present'' could streamline practices for caseworkers and eligibility workers at States and agencies.

Response: We agree that the changes we are finalizing will enable Exchanges and BHPs to more easily verify applicants' lawful presence. This should both simplify operations and decrease the proportion of cases in which caseworkers and eligibility workers need to ask consumers to provide additional information.

After consideration of public comments, we are finalizing these estimates using the calculation methodology as proposed with modifications to reflect that we are not finalizing the proposed changes for Medicaid and CHIP and to reflect the States that will operate BHPs as of the effective date of this rule and the most recent available data on DACA recipients.

1. Costs

The changes to 42 CFR 600.5 will treat DACA recipients the same as other recipients of deferred action, who are lawfully present under the definition used to determine eligibility for BHP, if otherwise eligible. The costs to States as a result of information collection changes associated with this proposal, which include initial system changes, costs to develop and update each State's eligibility systems and verification processes, and application processing costs to assist individuals with processing their applications, are discussed in sections IV.B.2. and IV.B.3. of this final rule, and the costs to consumers as a result of increased information collections associated with this policy, which include applying for BHP and submitting additional information to verify their lawful presence, if necessary, are discussed in section IV.B.4. of this final rule. As previously mentioned, we updated the cost estimates discussed in sections IV.B.2., IV.B.3., and IV.B.4. of this final rule to reflect the policies being finalized in this rule and updated data since publishing the proposed rule. States operating a BHP may choose to provide additional outreach to those eligible. In the proposed rule, we included costs related to the fact that a potential increase in the number of enrollees may increase Federal payments to a State's BHP trust fund. For further information, please see the ''Transfers'' section.

The changes to 45 CFR 152.2 and 155.20 will make DACA recipients eligible to enroll in a QHP through an Exchange, and for PTC and CSRs, if otherwise eligible. The costs to State Exchanges not on the Federal platform and the Federal Government as a result of information collection changes, which include initial system changes costs to develop and update each State's eligibility systems and verification processes and application processing costs to assist individuals with processing their applications, are discussed in section IV.B.3. of this final rule and the costs to consumers as a result of increased information collections associated with this policy, which include applying for Exchange coverage and submitting additional information to verify their lawful presence, if necessary, are discussed in section IV.B.4. of this final rule. This change may result in slightly increased traffic during open enrollment for the 2025 coverage year and beyond. Further, there may be a potential administrative burden on States and regulated entities that choose to conduct outreach and education efforts to ensure that consumers, agents, brokers, and assisters are aware of the changes proposed in this rule associated with the updated definitions of ''lawfully present'' for the purposes of the Exchanges and BHP. We clarify that CMS does not require States to fund additional outreach and enrollment activities as a result of this rule. Because SBE–FPs will not be required to incur costs related to implementation, application processing, or outreach and education, we estimate no increased costs for States operating SBE–FPs as a result of this rule. We also note that both State Exchanges not on the Federal platform and SBE–FPs may see an increase in the user fees they collect from issuers as a result of increased

[137] Dietz, Miranda; Kadiyala, Srikanth, and Lucia, Laurel; ''Extending Covered California subsidies to DACA recipients would fill coverage gap for 40,000 Californians''; UC Berkeley Labor Center; June 6, 2023; *https://laborcenter.berkeley.edu/extending-covered-california-subsidies-to-daca-recipients-would-fill-coverage-gap-for-40000-californians/#_ftn3.*

enrollment due to the policies finalized in this rule. We anticipate that the costs of additional outreach and education that States may choose to pursue would be minimal and sought comment on that assumption.

Whether the effects discussed above as ''costs'' are appropriately categorized depends on societal resource use. To the extent that resources (for example, labor and equipment associated with provision of medical care) are used differently in the presence of this final rule than in its absence, then the estimated effects are indeed costs. If resource use remains the same but different entities in society pay for them, then the estimated effects would instead be transfers. We requested comment that would facilitate refinement of the effect categorization.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters noted that this regulatory change will enable States that currently use State funds to cover DACA recipients to re-allocate State funding towards covering other uninsured individuals if DACA recipients are able to newly access Federally-funded QHPs. Commenters noted that 11 States and the District of Columbia currently use State-only funds to cover all income-eligible children, regardless of lawful presence status, and that certain additional States also cover pregnant and postpartum individuals. Commenters noted that New York and California currently use State funding to provide coverage to DACA recipients.

One commenter, a State government agency, noted that California currently expends approximately $13 million out of the State's General Fund to cover individuals who do not currently meet CMS' definitions of ''lawfully present,'' and that considering DACA recipients ''lawfully present'' has the potential to significantly lower or offset funds currently expended for health coverage for DACA recipients.

Response: We appreciate commenters sharing information about how States may otherwise cover this population. As previously mentioned, we are not finalizing the proposed changes for Medicaid and CHIP. However, State funds used to cover DACA recipients eligible for Medicaid/CHIP may be impacted if individuals currently covered under these State-funded programs choose to enroll in QHP or BHP coverage.

Comment: One commenter agreed with CMS' assumption that costs for outreach and education would be ''minimal'' since the State already conducts robust outreach during its Open Enrollment Period. The commenter stated that they agreed that costs for outreach and education would be ''minimal'' if supported by Federal financial participation and State funding.

Response: We agree that State Exchanges not on the Federal platform generally conduct robust outreach during their Open Enrollment Periods. We are committed to conducting outreach and education to reach individuals impacted by this rule to educate them that they may be newly eligible for health insurance affordability programs.

Comment: Commenters stated concerns about the costs associated with this rule. Commenters noted that this rule will increase costs to taxpayers and stated that illegal immigration is a net cost to taxpayers of about $151 billion per year, further alleging that illegal immigration costs each American taxpayer $1,156 per year. The commenter also highlighted that the U.S. government spends $2.3 trillion annually on Federal medical expenditures, and that it is ''impossible to estimate how many illegal aliens participate in the ACA now, and what level of Federal subsidy they receive,'' but that they believe this rule will place an ''even greater burden'' on taxpayers. Commenters stated concerns that this rule will drive the United States further into debt.

Response: We acknowledge commenters' concerns about the costs on the Federal government and Federal taxpayers associated with this rule. We believe the benefits of this rule outweigh the potential negative impacts identified by commenters. The benefits discussed in section V.C. of this final rule, including increased health coverage and a reduction in uncompensated care costs; ensuring equitable access to coverage across all populations served by the programs addressed in this rule, including members of underserved communities; and potential impacts on the risk pool, are important to balance against the costs of the rule identified in this section. Moreover, as clarified previously in this final rule, this rule aims to establish eligibility criteria for Exchanges and BHPs and does not address immigration policy, including DHS' DACA final rule. As discussed previously in this rule, individuals must have their immigration status or category electronically verified by DHS to enroll in Exchange or BHP coverage, which ensures that noncitizens without an eligible immigration status or category are not able to enroll. We therefore decline to make any changes in response to these comments.

Comment: One commenter associated with an academic institution stated concerns that allowing DACA recipients to access subsidized QHPs through Exchanges would increase the prices for non-subsidized health insurance. The commenter cited a JAMA Network Open study that found that between 2011 and 2021, median unsubsidized premium for individual market plans rose by 59 percent. The commenter stated that they saw ''little reason to expect that health care unaffordability will slow as government subsidies continue to grow.'' The commenter further hypothesized that subsidized health insurance programs make unsubsidized health insurance unaffordable because ''these programs require buy-in from powerful health care industry groups.'' They stated that taxpayer money is being channeled to contribute to industry groups' bottom lines, which inflates the cost of unsubsidized health insurance.

Response: We do not agree that allowing DACA recipients to access subsidized QHPs through Exchanges would increase the prices for unsubsidized health insurance. On the contrary, as discussed in section V.C. of this final rule, DACA recipients are generally younger than the average Exchange enrollee and comparably healthy to the general population, and their enrollment has the potential to improve the Exchange risk pool and lower health insurance premiums. Additionally, due to the medical loss ratio (MLR) requirements for issuers participating on the individual market Exchanges, if an issuer spends less than 80 percent of premiums on medical care and efforts to improve quality of care, it must refund this money to enrollees. These MLR requirements prevent excess contributions to ''industry groups' bottom lines'' and protects subsidized and unsubsidized consumers alike from premiums that are too high and are not spent on medical care and quality initiatives.

Comment: Commenters believe that U.S. tax dollars should not be spent on providing benefits, including health care benefits, to DACA recipients or other noncitizens. Commenters stated that they already face high tax burdens, and that tax revenue should be directed towards meeting the health care needs of other vulnerable groups, including senior citizens, members of the military, and veterans. Commenters also stated that the U.S. government already spends too much money, is $31 trillion in debt, and that our system is on the verge of bankruptcy. Commenters believe that

this proposed rule sets a bad precedent for expanding health care to individuals who are physically present in the United States without a valid immigration status, and that we cannot both be fiscally responsible and provide health care to noncitizens, citing Illinois as an example. Some commenters stated their belief that immigration reform is needed to stop this process from expanding to other immigrant populations. One commenter stated their belief that the parents of DACA recipients should be responsible for their children's wellbeing and provide a specific plan for obtaining independence, rather than the U.S. government being held responsible and providing government funded programs. Another commenter believes that there should be more accountability for those that use government sponsored public benefit programs.

Response: Although some of these comments are out of scope, we acknowledge the concerns noted by some commenters about the allocation of U.S. tax dollars and would like to clarify that allocating tax dollars is the purview of the Congress. As previously mentioned, the purpose of this final rule is to establish eligibility requirements for Exchanges and BHPs rather than dictate where tax dollars are directed. Moreover, as mentioned previously in this final rule, noncitizens must have their immigration status or category electronically verified by DHS to enroll in the specified insurance affordability programs, which ensures that noncitizens without an eligible immigration status or category are not able to enroll. Additionally, we would like to emphasize that immigration reform and parental responsibility are outside of our purview and the scope of this rule. Finally, we are engaged in many accountability initiatives for our programs, including APTC and CSR audits, which verify the enrollment of qualified individuals and the subsidies they receive. We welcome suggestions from interested parties regarding accountability for CMS programs.

After consideration of public comments, we are finalizing these cost estimates as discussed in section IV.B of this final rule.

2. Transfers

Transfers are payments between persons or groups that do not affect the total resources available to society. They are a benefit to recipients and a cost to payers.

The changes to 42 CFR 600.5 will treat DACA recipients the same as other recipients of deferred action, who are lawfully present under the definition used to determine eligibility for BHP, if otherwise eligible. Due to a potential increase in the number of enrollees, there may be an increase in Federal payments to a State's BHP trust fund, which represents a transfer.

We discuss how we calculated our BHP enrollment estimates earlier in this RIA. Federal funding for a BHP under section 1331(d)(3)(A) of the ACA is based on the amount of the PTC allowed and payments to cover required CSRs that would have been provided for the fiscal year to eligible individuals enrolled in BHP standard health plans in the State if such eligible individuals were allowed to enroll in a QHP through an Exchange.[138] These funds are paid to trusts established by the States and dedicated to the BHP, and the States then administer the payments to standard health plans within the BHP. In the proposed rule, to calculate costs, we used 2022 data from USCIS to determine the average age of a DACA recipient, which was 29, and we used PTC data to determine the average PTC for a 29-year-old, which was estimated to be $289 per month, and multiplied this by 12 months per year and by the projected number of enrollees per year to arrive at annual costs. We are modifying the costs in this final rule to use updated data.[139] Therefore, to calculate costs, we use 2023 data from USCIS to determine the average age of a DACA recipient, which is 30, and we use PTC data to determine the average PTC for a 30-year-old, which is estimated to be $274 per month, and multiplied this by 12 months per year and by the projected number of enrollees eligible for PTC to arrive at annual costs.[140] Our estimates for BHP expenditures as a result of the policies in this rule are shown in Table 4. We sought comment on these estimates and the assumptions and methodology used to calculate them.

TABLE 4: BHP Projected Expenditures, FY 2024 – 2028

	2024	2025	2026	2027	2028
Expenditures	$0	$5,000,000	$5,000,000	$5,000,000	$5,000,000

The policies at 45 CFR 152.2 and 155.20 will generate a transfer from the Federal Government to consumers in the form of increased PTC payments due to individuals who will be eligible for Exchange coverage and APTC based on the policies in this final rule.

We discuss how we calculated our Exchange enrollment estimates earlier in this RIA. In the proposed rule, to calculate costs, we used 2022 data from USCIS to determine the average age of a DACA recipient, which was 29. For 2024, the average PTC for a 29-year-old was estimated to be $289 per month. We multiplied this by 12 months per FY and by the number of enrollees to arrive at annual costs. We are modifying the costs in this final rule to use updated data. Therefore, to calculate costs, we use 2023 data from USCIS to determine the average age of a DACA recipient, which is 30. For 2025, the average PTC for a 30-year-old is estimated to be $274 per month, and we multiplied this by 12 months per FY and by the projected number of enrollees eligible for PTC to

[138] On October 11, 2017, the Attorney General of the United States provided HHS and the Department of the Treasury (the Departments) with a legal opinion indicating that the permanent appropriation at 31 U.S.C. 1324, from which the Departments had historically drawn funds to make CSR payments, cannot be used to fund CSR payments to insurers. In light of this opinion—and in the absence of any other appropriation that could be used to fund CSR payments—HHS directed CMS to discontinue CSR payments to issuers until the Congress provides for an appropriation. See *https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf* for more information. In the absence of a Congressional appropriation for Federal funding for CSR payments, we cannot provide States with a Federal payment attributable to CSRs that would have been paid on behalf of BHP enrollees had they been enrolled in a QHP through an Exchange.

[139] These costs also reflect that the two States that will operate a BHP when these policies go into effect are Minnesota and Oregon rather than Minnesota and New York as anticipated in the proposed rule.

[140] The estimate for FY 2025 only includes 11 months, assuming these individuals will enroll in a BHP beginning November 1, 2024, as the BHPs included in this analysis have, or are anticipated to have, continuous enrollment. We project no change in Federal BHP expenditures for FY 2024 as this rule will not take effect until FY 2025.

arrive at annual costs.[141] These costs are projected to increase using the trends assumed in the President's FY 2025 Budget.

We present these estimates in Table 5 and sought comment on the estimates and the assumptions and methodology used to calculate them.

TABLE 5: Exchange Projected Expenditures, FY 2024 – 2028

	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028
PTC Expenditures	$0	$240,000,000	$300,000,000	$290,000,000	$300,000,000

We did not receive public comments on the transfers estimated in this rule specific to PTC expenditures, and therefore, we are finalizing these estimates with modifications as described previously in this section.

3. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret the proposed rule, we estimate the cost associated with regulatory review. There is uncertainty involved with accurately quantifying the number of entities that would review the rule. However, for the purposes of this final rule, we assume that the total number of unique commenters on the proposed rule (284) will be the number of reviewers of this final rule.

Using the median wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $106.42 per hour, including overhead and fringe benefits. Assuming an average reading speed of 250 words per minute, we estimate that it will take approximately 3.3 hours for each individual to review the entire final rule (approximately 49,000 words/250 words per minute = 196 minutes). Therefore, we estimate that the total one-time cost of reviewing this regulation is approximately $99,737 ([$106.42 × 3.3 hours per individual review] × 284 reviewers).

D. Regulatory Alternatives Considered

In developing this rule, we considered not proposing or finalizing the technical and clarifying changes to our definitions of ''lawfully present,'' discussed in section II.B.2 of the proposed rule, as these changes are expected to impact fewer individuals than the proposal to treat DACA recipients the same as other recipients of deferred action. However, in our comprehensive review of current CMS definitions of ''lawfully present,'' we determined that the proposed and finalized changes discussed in section II.B.2 of this final rule will simplify verification of applicants' immigration status or category, our eligibility determination processes and increase efficiencies for individuals seeking health coverage and State and Federal entities administrating insurance affordability programs. Additionally, the small number of individuals included in the proposed eligibility categories will benefit from increased access to health coverage through the Exchange or a BHP.

In the proposed rule, we sought comments on these proposals, and we respond to those comments in the associated preamble sections of this final rule. As discussed in those preamble sections, we are finalizing the Exchange and BHP policies as discussed in the associated sections of this final rule, and not finalizing the Medicaid and CHIP proposals at this time.

E. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), we have prepared an accounting statement in Table 6 showing the classification of the impact associated with the provisions of the final rule. We prepared these impact estimates utilizing a baseline of ''no action,'' comparing the effect of the proposals against not proposing the rule at all.

The final rule finalizes standards for programs that will have numerous effects, including allowing DACA recipients to be treated the same as other deferred action recipients for specific health insurance affordability programs, and increasing access to affordable health insurance coverage. The effects in Table 6 reflect a qualitative assessment of impacts and the estimated direct monetary costs and transfers resulting from the provisions of the final rule for the Federal Government, State Exchanges, BHPs, and consumers.

[141] The estimate for FY 2025 only includes 9 months, assuming these individuals will enroll in a QHP beginning January 1, 2025. It is possible that individuals impacted by this rule could enroll in coverage effective December 1, 2024, but we do not have a reliable way to estimate how many individuals would enroll with that coverage effective date. Therefore, we project no change in PTC expenditures in FY 2024.

TABLE 6: Accounting Table

Benefits:				
Qualitative: • Additional enrollment in the BHP, anticipated to be 1,000 individuals annually beginning in 2025. • Additional enrollment in the Exchanges, which will be subsidized depending on individuals' household incomes, anticipated to be 99,000 individuals in 2025 and 85,000 individuals annually beginning in 2026. • Increased access to health coverage for DACA recipients and certain other noncitizens, which will mitigate existing disparities in access to care, which in turn may also decrease costs for emergency medical expenditures. • Improved health and well-being of many DACA recipients and certain other noncitizens currently without health care coverage. • Greater economic contribution and productivity of DACA recipients and certain other noncitizens from improving their health outcomes. • Reduced burden on Exchanges and BHPs to determine applicants' immigration statuses.				
Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$3.52 Million	2024	7 percent	2024-2028
	$3.59 Million	2024	3 percent	2024-2028
Quantitative: • System changes costs estimated at $19,465 in 2024 for States that operate a BHP to develop and code changes to their eligibility systems and verification processes to include the categories of noncitizens impacted by this final rule for BHP eligibility. • System changes costs estimated at $175,185 for State Exchanges not on the Federal platform and $9,733 for the Federal Government in 2024 to develop and code changes to each Exchange's eligibility systems and verification processes to include the categories of noncitizens impacted by this final rule for Exchange and Exchange-related subsidy eligibility. • Application processing costs estimated at $624,142 for States (excluding States operating SBE-FPs) and $583,875 for the Federal Government per year starting in 2025 to assist individuals impacted by this final rule with processing their applications. • Costs to individuals impacted by the proposals in this rule of $3,254,124 per year starting in 2025 to apply for BHP or Exchange health coverage, including costs to submit additional information to verify their lawful presence status if it is unable to be verified electronically through the application.				
Transfers:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$220.84 Million	2024	7 percent	2024-2028
	$226.05 Million	2024	3 percent	2024-2028
Quantitative: • Increased Federal BHP expenditures of $5 million annually beginning in 2025 due to increased enrollment as a result of changes to the definition of "lawfully present" for purposes of a BHP finalized in this rule. • Increased PTC expenditures from the Federal Government to individuals of $240 million in 2025, $300 million in 2026, $290 million in 2027, and $300 million in 2028 due to increased enrollment and subsidy eligibility as a result of the changes to the definition of "lawfully present" for purposes of the Exchanges finalized in this rule.				

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimated that small businesses, nonprofit organizations, and small governmental jurisdictions are small entities as that term is used in the RFA. The great majority of hospitals and most other health care providers and suppliers are small entities, either because they are nonprofit organizations, or they meet the Small Business Administration (SBA) definition of a small business (having revenues of less than $8.0 million to $41.5 million in any 1 year). Individuals and States are not included in the definition of a small entity.

For purposes of the RFA, we believe that health insurance issuers and group health plans will be classified under the North American Industry Classification System (NAICS) code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of

$47 million or less would be considered small entities for these NAICS codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $44.5 million or less.[142] We believe that few, if any, insurance companies underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds. Based on data from medical loss ratio (MLR) annual report submissions for the 2021 MLR reporting year, approximately 87 out of 483 issuers of health insurance coverage nationwide had total premium revenue of $47 million or less.[143] This estimate may overstate the actual number of small health insurance issuers that may be affected, since over 77 percent of these small issuers belong to larger holding groups, and many, if not all, of these small companies are likely to have non-health lines of business that will result in their revenues exceeding $47 million.

In this final rule, we are finalizing standards for eligibility for Exchange enrollment, APTC and CSRs, and BHP enrollment. Because we believe that insurance firms offering comprehensive health insurance policies generally exceed the size thresholds for ''small entities'' established by the SBA, we did not believe that an initial regulatory flexibility analysis is required for such firms and therefore do not believe a final regulatory flexibility analysis is required. Furthermore, the policies related to BHPs involve State governments, but as States do not constitute small entities under the statutory definition, an impact analysis for that provision is not required under the RFA.

As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than three to five percent. We do not believe that this threshold will be reached by the requirements in this final rule. Therefore, the Secretary has certified that this final rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. While this rule is not subject to section 1102 of the Act, we have determined that the final rule will not adversely affect small rural hospitals. Therefore, the Secretary has certified that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million. Based on information currently available, we expect the combined impact on State, local, or Tribal governments and the private sector does not meet the UMRA definition of unfunded mandate.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications.

While developing this rule, we attempted to balance States' interests in running their own Exchanges and BHPs with CMS' interest in establishing a consistent definition of ''lawfully present'' for use in eligibility determinations across our programs, to the extent possible. We also attempted to balance States' interests with the overall goals of the ACA, as well as the goals and provisions of the DHS DACA final rule. By doing so, we complied with the requirements of E.O. 13132.

In our view, while the provisions of this final rule related to the Exchanges (45 CFR 152.2 and 155.20) and BHPs (42 CFR 600.5) will not impose any requirement costs on State and local governments that do not operate their own Exchanges, or that operate SBE–FPs, this regulation has federalism implications for other States. State Exchanges not on the Federal platform and BHPs will be required to update their eligibility systems to accurately evaluate applicants' lawful presence. State Exchanges not on the Federal platform and BHPs may wish to conduct outreach to groups such as DACA recipients who will newly be considered lawfully present under the rule. By our estimate, these requirements do not impose substantial direct costs on the affected States, which in any event have chosen to operate their own Exchanges and eligibility and enrollment platforms, or the optional BHP. After establishment, Exchanges must be financially self-sustaining, with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers, and as indicated earlier, a BHP is optional for States. Therefore, if implemented in a State, a BHP provides access to a pool of Federal funding that will not otherwise be available to the State. States that do not have a BHP and do not operate their own Exchange, including SBE–FP States, are not expected to incur any costs as a result of this rule.

We included policies in the proposed rule related to Medicaid and CHIP that might have imposed substantial direct costs on State governments. However, as discussed earlier in this rule, we are not finalizing those provisions at this time and therefore they do not have federalism implications.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on April 15, 2024.

List of Subjects

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

42 CFR Part 600

Administrative practice and procedure, Health care, health insurance, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 152

Administrative practice and procedure, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Aged, Brokers, Citizenship and naturalization, Civil

[142] Available at *https://www.sba.gov/document/support--table-size-standards.*

[143] Available at *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

rights, Conflicts of interests, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Sex discrimination, State and local governments, Taxes, Technical assistance, Women, Youth.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below.

Title 42—Public Health

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

■ 1. The authority citation for part 435 continues to read as follows:

Authority: 42 U.S.C. 1302.

PART 435 [Amended]

■ 2. Part 435 is amended by—
■ a. Removing all instances of the words ''non-citizen'' and ''non-citizens'' and adding in their places the words ''noncitizen'' and ''noncitizens'', respectively; and
■ b. Removing all instances of the words ''Qualified Non-citizen'' and adding in their place the words ''qualified noncitizen''.

■ 3. Section 435.4 is amended by revising the definition of ''Qualified noncitizen'' to read as follows:

§ 435.4 Definitions and use of terms.

* * * * *

Qualified noncitizen means:

(1) a ''Qualified alien,'' as defined in 8 U.S.C. 1641(b) and (c); who is:

(i) A noncitizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [8 U.S.C. 1101 *et seq.*];

(ii) A noncitizen who is granted asylum under section 208 of such Act [8 U.S.C. 1158];

(iii) A refugee who is admitted to the United States under section 207 of such Act [8 U.S.C. 1157];

(iv) A noncitizen who is paroled into the United States under section 212(d)(5) of such Act [8 U.S.C. 1182(d)(5)] for a period of at least 1 year;

(v) A noncitizen whose deportation is being withheld under section 243(h) of such Act [8 U.S.C. 1253] (as in effect immediately before the effective date of section 307 of division C of Public Law 104–208) or section 241(b)(3) of such Act [8 U.S.C. 1231(b)(3)] (as amended by section 305(a) of division C of Public Law 104–208);

(vi) A noncitizen who is granted conditional entry pursuant to section 203(a)(7) of such Act [8 U.S.C. 1153(a)(7)] as in effect prior to April 1, 1980;

(vii) A noncitizen who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);

(viii) An individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in 8 U.S.C. 1612(b)(2)(G);

(ix) A noncitizen who—

(A) Has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented to, or acquiesced in, such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Has been approved or has a petition pending which sets forth a prima facie case for—

(*1*) Status as a spouse or a child of a United States citizen pursuant to clause (ii), (iii), or (iv) of section 204(a)(1)(A) of the Immigration and Nationality Act [8 U.S.C. 1154(a)(1)(A)(ii), (iii), (iv)];

(*2*) Classification pursuant to clause (ii) or (iii) of section 204(a)(1)(B) of the Act [8 U.S.C. 1154(a)(1)(B)(ii), (iii)];

(*3*) Suspension of deportation under section 244(a)(3) of the Immigration and Nationality Act [8 U.S.C. 1254(a)(3)] (as in effect before the title III–A effective date in section 309 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996);

(*4*) Status as a spouse or child of a United States citizen pursuant to clause (i) of section 204(a)(1)(A) of such Act [8 U.S.C. 1154(a)(1)(A)(i)], or classification pursuant to clause (i) of section 204(a)(1)(B) of such Act [8 U.S.C. 1154(a)(1)(B)(i)]; or

(*5*) Cancellation of removal pursuant to section 240A(b)(2) of such Act [8 U.S.C. 1229b(b)(2)];

(x) A noncitizen—

(A) Whose child has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented or acquiesced to such battery or cruelty, and the alien did not actively participate in such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Who meets the requirement of 8 U.S.C. 1641(c)(1)(B);

(xi) A noncitizen child who—

(A) Resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Who meets the requirement of 8 U.S.C. 1641(c)(1)(B); or

(xii) A noncitizen who has been granted nonimmigrant status under section 101(a)(15)(T) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(T)) or who has a pending application that sets forth a prima facie case for eligibility for such nonimmigrant status.

(2) Noncitizens who are treated as refugees under other Federal statutes:

(i) Noncitizens who are victims of a severe form of trafficking in persons, as described in 22 U.S.C. 7105(b)(1)(C), or who are classified as nonimmigrants under section 101(a)(15)(T)(ii) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(T)(ii)), pursuant to 22 U.S.C. 7105(b)(1)(A);

(ii) Iraqi and Afghan special immigrants, as described in Public Law 110–181, section 1244(g) (2008), Public Law 111–8, section 602(b)(8) (2009), Public Law 111–118, section 8120(b) (2010), and Public Law 113–291, section 1227 (2014);

(iii) Amerasian immigrants, described in Public Law 100–202, section 101(e) (8 U.S.C. 1101 note);

(iv) Certain Afghan parolees, in accordance with Section 2502 of Public Law 117–43, as amended; and

(v) Certain Ukrainian parolees, in accordance with Section 401 of Public Law 117–128, as amended.

* * * * *

■ 4. Section 435.406 is amended by—

■ a. Removing all instances of the words ''non-citizen'' and ''non-citizens'' and adding in their places the words ''noncitizen'' and ''noncitizens'', respectively; and

■ b. Removing all instances of the words ''Qualified Non-Citizen'' and adding in its place the words ''qualified noncitizen''.

■ c. Revising paragraph (a)(2)(i).

The revision reads as follows:

§ 435.406 Citizenship and noncitizen eligibility.

(a) * * *

(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified noncitizens), qualified noncitizens as described in 42 CFR 435.4 (including qualified noncitizens subject to the 5-year bar) who have provided satisfactory documentary evidence of qualified noncitizen status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is a noncitizen in a satisfactory immigration status.

* * * * *

PART 457—ALLOTMENTS AND GRANTS TO STATES

■ 5. The authority citation for part 457 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 6. Section 457.320 is amended by—

■ a. Removing all instances of the words ''qualified aliens'' and adding in its place the words ''qualified noncitizens'';

■ b. Revising paragraphs (b)(6); and

■ c. Adding paragraph (c).

The revision and addition read as follows:

§ 457.320 Other eligibility standards.

* * * * *

(b) * * *

(6) Exclude individuals based on citizenship or nationality, to the extent that the children are U.S. citizens, U.S. nationals or qualified noncitizens (as defined at paragraph (c) of this section); or

* * * * *

(c) *Definitions.* As used in this subpart:

Qualified noncitizen has the meaning assigned at § 435.4 of this chapter.

* * * * *

PART 600—ADMINISTRATION, ELIGIBILITY, ESSENTIAL HEALTH BENEFITS, PERFORMANCE STANDARDS, SERVICE DELIVERY REQUIREMENTS, PREMIUM AND COST SHARING, ALLOTMENTS, AND RECONCILIATION

■ 7. The authority citation for part 600 continues to read as follows:

Authority: Section 1331 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, 124 Stat 1029).

■ 8. Section 600.5 is amended by revising the definition of ''Lawfully present'' to read as follows:

§ 600.5 Definitions and use of terms.

* * * * *

Lawfully present has the meaning given in 45 CFR 155.20.

* * * * *

For the reasons set forth in the preamble, under the authority at 5 U.S.C. 301, the Department of Health and Human Services amends 45 CFR subtitle A, subchapter B, as set forth below.

Title 45—Public Welfare

PART 152—PRE–EXISTING CONDITION INSURANCE PLAN PROGRAM

■ 9. The authority citation for part 152 continues to read as follows:

Authority: Sec. 1101 of the Patient Protection and Affordable Care Act (Pub. L. 111–148).

■ 10. Section 152.2 is amended by revising the definition of ''Lawfully present'' to read as follows:

§ 152.2 Definitions.

* * * * *

Lawfully present has the meaning given the term at 45 CFR 155.20.

* * * * *

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 11. The authority citation for part 155 continues to read as follows:

Authority: 42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083.

■ 12. Section 155.20 is amended by revising the definition of ''Lawfully present'' to read as follows:

§ 155.20 Definitions.

* * * * *

Lawfully present means a noncitizen who—

(1) Is a qualified noncitizen as defined at 42 CFR 435.4;

(2) Is in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

(3) Is paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for a noncitizen paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) Is granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a;

(5) Is granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a;

(6) Is granted employment authorization under 8 CFR 274a.12(c);

(7) Is a Family Unity beneficiary in accordance with section 301 of Pub. L. 101–649 as amended; or section 1504 of the LIFE Act Amendments of 2000, title XV of H.R. 5666, enacted by reference in Pub. L. 106–554 (see section 1504 of App. D to Pub. L. 106–554);

(8) Is covered by Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(9) Is granted deferred action, including but not limited to individuals granted deferred action under 8 CFR 236.22;

(10) Has a pending application for adjustment of status;

(11)(i) Has a pending application for asylum under 8 U.S.C. 1158, for withholding of removal under 8 U.S.C. 1231(b)(3)(A), or for protection under the regulations implementing the Convention Against Torture; and

(ii) Is under the age of 14;

(12) Has been granted withholding of removal under the regulations implementing the Convention Against Torture; or

(13) Has a pending or approved petition for Special Immigrant Juvenile classification as described in 8 U.S.C. 1101(a)(27)(J).

* * * * *

■ 13. Section 155.30 is added to read as follows:

§ 155.30 Severability.

(a) Any part of the definition of ''lawfully present'' in § 155.20 held to be invalid or unenforceable, including as applied to any person or circumstance, shall be construed so as

to continue to give the maximum effect to the provision as permitted by law, along with other provisions not found invalid or unenforceable, including as applied to persons not similarly situated or to dissimilar circumstances, unless such holding is that the provision of this subpart is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of this subpart and shall not affect the remainder thereof.

(b) The provisions in § 155.20 with respect to the definition of ''lawfully present'' are intended to be severable from one another.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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