The Effects of DACA on Health Insurance, Access to Care, and Health Outcomes

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Abstract

This paper studies the effects of the 2012 Deferred Action for Childhood Arrivals (DACA) initiative on health insurance coverage, access to care, health care use, and health outcomes. We exploit a difference-in-differences that relies on the discontinuities in the program eligibility criteria. We find that DACA increased insurance coverage. In states that granted access to Medicaid, the increase was driven by an increase in public insurance take-up. Where public coverage was not available, DACA eligibility increased individually purchased insurance. Despite the increase in insurance coverage, there is no evidence of significant increases in health care use, although there is some evidence that DACA increased demand for mental health services. After 2012, DACA-eligible individuals were also more likely to report a usual place of care and less likely to delay care because of financial restrictions. Finally, we find some evidence that DACA improved self-reported health and reduced depression symptoms, indicators of stress and anxiety, and hypertension. These improvements are concentrated among individuals with income below the federal poverty level.

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1 Introduction

Immigration continues to be a contentious topic in the political arena and the discussion of immigration reforms ignites the public debate in many advanced economies. In 2015, there were 11 million unauthorized immigrants in the U.S., representing 3.4% of the country's population and more than 5% of its labor force (Krogstad et al., 2015). Despite a recent slowdown in the influx of undocumented immigrants into the U.S. (source : PEW Research Center on Migration), regulating their status without further increasing illegal immigration remains a crucial challenge for the government. Legalization programs have been historically used as a policy tool to foster immigrants' integration and well-being. The debate on the costs and effectiveness has become even more relevant with the announced changes in the U.S. immigration policy that are currently under discussion.

Illegal immigrants constantly face the threat of deportation and the lack of work permits, access to credit, and access to government welfare programs (e.g. Medicaid, unemployment insurance, Social Security). These challenges can have detrimental effects on their human capital and productivity. Previous research shows that illegal immigrants have substantially lower hourly wage rates (for both genders), family income, and higher male labor force participation rates than their legal immigrant or native-born counterparts (Capps, 2007; Rivera-Batiz, 1999; Borjas, 2017). Studies also suggest that legalization of these immigrants can increase their probability of being employed, participate in the labor force (Devillanova et al., 2014; Amuedo-Dorantes and Antman, 2017; Pope, 2016), and can lead to a significant growth in their wages (Rivera-Batiz, 1999).

Most of the political discussion on immigrant legalization programs focuses on the potential costs associated with regulating undocumented immigrants. Yet little is known about how legalization affects public programs take-up. There are two notable exceptions. In a recent study, Cascio and Lewis (2016) explore the effects of the 1986 Immigration Reform and Control Act (IRCA) on Earned Income Tax Credit (EITC), and find that areas with higher applicant shares experienced relatively large increases in EITC transfers after IRCA. Borjas and Slusky (2017) use counterfactual analysis to estimate the additional public costs of legalizing the undocumented population by estimating models of disability as a function of medical conditions. However, to the best of our knowledge, there has been no analysis of the effects of immigrant legalization on health insurance coverage

and health care use, and only a few recent studies have considered the effects on health outcomes (Venkataramani et al., 2017; Hainmueller et al., 2017). Our paper intends to fill this gap in the literature.

We focus on the effect of a large-scale immigration policy change - 2012 Deferred Action for Childhood Arrivals (DACA). DACA is an executive memorandum issued by President Obama on June 15, 2012, which provides certain unauthorized immigrants who came to the U.S. as minors with temporary reprieve from deportation and work authorization (DACA status can be renewed every two years). Although DACA does not provide a path to citizenship or a *de jure* legal status, one can think of it as a (temporary) *de facto* immigrant legalization.

To estimate the effects of DACA, we employ a difference-in-differences strategy exploiting the discontinuities in the DACA eligibility criteria. We confirm that DACA-eligible immigrants are more likely to participate in the labor force and some evidence of an increase in income (Pope, 2016). Using American Community Survey data, we document that DACA eligibility increased health insurance coverage. We show that DACA increased insurance coverage throughout the country by enhancing individual ability to purchase private plans. In California and New York (among the three states with the highest DACA-eligible population), where Medicaid eligibility was granted to DACA recipients, the increase in insurance coverage was mostly driven by an increase in public insurance coverage. Despite the increase in insurance coverage, using data from the National Health Interview Survey and the California Health Interview Survey, we find little evidence of significant effects on health care use, although after 2012, DACA-eligible individuals reported more mental health care visits. On the other hand, we provide evidence that DACA increased the likelihood of reporting a usual place of care and reduced the likelihood of deferring care due to financial reasons. There is also some evidence of improvements in mental health outcomes and self-reported health. These effects are largely driven by subjects with income below the federal poverty level. Our findings are largely consistent with the evidence from the Rand Health Insurance Experiment and the Oregon Health Insurance Experiment (Aron-Dine et al., 2013; Finkelstein et al., 2012; Kamberg and Newhouse, 1985) showing that health insurance coverage had no or little effect on physical health, but possibly improved perceived health and mental health among the population at higher risk. The lack of significant impact on health care use is likely explained by the demographic characteristics of the DACA-eligible population.

Our paper is closely related to a handful of recent studies analyzing the economic effects of DACA. Pope (2016) documented the positive effects of DACA on the labor market opportunities of undocumented immigrants. There is also evidence that DACA reduced the likelihood of life in poverty (Amuedo-Dorantes and Antman, 2016), while Ortega et al. (2018) estimate that DACA increased GDP by almost 0.02%. The evidence on the effects of DACA on human capital is less conclusive. Amuedo-Dorantes and Antman (2017) and Hsin and Ortega (2017) show that DACA may have incentivized work over educational investment. However, using administrative data from California, Kuka et al. (2018) find evidence that DACA increased high school graduation rates and college attendance. Finally, a few recent studies examined the effects of DACA on health. Venkataramani et al. (2017) using data from the National Health Interview Survey provide evidence that economic opportunities and protection from deportation can have large positive effects on the mental health of undocumented immigrants, confirming associations found by Patler and Pirtle (2017). Using Medicaid claims data from Oregon, Hainmueller et al. (2017) find that children of DACA-eligible mothers had 50% fewer diagnoses of adjustment and anxiety disorder than children with non-eligible mothers. However, to the best of our knowledge, this is the first paper to provide a systematic analysis of the effects of DACA on insurance coverage, access to care, health care use, and health outcomes. Furthermore, our findings highlight that the effects of DACA on stress and mental health outcomes are concentrated at the bottom of the income distribution.

The paper is organized as follows: Section 2 discusses the background. In Section 3, we illustrate the data and identification strategy. We present the results in Section 4. Section 5 concludes.

2 Background, Identification Strategy, and Data

2.1 Deferred Action for Childhood Arrivals (DACA)

On June 15, 2012, President Obama issued an executive memorandum announcing the Deferred Action for Childhood Arrivals. It is the largest immigration reform since the approval of the Immigration Reform and Control Act (IRCA, 1986). The program originally targeted 1.7 million unauthorized immigrants providing eligible applicants with a two-year renewable reprieve from deportation, work authorization, and a temporary Social Security number. DACA does not provide any form of legal immigrant status or a path to citizenship. The United States Department of

Homeland Security's Citizenship and Immigration Services started accepting applications for the program on August 15, 2012.

To be eligible, applicants have to meet the following seven criteria: (1) no lawful status as of June 15, 2012; (2) under the age of 31 as of June 15, 2012; (3) entered U.S. before reaching 16th birthday; (4) continuously residing in the States since June 15, 2007; (5) physically present in the U.S. on June 15, 2012, and at the time of applying for DACA; (6) currently in school, with high school diploma (or GED), or honorably discharged veteran of the Coast Guard or Armed Forces of the United States; (7) not convicted of felony, significant misdemeanor, or three or more other misdemeanors. In addition, applicants have to be 15 years or older, and they are required to pay a processing fee of 495 dollars. DACA applicants have to provide evidence that they were living in the United States at the prescribed times, proof of education, and confirmation of their identities. They also have to pass a background check, fingerprinting, and other checks that consider their identifying biological features. Applicants do not need legal representation. Officials can revoke DACA protection if individuals pose a threat to public safety or national security. About 1,500 people have had their deferral canceled due to a crime or gang-related activity or an admission to such activity. This is less than 0.2% of the total number of people accepted into the program (source: Immigration and Customs Enforcement).

As of 2017, approximately 800,000 individuals enrolled in the program. There have been 606,264 renewal cases, with 526,288 of them approved, 4,703 denied, and 75,205 pending. Most of current DACA recipients come from Latin America. Mexico is the major source country (548,000), followed by El Salvador (26,000) and Guatemala (17,700). 75% of DACA recipients live in 20 U.S. metropolitan areas. Los Angeles-Long Beach-Anaheim had the largest concentration of DACA enrollees (89,900 DACA recipients) followed by New York (47,200) and Dallas (36,700). A third of DACA recipients live in California (29%), while 16% of the enrolled in DACA are in Texas. Approximately 66% of the approved applicants are 25 or younger, 53% of them women, and 85% of them are single (PEW Research Center).

The program was rescinded by President Trump's administration in September 2017, although this repeal of DACA has since been blocked by a preliminary injunction issued by the District Court for the Northern District of California on January 9, 2018. As a result, Department of Homeland Security is currently accepting only requests for renewal of the existing status, but not

new applications (source: U.S. Citizenship and Immigration Services).

The main benefits of DACA for unauthorized immigrants are the deferral of deportation and the working permit. DACA recipients receive a Social Security Number which enables them to open a bank account and build credit history. Furthermore, most states (the only exceptions being Arizona and Nebraska) allow DACA recipients to obtain a driver's license. DACA does not provide access to federal welfare programs or federal student aid. However, DACA recipients are immediately eligible for Earned Income Tax Credit (upon meeting all other criteria) since Social Security Administration does not distinguish between DACA and non-DACA Social Security Numbers.

DACA-eligible individuals are no different than their ineligible counterparts when it comes to the eligibility for Medicaid or the ability to purchase health insurance through Marketplaces (see Wiley, 2014). In other words, no provisions of the 2010 Patient Protection and Affordable Care Act apply to them. However, DACA-eligible immigrants can obtain employer-sponsored insurance or buy health insurance directly from the carrier.

California and New York are respectively the first and the third state with the largest DACA-eligible population.[1] In these two states, low-income DACA recipients are eligible for full scope state-funded Medicaid since they fall under the state definition of Permanently Residing in the U.S. under Color of Law (PRUCOL). In New York, DACAmented individuals became eligible for Medicaid immediately because of a 2001 State Court of Appeals ruling. In California, the expansion of Medi-Cal coverage to DACA recipients did not take place until January 2014 (Brindis et al., 2014). While other states also expanded Medicaid to grant access to DACA-eligible population (Minnesota, Massachusetts, D.C., Illinois, Oregon, Washington state), the expansion was limited or started after the end of our study period.[2]

2.2 Identification Strategy

To identify the effect of DACA, we follow the difference-in-differences approach proposed by Pope (2016), which exploits the discontinuities in the eligibility criteria of the DACA program and

[1] Migration Policy Institute's *Deferred Action for Childhood Arrivals (DACA) Data Tools*: `https://www.migrationpolicy.org/programs/data-hub/deferred-action-childhood-arrivals-daca-profiles`.

[2] Minnesota extended eligibility for its state-funded MinnesotaCare program to DACA recipients in January 2017 (outside of our study period). In D.C., all low-income undocumented immigrants (regardless of DACA status) are eligible for the locally-funded Health Care Alliance program. In Washington state, only disabled DACA recipients are eligible for the state-funded Medical Care Services. And finally, California, New York, Illinois, Massachusetts, Oregon, and Washington state use state-only funds to provide health insurance coverage to all undocumented children.

compares DACA-eligible with DACA-ineligible individuals, before and after the implementation of the reform. DACA-eligible individuals are defined as those who: (1) were under the age of 31 as of June 15, 2012; (2) have lived in the U.S. since June 15, 2007; (3) entered U.S. before reaching 16th birthday; (4) have at least a high school degree (or equivalent); (5) were born outside the U.S. (or its territories); and (6) are not U.S. citizens.[3]

In the ACS, our main estimation sample comprises all non-citizens ages 18-35 with at least a high school degree (or equivalent).[4] In the NHIS and CHIS, to ensure we have enough identification power, we extend the sample to all non-citizens and citizens aged 18-50 with at least a high school degree (or equivalent). While we use a larger control group to increase the sample size with these survey data, as a robustness check, we test the sensitivity of results to different sample choices. The main empirical specification has the following form:

$$\mathrm{Y}_{it} = \alpha + \beta_1 \mathrm{Post}_{it} + \beta_2 \mathrm{Elig}_{it} + \tau \mathrm{Post}_{it} * \mathrm{Elig}_{it} + \beta_3 X_{it} + \beta_4 Z_{it} + \Lambda_t + \Theta_c + \Theta_c t + \epsilon_{it} \qquad (1)$$

where Y_{it} refers to the outcome of interest of individual i in year t (e.g. health status, health insurance coverage, etc.); $Post_{it}$ is a binary variable equal to one if the survey took place in a year after DACA implementation (2013 or later); and $Elig_{it}$ is a dummy equal to one if individual i is DACA-eligible when the survey is administered. The coefficient of interest (τ) measures the intention-to-treat effect of DACA. The regression also controls for individual i's demographic characteristics[5] (X_{it}), year fixed effects (Λ_t), area (county, state, or region) fixed effects (Θ_c), and state or region-specific time trends ($\Theta_c t$). Finally, the vector Z_{it} non-parametrically controls for eligibility criteria by including fixed effects for individual i's age, education, and age of arrival into the U.S. Equation (1) is estimated using ordinary least squares. Standard errors are heteroskedasticity-robust (NHIS sample; CHIS sample; ACS: California + New York sample), or clustered at the state-year level (ACS: total U.S. sample; ACS: U.S. without CA and NY sample). Our DID estimates can be interpreted as the intention-to-treat effect of DACA, and can therefore

[3] Similarly, to define the DACA-eligible population in year 2012 and before, we restricted to those who were: (1) under the age 31 as of June 15 of the previous calendar year; (2) have lived in the U.S. for at least six years; (3) entered U.S. before reaching 16th birthday; (4) have at least a high school degree (or equivalent); (5) were born outside the U.S. (or its territories); and (6) are not U.S. citizens.

[4] This is the same sample used by Pope (2016).

[5] Sex, race, ethnicity, and marital status.

be understood as a lower bound to the actual treatment effect.

2.3 Data

We use data from three different sources: the American Community Survey (ACS), the National Health Interview Survey (NHIS), and the California Health Interview Survey (CHIS).

ACS

To analyze labor market outcomes and insurance coverage we use data from the American Community Survey (2005-2016), the largest household survey that the U.S. Census Bureau administers (Ruggles et al., 2017). We start with 2005 since it's the first year with a full one-percent sample of the U.S. population. 2016 is the last year for which the survey data is available. Designed as a replacement for the long form of the decennial census, ACS contains a detailed set of standard socio-demographic characteristics and labor market outcomes (e.g. employment, labor force participation, annual income). Furthermore, since 2008, the survey provides information on health insurance coverage and the type of coverage. The ACS also contains information on US citizenship status, number of years spent in the US, quarter of birth, and educational attainment, which can be used to determine respondents' DACA eligibility status. However, the survey does not include information about individual criminal convictions, or whether the respondent has been honorably discharged from the military. As far as the sampling procedure is concerned, unauthorized immigrants are no more or less likely to be selected into the sample than authorized immigrants or natives. This follows from the fact that U.S. Census Bureau uses a near universe of housing addresses from its Master Address File as the sample frame from which it draws systematic sample of addresses each month. The ACS is then mailed to the selected addresses. Non-respondents are contacted one month later for a computer-assisted telephone interview. After that, one third of non-respondents who still remain are contacted in person to complete the ACS one month after the telephone survey attempt (Pope, 2016). Between 2005 and 2016, The Master Address File covered 98.3-99.1% of all housing units and 76.2-99.8% of all group quarters in the U.S., encompassing 91.9-95.1% of the total U.S. population. The survey response rate in this period was 89.9-98.0% for the housing units and 95.1-98.0% for the group quarters.[6]

[6] https://www.census.gov/acs/www/methodology/sample-size-and-data-quality/

NHIS

NHIS is the largest health survey in the United States and the nation's primary source of general health information (Blewett et al., 2016). It is designed by CDC's National Center for Health Statistics and administered by the U.S. Census Bureau. The survey is conducted continuously since 1957 via in-person interviews, and each annual national sample consists of roughly 90,000 individuals. The annual response rate is approximately 70% of the eligible households in the sample.[7] We focus on the period 2000-2016. Unfortunately, the public version of NHIS data that we use does not contain precise information on the number of years since migration, which determines two of our three eligibility cutoffs. Instead, foreign-born respondents are grouped into the following categories: (1) less than 1 year; (2) 1 year to less than 5 years; (3) 5 years to less than 10 years; (4) 10 years to less than 15 years; (5) 15 years or more. Therefore, we classify as DACA-eligible only those individuals for whom we know for sure that they meet the age of entry and length of residence criteria. This measurement error will likely result in attenuation bias as many DACA-eligible respondents will be labeled as ineligible.

CHIS

The California Health Interview Survey (CHIS) is the nation's largest state health survey (UCLA Center for Health Policy Research, 2016). The survey is conducted by the UCLA Center for Health Policy Research in collaboration with the California Department of Public Health, and the Department of Health Care Services. It is a random-dial telephone survey conducted on a continuous basis and covers a wide range of health topics. Both landline and cellular phone numbers are sampled and the interview is computer-assisted. The survey provides a detailed picture of the health and health care needs of California's large and diverse population. The first survey was conducted in 2000-01 on 55,000 households. Biennial surveys were conducted until 2011 on approximately 45,000 households. Starting in 2011, CHIS transitioned from a biennial survey model to a continuous survey model, interviewing roughly 20,000 Californians (adults, teenagers, and children) each year. Yearly samples are representative of California's population. Our analysis employs confidential data from 2003-2015, which includes precise information on the number of

[7] https://www.cdc.gov/nchs/nhis/about_nhis.htm

years foreign-born individuals lived in the U.S., exact date of CHIS interview, respondent's month and year of birth, and other variables which enable us to minimize the measurement error in the definition of the DACA-eligible population.[8] Since CHIS is a telephone-based survey, the response rates are lower than for the ACS or NHIS. However, as noted in the survey documentation, "CHIS response rates are similar to, and sometimes higher than other comparable surveys that interview by telephone."[9]

3 Results

3.1 DACA and Health Insurance Coverage

Difference-in-differences estimates of the effect of DACA on health insurance coverage are reported in Table 1. Panel A reveals that throughout the country, DACA-eligible immigrants were more likely to acquire insurance coverage after 2012. This finding is confirmed in Figures 1-5, which plot the interactions between DACA eligibility indicator and year-specific indicators. In states that extended full-scope Medicaid coverage to low-income DACA recipients (California and New York), insurance coverage increased due to a sharp increase in public coverage (Figures 6-10). This increase begins in 2014 - the year when DACA recipients in California became eligible for the state-funded Medi-Cal.[10] As Panel B, column 1 reports, DACA-eligible immigrants were 4 percentage points more likely to report insurance coverage in California and New York, a 6% increase with respect to the insurance rate in the sample. Although this surge in coverage is largely driven by the Medicaid (Panel B, column 2), there is also evidence of a 1 percentage point increase in private coverage (column 3), and in particular employer-based insurance (column 4).

In the rest of the U.S., there was no increase in public coverage as immigrants were not eligible for Medicaid or other public programs, but private insurance coverage did go up (Figures 11-15). The increase in insurance coverage is substantially smaller than in New York and California, and it is driven by the 7% increase (with respect to the mean) in individually purchased insurance (see Panel C, columns 1 and 5). However, we cannot reject that the effect of DACA on any private

[8] Data from 2000-01 survey are not included in the analysis because many variables from this wave cannot be trended with subsequent waves of the survey.

[9] `http://healthpolicy.ucla.edu/chis/design/Documents/CHIS_2015-2016_MethodologyReport3_DataProcessing.pdf`

[10] As noted earlier, DACA recipients in New York became eligible for the state-funded Medicaid immediately.

coverage is the same in California and New York as in the rest of the states, suggesting that crowding out effects of access to public coverage are negligible. Results on health insurance are robust to eliminating (a number of) legal immigrants from the main sample using Borjas (2017)' residual method (see Table A.1).[11] Moreover, findings are robust to including individuals with less than a high school diploma but still in school, as these were also eligible for DACA (results available upon request).

3.2 DACA, Access to Care, and Health Care Use

Using NHIS data, we examined the impact of DACA on access to care and health care utilization. DACA-eligible individuals after 2012 were less likely to delay care because of financial constraints (-20%). We also find that DACA led to a 5 percentage point decrease in the cost-related inability to seek specialized care when needed (Figure 16 and Table 2). In California, DACA increased the likelihood of reporting having a usual place of care by 11% and a personal doctor by 13% (Figure 17, Table 3). Despite the observed increase in insurance coverage and access to care, there is little evidence of any increase in health care use (e.g. total doctor visits, emergency room visits; see Figures 18-19, and Tables 4-5).[12] However, in California after 2012, DACA-eligible individuals were more likely to receive mental care services (Figure 19, Table 5 - columns 4 and 5). We find no evidence of significant differences even when restricting to individuals below the federal poverty level (Tables A.2-A.3).

[11] Following the approach proposed by Borjas (2017) and based on previous work by Passel and Cohn (2014), we exclude from the sample immigrants who are likely to have a legal status, thus reducing the attenuation bias of our estimates. It is worth noting that in our case, we can only use a subset of the exclusion conditions used by Borjas (2017), as some of the criteria used to identify legal immigrants from the sample (e.g. local/state government employment, occupational licensing) may lead to the exclusion of DACAmented individuals. In practice, we only exclude any foreign-born non-citizen who satisfies one (or more) of the following conditions:

(a) arrived in the U.S. before 1980;

(b) was born in Cuba;

(c) is federal government employee;

(d) receives any Social Security benefits or Supplementary Security Income (SSI).

[12] In addition to the variables presented in Table 4, in NHIS, we tested the effect of DACA on a number of other measures of health care utilization. We found no effect of the policy in all instances. The following variables were considered: *Number of nights in hospital (past 12 mo.); Number of times in hospital overnight (past 12 mo.); Number of ER visits (past 12 mo.); Time since last doctor visit; Individual saw/talked to a general doctor (past 12 mo.); Individual saw/talked to a foot doctor (past 12 mo.), Individual ever received dental care; Time since last dental care visit; Individual had a surgery (past 12 mo.).*

3.3 Effects on Health Status and Mental Health

There is some evidence that DACA had mild positive effects on self-reported health status and mental health (Figure 20 and Table 6). While the direction of the effect is consistent across the outcomes considered (columns 1-9), results are precisely estimated only when examining self-reported health status (columns 1 and 2). Despite the large standard errors, our estimates suggest that DACA eligibility reduced the likelihood of reporting depression symptoms, moderate or serious psychological distress, and hypertension. Interestingly, when we restrict the analysis to individuals with income below the federal poverty level (Table 7), we find evidence of significant improvements in mental health and well-being (columns 4-9). For this group, DACA reduced by 36% the likelihood of reporting depression, by 50% the likelihood of feeling hopeless, and by 34% the likelihood of feeling that "everything had been an effort". In addition, the measure of non-specific psychological distress (Kessler 6 Scale) declined by about 23%, the likelihood of reporting moderate or serious psychological distress by 29%, and the probability of being diagnosed with hypertension also by 29% with respect to the sample mean.

Examining CHIS data (Figure 21 and Table 8), we find mild evidence of improvements in self-reported health status in the overall sample, but consistent with results from NHIS, there is evidence of significant reductions in anxiety, distress, and hypertension among those below the poverty level (Table 9). In this group, DACA eligibility reduced the likelihood of feeling restless and experiencing psychological distress by approximately 50%, and the likelihood of reporting hypertension by 33%.

3.4 Potential Mechanisms

The increase in private insurance coverage and the mild positive effects on mental health may be in part explained by the positive effects on labor market outcomes documented in previous studies (Pope, 2016; Amuedo-Dorantes and Antman, 2016). Using data from the American Community Survey, we replicated the findings of Pope (2016), extending the analysis by including 2015 and 2016. We confirm that DACA substantially increased the likelihood of recipients currently working or having worked at some point in the past year. In addition, DACA led to a higher immigrant labor force participation and a lower probability of being unemployed (Figure A.1). Finally, consistent with Pope (2016), DACA had a positive effect on the number of hours worked and income of eligible

individuals, but no significant effect on self-employment (Figures A.1 and A.2).

We have also considered the effects of DACA on non-pecuniary working conditions. As Figure A.2 depicts, there is no evidence of any changes in the work schedules or task-intensity of immigrant jobs (Peri and Sparber, 2009; Giuntella et al., 2017), suggesting that DACAmented individuals are not moving to "better" jobs in terms of these particular non-pecuniary characteristics. Results are similar when restricting the analysis to California alone (Figures A.3 and A.4).

Temporary work authorization also reduced immigrants' exposure to chronic stressors, such as the constant fear of being deported, the inability to get a driver's license, or open a bank account. Observational studies suggest that undocumented immigrants who belong to the 1.5 generation report higher levels of anxiety, depression, and fear, which affect their transition from adolescence to adulthood, during which about 75% of lifetime psychiatric disorders can emerge (Stacciarini et al., 2015; Gonzales et al., 2014; Delva et al., 2013). Taken together, our findings suggest that the reduced exposure to chronic stressors, increased income, higher labor force participation, improved access to care, and the financial security associated with insurance coverage can explain the positive effects on health and depression symptoms, which are stronger among those at the bottom of the income distribution.

3.5 Robustness Checks

In the Appendix, we report a full set of robustness checks. Table A.1 shows the sensitivity of our analysis to restricting the sample to individuals who are more likely to be undocumented. Unfortunately, we can only conduct this test using ACS data, as we have limited information and limited sample sizes when using NHIS and CHIS data. Reassuringly, the results lean in the same direction and, if anything, point estimates are slightly larger than the ones presented in Table 1, consistent with a reduction in attenuation bias due to measurement error in the definition of the eligible population.

Tables A.4-A.9 replicate Tables 2-6 and Table 8, restricting the sample to non-citizens aged 18-35, and with a high school degree or equivalent. For most of the outcomes the results lean in the same direction and point estimates are not substantially different, although due to the small sample sizes, standard errors increase substantially and many of the coefficients are not precisely estimated.

4 Conclusion

The Deferred Action for Childhood Arrivals (DACA) is currently a subject of intense political debate. Previous studies showed evidence of positive effects of this reform on labor market participation and income of those at the bottom of the income distribution, but documented some negative effects on academic outcomes. Furthermore, there is evidence that DACA had positive effects on adult mental health and child health outcomes.

We examine the effects of DACA on health insurance coverage and provide evidence that DACA eligibility increased insurance coverage. This increase was driven by an increase in public coverage in states that extended Medicaid access to low-income DACA-eligible immigrants. However, even in states that did not expand Medicaid to include DACA-eligible immigrants, there was an increase in individually purchased health insurance. Despite the increase in insurance coverage, there is little evidence of significant increases in health care use, although DACA-eligible individuals were more likely to report a usual place of care and less likely to delay health care due to financial constraints. Finally, we find some evidence that DACA led to improvement in self-reported health, mental health, stress, and hypertension. These positive effects are concentrated among individuals with income below the federal poverty level. Our findings are broadly consistent with previous experimental evidence on the health effects of health insurance coverage (Aron-Dine et al., 2013; Finkelstein et al., 2012).

Overall, our results suggest that DACA promoted financial security through its effects on income and insurance coverage, and improved perceived health and mental health of DACA-eligible immigrants – particularly those with an income below the federal poverty level – without significantly changing their demand for care. These effects should not be neglected when examining the impact of DACA. In contrast, restricting DACA might have detrimental effects on the access to care and mental health of DACA-eligible individuals, and particularly on the 1 million people who benefited from the program thus far. The lack of alternative policy solutions will pose difficult challenges to health care providers and public health officials across the country.

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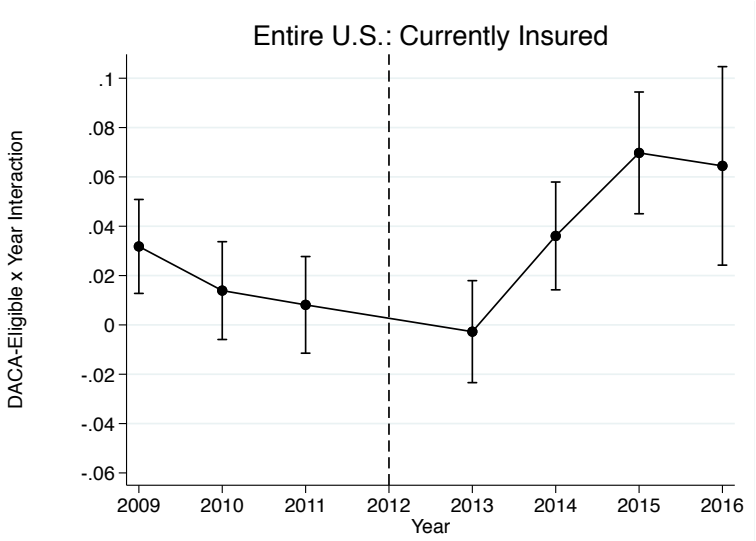
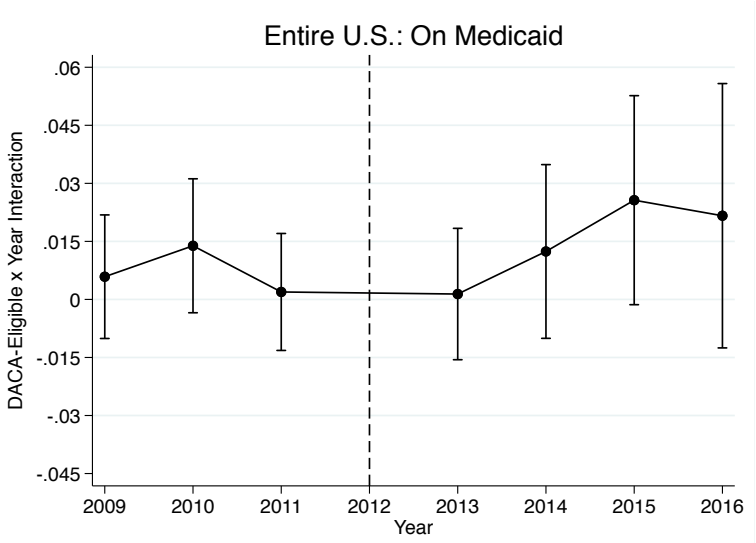
Figure 1: DACA and Insurance Coverage in U.S.



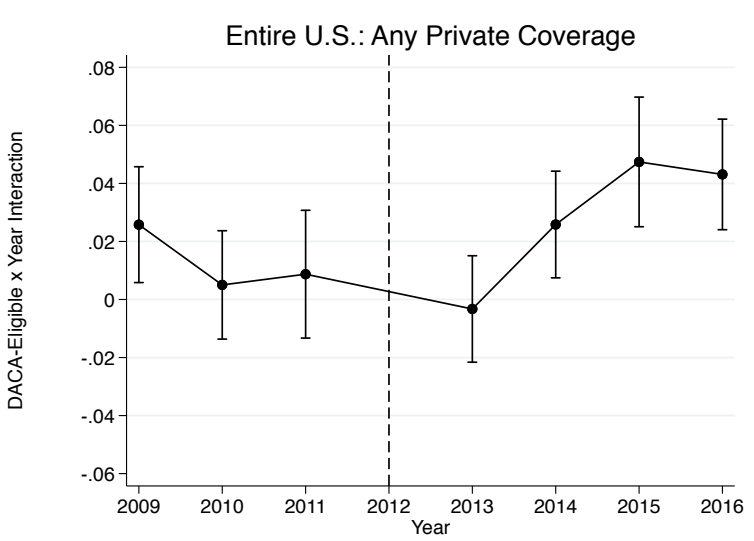
Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graph. The dependent variable - *Any Coverage* - is binary var. equal 1 if individual is currently with health insurance coverage. Estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2008-2016 waves of ACS. Regression controls for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), state fixed effects, year fixed effects, and state-specific time trends. Standard errors are clustered at state-year level.

Figure 2: DACA and Medicaid Coverage in U.S.



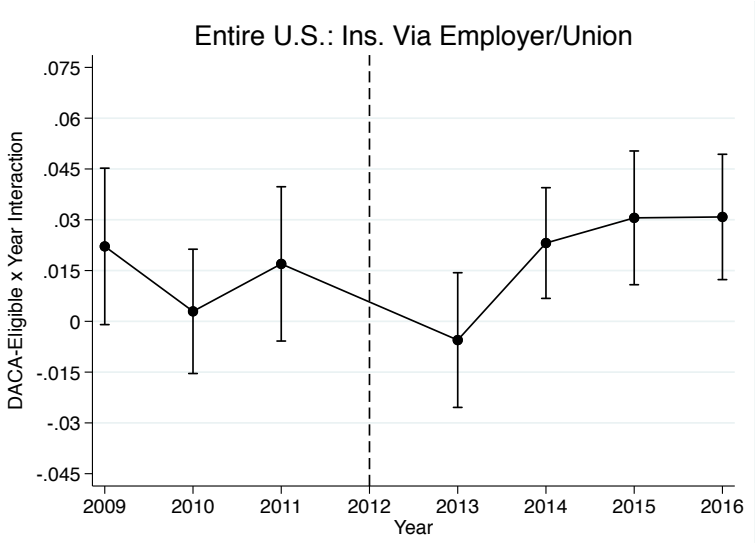
Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graph. The dependent variable - *Medicaid* - is binary var. equal 1 if individual is currently on Medicaid. Estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2008-2016 waves of ACS. Regression controls for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), state fixed effects, year fixed effects, and state-specific time trends. Standard errors are clustered at state-year level.

Figure 3: DACA and Any Private Coverage in U.S.



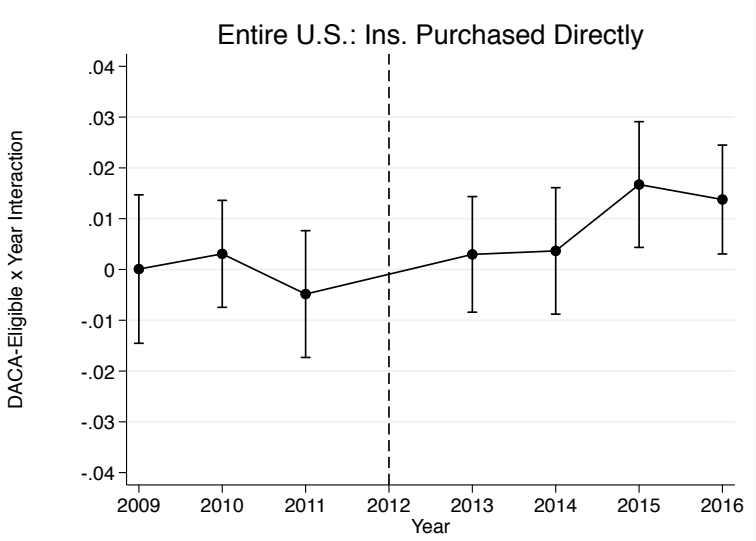
Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graph. The dependent variable - *Any Private* - is binary var. equal 1 if individual is currently with private health insurance (i.e. via employer/union or purchased directly from insurer). Estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2008-2016 waves of ACS. Regression controls for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), state fixed effects, year fixed effects, and state-specific time trends. Standard errors are clustered at state-year level.

Figure 4: DACA and Employer-Sponsored Coverage in U.S.



Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graph. The dependent variable - *Employer-Sponsored* - is binary var. equal 1 if individual is currently with health insurance via employer or union. Estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2008-2016 waves of ACS. Regression controls for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), state fixed effects, year fixed effects, and state-specific time trends. Standard errors are clustered at state-year level.

Figure 5: DACA and Individually Purchased Coverage in U.S.



Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graph. The dependent variable - *Indiv. Purchased* - is binary var. equal 1 if individual is currently with health insurance purchased directly from insurer. Estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2008-2016 waves of ACS. Regression controls for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), state fixed effects, year fixed effects, and state-specific time trends. Standard errors are clustered at state-year level.

Figure 6: DACA and Insurance Coverage in California and New York

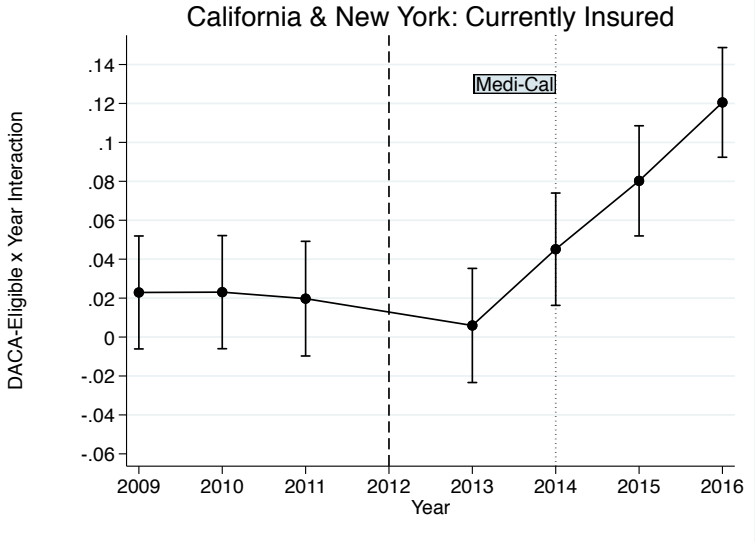


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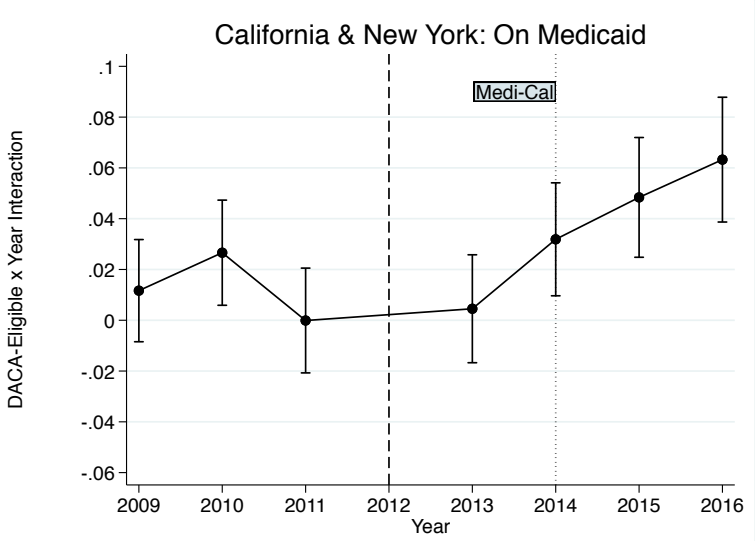
Figure 7: DACA and Medicaid Coverage in California and New York



Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graph. The dependent variable - *Medicaid* - is binary var. equal 1 if individual is currently on Medicaid. Estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2008-2016 waves of ACS. Regression controls for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), PUMA fixed effects, year fixed effects, and state-specific time trends. Standard errors are heteroskedasticity-robust.

Figure 8: DACA and Any Private Coverage in California and New York

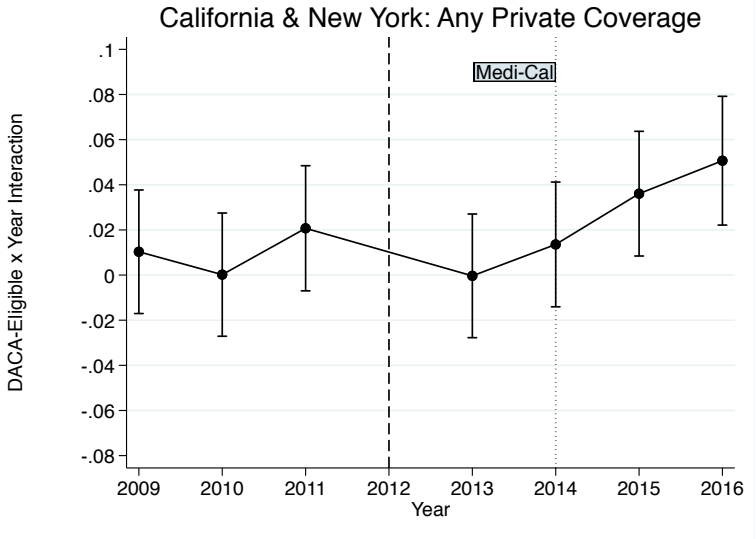


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Figure 9: DACA and Employer-Sponsored Coverage in California and New York

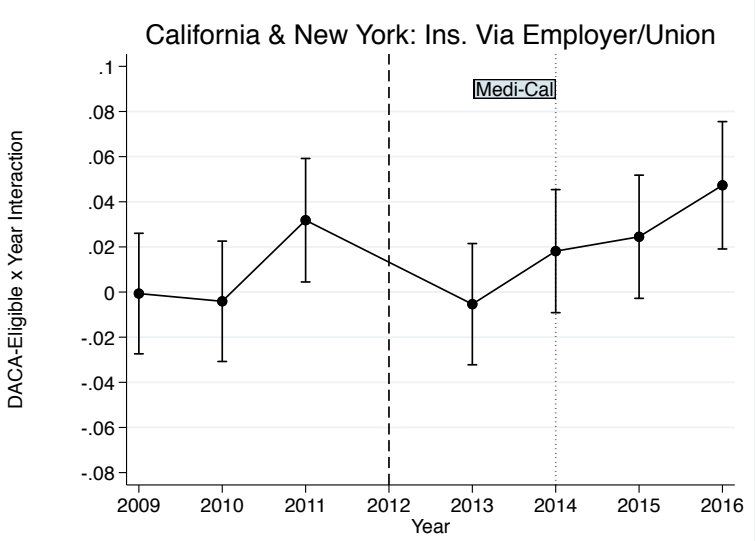

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Figure 10: DACA and Individually Purchased Coverage in California and New York

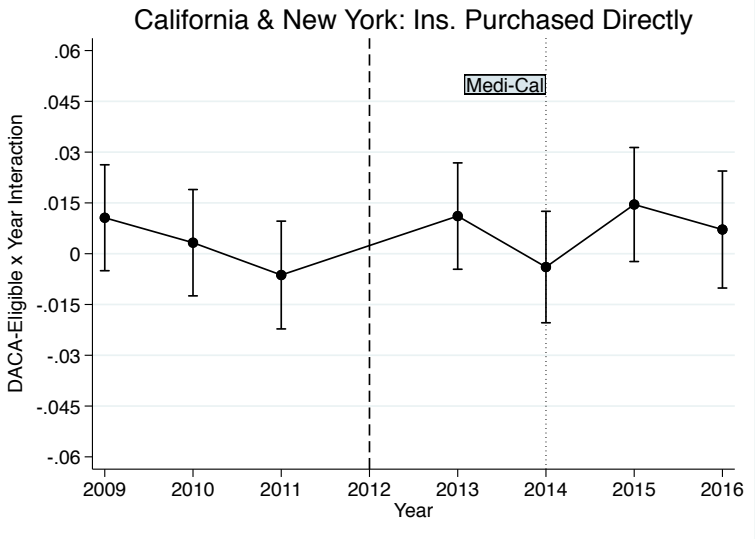

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Figure 11: DACA and Insurance Coverage in U.S. (outside CA, NY)

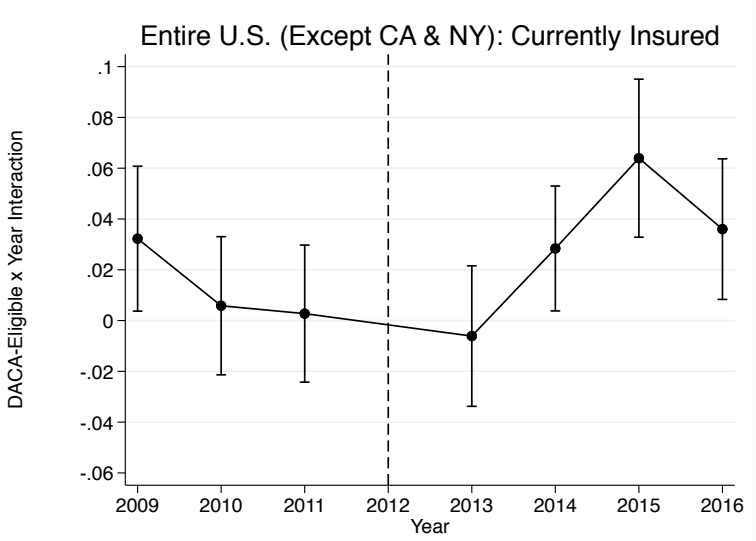

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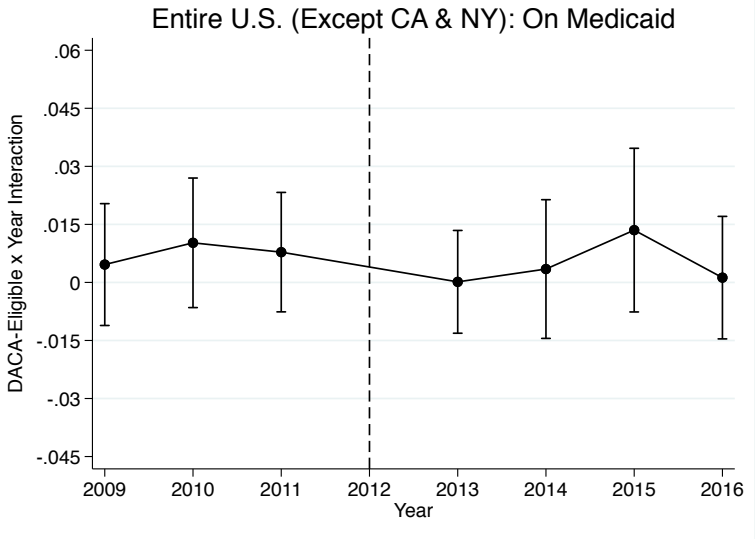
Figure 12: DACA and Medicaid Coverage in U.S. (outside CA, NY)



Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graph. The dependent variable - *Medicaid* - is binary var. equal 1 if individual is currently on Medicaid. Estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2008-2016 waves of ACS. Regression controls for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), state fixed effects, year fixed effects, and state-specific time trends. Standard errors are clustered at state-year level.

Figure 13: DACA and Any Private Coverage in U.S. (outside CA, NY)

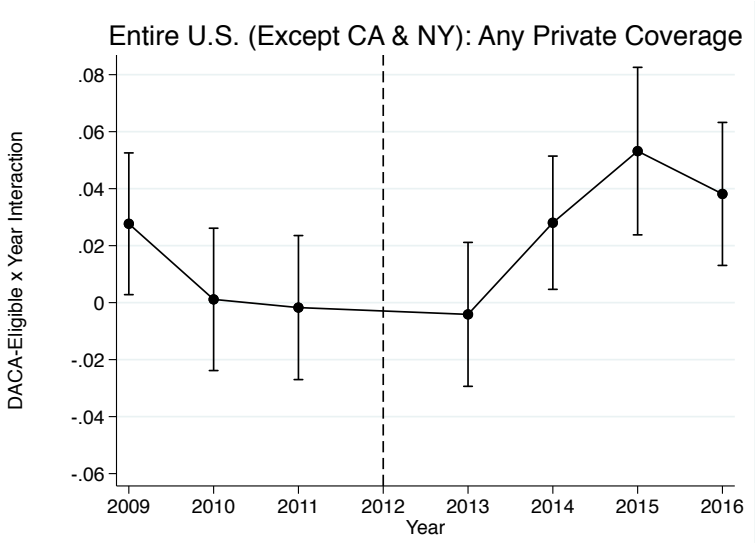


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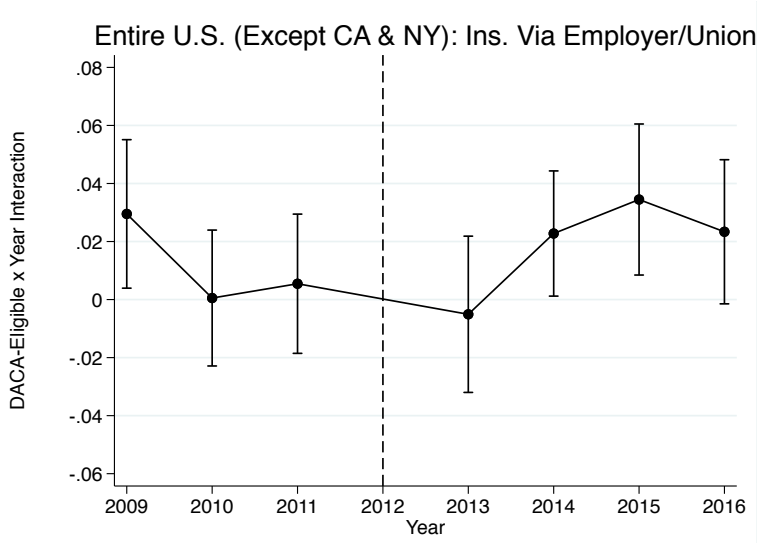
Figure 14: DACA and Employer-Sponsored Coverage in U.S. (outside CA, NY)



Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graph. The dependent variable - *Employer-Sponsored* - is binary var. equal 1 if individual is currently with health insurance via employer or union. Estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2008-2016 waves of ACS. Regression controls for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), state fixed effects, year fixed effects, and state-specific time trends. Standard errors are clustered at state-year level.

Figure 15: DACA and Individually Purchased Coverage in U.S. (outside CA, NY)

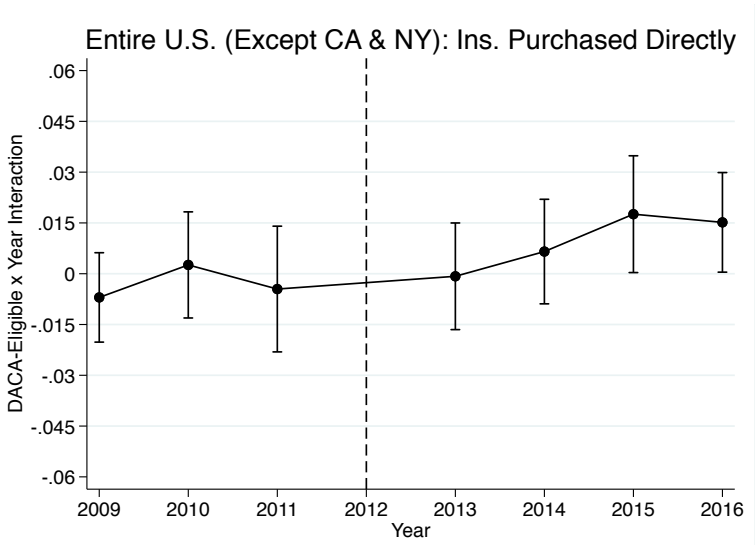


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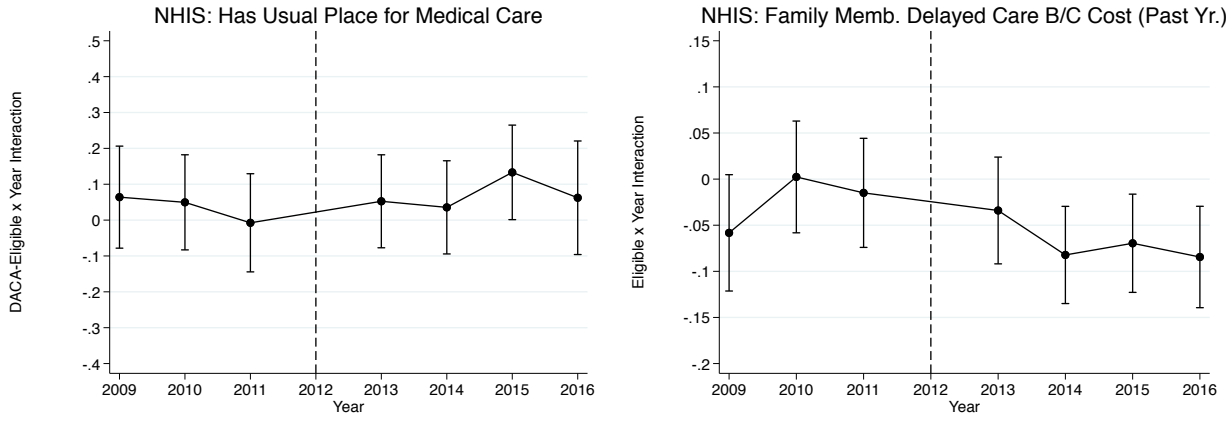
Figure 16: DACA and Health Care Access, Affordability (Entire U.S.: NHIS)



Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graphs. Following dependent variables were used in the regressions (left-to-right): *Usual* - binary var. equal 1 if individual has usual place to go to when sick or needing health advice; *Any Care Delay* - binary var. equal 1 if any member of respondent's family delayed seeking medical care due to cost (in past 12 months). All estimates are derived from a sample of non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are taken from the 2000-2016 waves of NHIS. Regressions control for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), region fixed effects, year fixed effects, and region-specific time trends. Standard errors are heteroskedasticity-robust.

Figure 17: DACA and Health Care Access (California: CHIS)

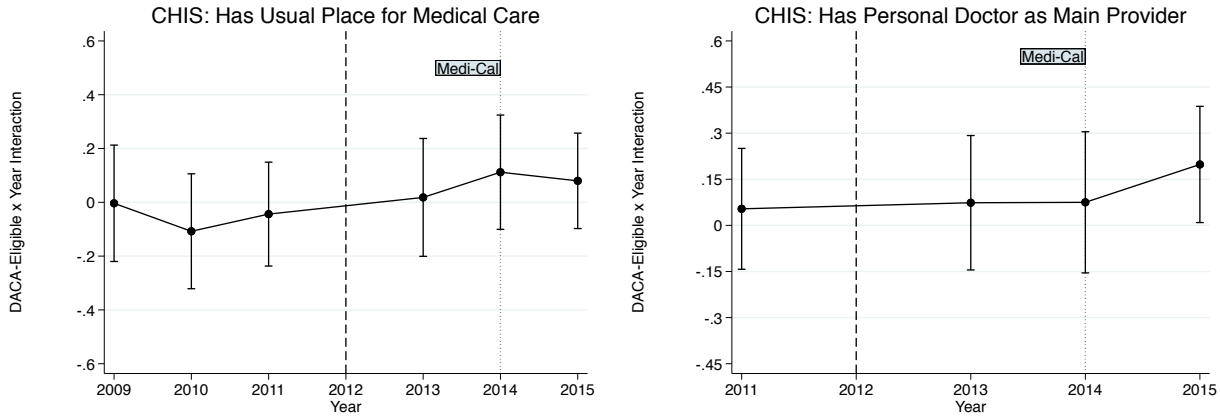


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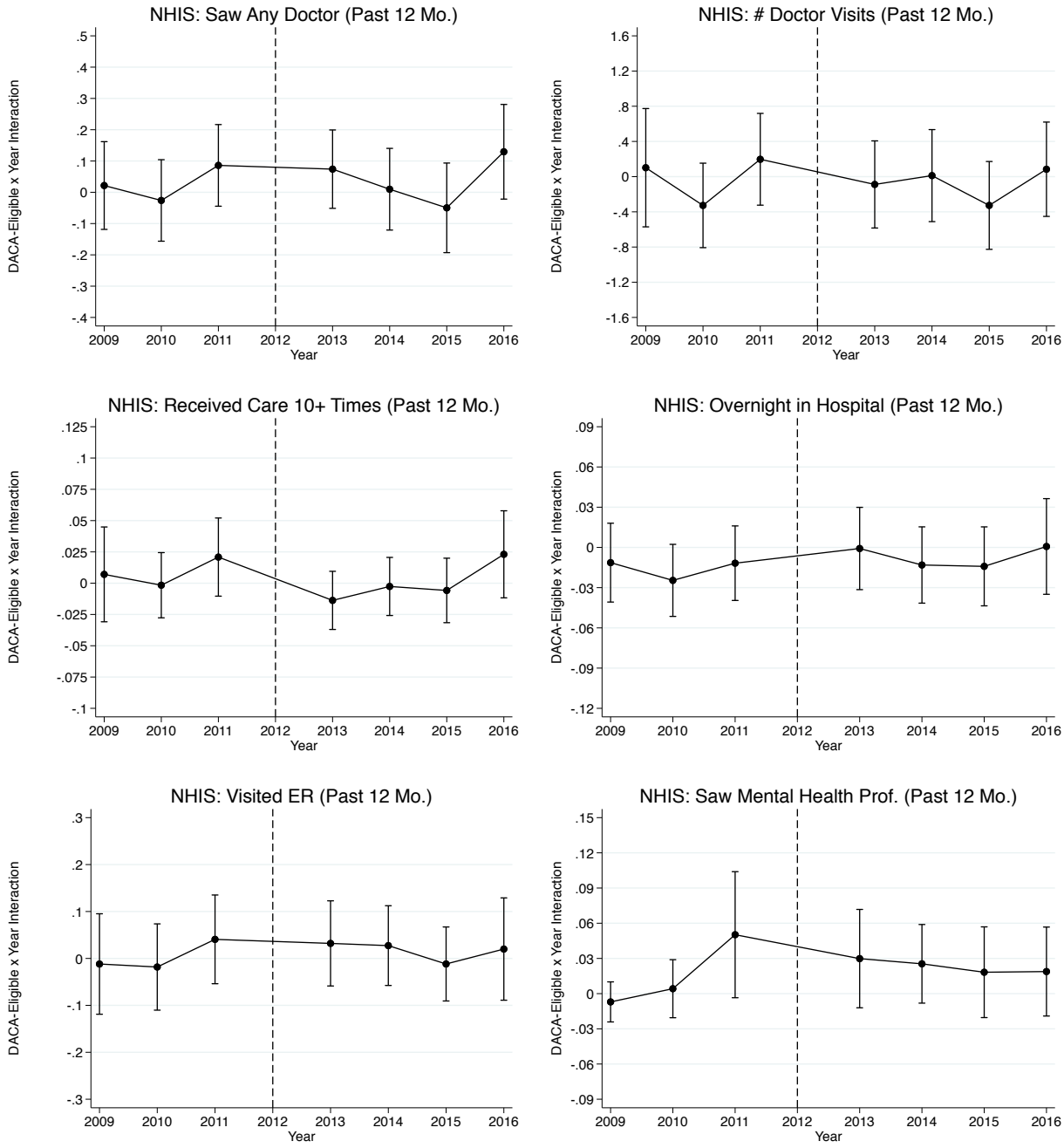
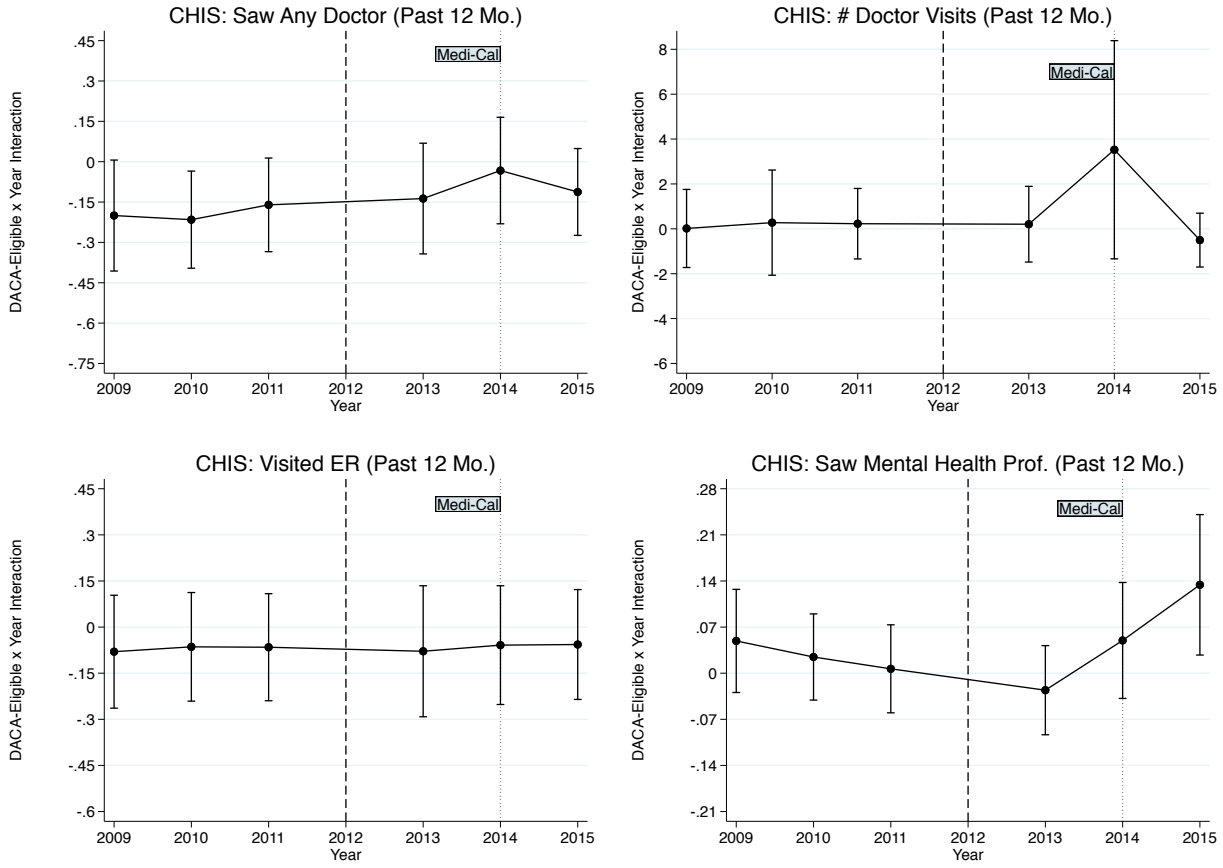
Figure 18: DACA and Health Care Use (Entire U.S.: NHIS)



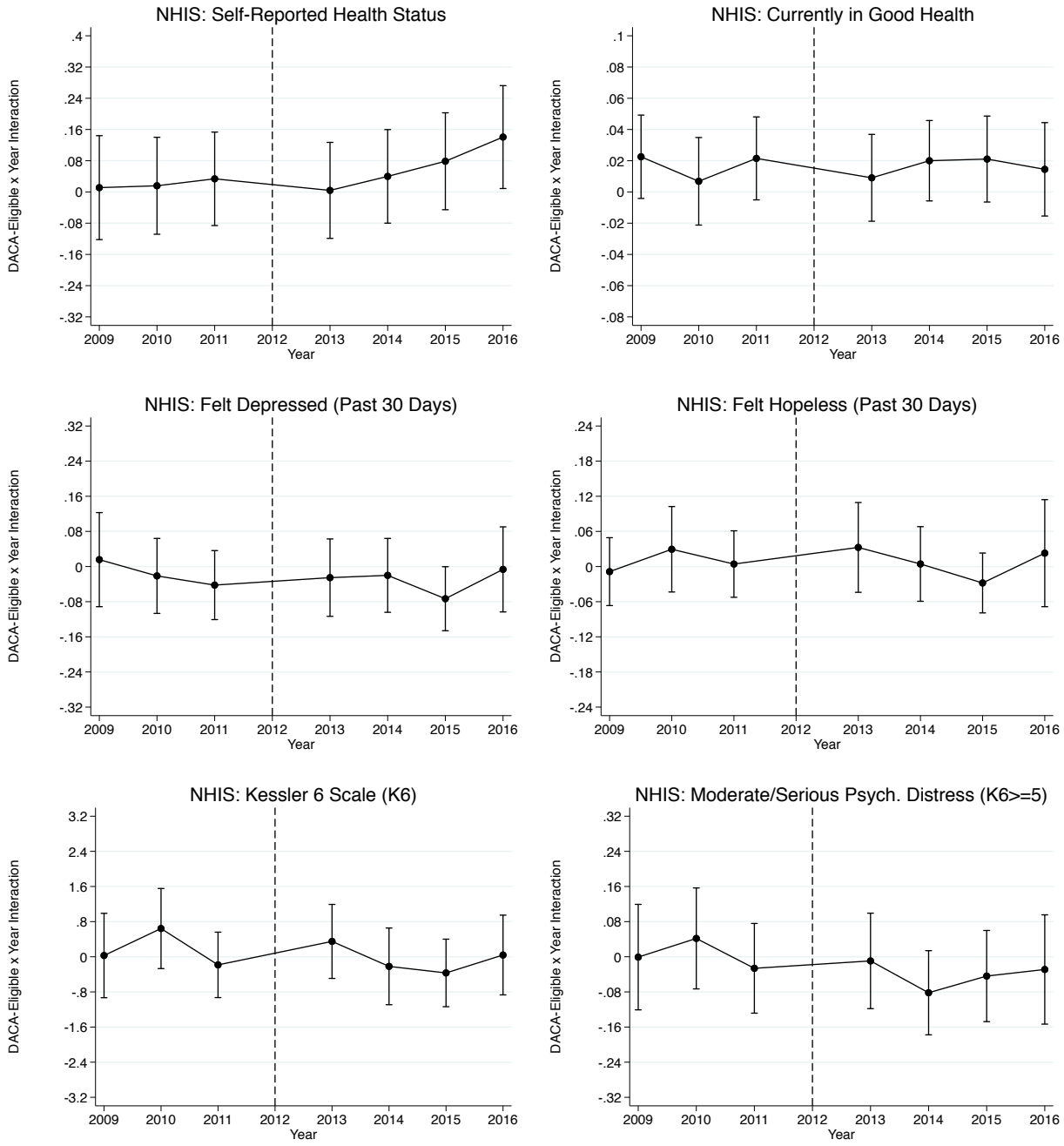
Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graphs. Following dependent variables were used in the regressions (left-to-right, starting with the uppermost row): *Doctor* - binary var. equal 1 if individual saw/talked to any doctor in past 12 months; *# Visits* - total number of doctor's office visits in past 12 months; *Care 10+* - binary var. equal 1 if individual received medical care 10+ times in past 12 months; *Hosp. Night* - binary var. equal 1 if individual was in a hospital overnight in past 12 months; *ER* - binary var. equal 1 if individual visited emergency room in past 12 months; *Saw Mental* - binary var. equal 1 if individual saw/talked to mental health professional (psychiatrist, psychologist, etc.) in past 12 months. All estimates are derived from a sample of non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are taken from the 2000-2016 waves of NHIS. Regressions control for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), region fixed effects, year fixed effects, and region-specific time trends. Standard errors are heteroskedasticity-robust.

Figure 19: DACA and Health Care Use (California: CHIS)



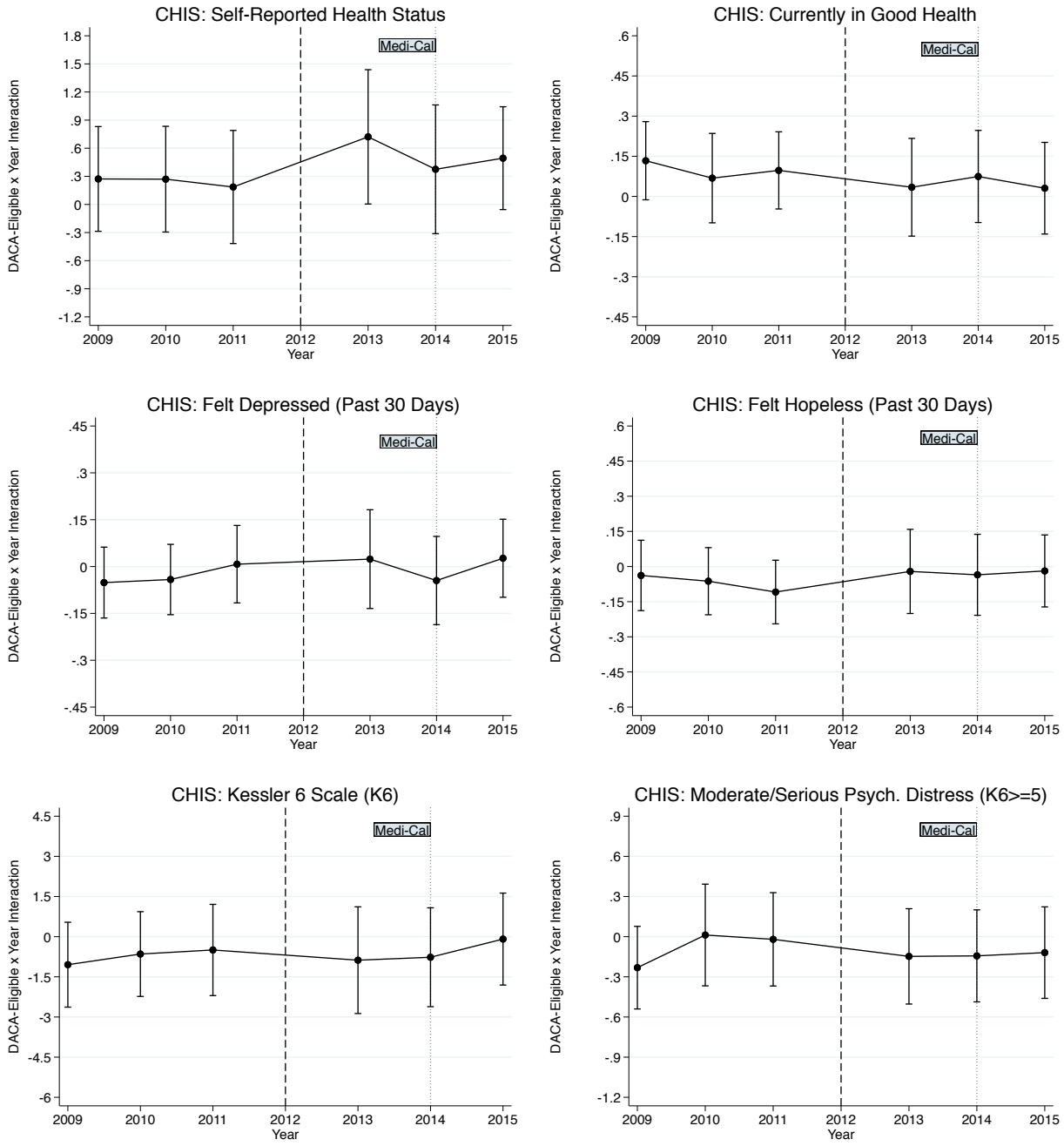
Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Eligi_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graphs. Following dependent variables were used in the regressions (left-to-right, starting with the uppermost row): *Doctor* - binary var. equal 1 if individual saw/talked to any doctor in past 12 months; *# Visits* - total number of doctor's office visits in past 12 months; *ER* - binary var. equal 1 if individual visited emergency room in past 12 months; *Saw Mental* - binary var. equal 1 if individual saw/talked to a medical professional (psychiatrist, psychologist, etc.) for mental or alcohol/drug problems in past 12 months. All estimates are derived from a sample of non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are taken from the 2003-2015 waves of CHIS. Regressions control for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), county fixed effects, and year fixed effects. Standard errors are heteroskedasticity-robust.

Figure 20: DACA and Health (Entire U.S.: NHIS)



Notes - The figure plots the coefficients obtained from estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graphs. Following dependent variables were used in the regressions (left-to-right, starting with the uppermost row): *Health* - self-reported general health status (categorical variable: 1 - poor, 2 - fair, 3 - good, 4 - very good, 5 - excellent); *Good Health* - binary var. equal 1 if individual self-reported his/her general health status as excellent, very good, or good (categories 5, 4, 3); *Depressed* - binary var. equal 1 if individual reported feeling sad or depressed such that "nothing could cheer them up" some/most/all of the time in past 30 days; *Hopeless* - binary var. equal 1 if individual reported feeling hopeless some/most/all of the time in past 30 days; *K6 Scale* - continuous measure of nonspecific psychological distress during the past 30 days using Kessler 6-Item (K6) Psychological Distress Scale (0-24; higher values represent higher levels of distress); *Distress* - binary var. equal 1 if individual experienced moderate or serious psychological distress in past 30 days (i.e. *K6 Scale* $>= 5$). All estimates are derived from a sample of non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are taken from the 2000-2016 waves of NHIS. Regressions control for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), region fixed effects, year fixed effects, and region-specific time trends. Standard errors are heteroskedasticity-robust.

Figure 21: DACA and Health (California: CHIS)



Notes - The figure plots the coefficients obtained estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graphs. Following dependent variables were used in the regressions (left-to-right, starting with the uppermost row): *Health* - self-reported general health status (categorical variable: 1 - poor, 2 - fair, 3 - good, 4 - very good, 5 - excellent); *Good Health* - binary var. equal 1 if individual self-reported his/her general health status as excellent, very good, or good (categories 5, 4, 3); *Depressed* - binary var. equal 1 if individual reported feeling sad or depressed such that "nothing could cheer them up" some/most/all of the time in past 30 days; *Hopeless* - binary var. equal 1 if individual reported feeling hopeless some/most/all of the time in past 30 days; *K6 Scale* - continuous measure of nonspecific psychological distress during the past 30 days using Kessler 6-Item (K6) Psychological Distress Scale (0-24; higher values represent higher levels of distress); *Distress* - binary var. equal 1 if individual experienced moderate or serious psychological distress in past 30 days (i.e. *K6 Scale* $>= 5$). All estimates are derived from a sample of non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are drawn the 2003-2015 waves of CHIS. Regressions control for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), county fixed effects, and year fixed effects. Standard errors are heteroskedasticity-robust.

Table 1: The Effects of DACA on Health Insurance Coverage

	(1) Any Coverage	(2) Medicaid	(3) Any Private	(4) Employer-Sponsored	(5) Indiv. Purchased
Panel A: Entire U.S.					
DACA-Eligible * Post 2012	0.0224***	0.0084	0.0137**	0.0061	0.0081**
	(0.008)	(0.007)	(0.006)	(0.006)	(0.004)
Observations	395,902	395,902	395,902	395,902	395,902
R-squared	0.221	0.079	0.250	0.188	0.095
Mean of Dep. Var.	0.642	0.089	0.558	0.435	0.137
Std. Dev. of Dep. Var.	0.480	0.284	0.497	0.496	0.344
Panel B: California & New York					
DACA-Eligible * Post 2012	0.0409***	0.0256***	0.0134*	0.0114	0.0025
	(0.007)	(0.006)	(0.007)	(0.007)	(0.004)
Observations	127,886	127,886	127,886	127,886	127,886
R-squared	0.193	0.111	0.261	0.207	0.124
Mean of Dep. Var.	0.662	0.147	0.521	0.409	0.127
Std. Dev. of Dep. Var.	0.473	0.354	0.500	0.492	0.333
Panel C: Entire U.S. (except California and New York)					
DACA-Eligible * Post 2012	0.0145*	-0.0019	0.0171**	0.0074	0.0107**
	(0.008)	(0.004)	(0.007)	(0.007)	(0.004)
Observations	268,187	268,187	268,187	268,187	268,187
R-squared	0.249	0.059	0.267	0.198	0.101
Mean of Dep. Var.	0.632	0.061	0.575	0.447	0.142
Std. Dev. of Dep. Var.	0.482	0.240	0.494	0.497	0.349

Notes - *Any Coverage* - binary var. equal 1 if individual currently with health insurance coverage; *Medicaid* - binary var. equal 1 if individual currently on Medicaid; *Any Private* - binary var. equal 1 if individual currently with private health insurance (i.e. via employer/union or purchased directly from insurer); *Employer-Sponsored* - binary var. equal 1 if individual currently with health insurance via employer or union; *Indiv. Purchased* - binary var. equal 1 if individual currently with health insurance purchased directly from insurer. Standard errors in parentheses, heteroskedasticity-robust (Panel B), and clustered at state-year level (Panels A and C). Estimates in all columns are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2008-2016 waves of ACS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), year fixed effects, and state-specific time trends. In addition, all columns in Panels A and C control for state fixed effects, while all columns in Panel B control for PUMA fixed effects. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table 2: DACA and Health Care Access, Affordability (Entire U.S.: NHIS)

	(1) Usual	(2) Any Care Delay	(3) Special. Not Afford.
DACA-Eligible * Post 2012	0.0146	-0.0325***	-0.0511**
	(0.031)	(0.011)	(0.024)
Observations	247,900	583,051	92,841
R-squared	0.072	0.025	0.017
Mean of Dep. Var.	0.812	0.157	0.052
Std. Dev. of Dep. Var.	0.390	0.364	0.221

Notes - *Usual* - binary var. equal 1 if individual has usual place to go to when sick or needing health advice; *Any Care Delay* - binary var. equal 1 if any member of respondent's family delayed seeking medical care due to cost (in past 12 months); *Special. Not Afford.* - binary var. equal 1 if individual needed but couldn't afford specialist (in past 12 months). Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are taken from the 2000-2016 waves of NHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), year fixed effects, region fixed effects, and region-specific time trends. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table 3: DACA and Health Care Access (California: CHIS)

	(1) Usual	(2) Personal MD
DACA-Eligible * Post 2012	0.0918**	0.0913
	(0.046)	(0.066)
Observations	106,247	31,396
R-squared	0.079	0.108
Mean of Dep. Var.	0.848	0.683
Std. Dev. of Dep. Var.	0.359	0.465

Notes - *Usual* - binary var. equal 1 if individual has usual place to go to when sick or needing health advice; *Personal MD* - binary var. equal 1 if individual has personal doctor as main medical provider. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are taken from the 2003-2015 waves of CHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), county fixed effects, and year fixed effects. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table 4: DACA and Health Care Use (Entire U.S.: NHIS)

	(1) Doctor	(2) # Visits	(3) Care 10+	(4) Hosp. Night	(5) ER	(6) Saw Special	(7) Saw Eye	(8) Saw Mental
DACA-Eligible * Post 2012	0.0112	0.0411	0.0001	0.0012	0.0089	-0.0119	0.0013	0.0083
	(0.031)	(0.109)	(0.006)	(0.007)	(0.022)	(0.014)	(0.027)	(0.010)
Observations	246,178	246,178	582,213	582,929	247,041	247,025	247,090	247,101
R-squared	0.072	0.073	0.019	0.018	0.024	0.027	0.042	0.020
Mean of Dep. Var.	0.776	2.243	0.082	0.065	0.195	0.192	0.315	0.086
Std. Dev. of Dep. Var.	0.417	2.161	0.274	0.247	0.396	0.394	0.464	0.281

Notes - *Doctor* - binary var. equal 1 if individual saw/talked to any doctor in past 12 months; *# Visits* - total number of doctor's office visits in past 12 months; *Care 10+* - binary var. equal 1 if individual received medical care 10+ times in past 12 months; *Hosp. Night* - binary var. equal 1 if individual was in a hospital overnight in past 12 months; *ER* - binary var. equal 1 if individual visited emergency room in past 12 months; *Saw Special* - binary var. equal 1 if individual saw/talked to medical specialist in past 12 months; *Saw Eye* - binary var. equal 1 if individual saw/talked to eye doctor in past 12 months; *Saw Mental* - binary var. equal 1 if individual saw/talked to mental health professional (psychiatrist, psychologist, etc.) in past 12 months. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are taken from the 2000-2016 waves of NHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), year fixed effects, region fixed effects, and region-specific time trends. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table 5: DACA and Health Care Use (California: CHIS)

	(1) Doctor	(2) # Visits	(3) ER	(4) Saw Mental	(5) # Mental Visits
DACA-Eligible * Post 2012	0.0094	0.9150	-0.0084	0.0387*	0.8404*
	(0.047)	(0.918)	(0.040)	(0.023)	(0.487)
Observations	106,247	106,247	85,776	66,315	66,315
R-squared	0.055	0.028	0.020	0.041	0.018
Mean of Dep. Var.	0.807	4.075	0.184	0.159	1.808
Std. Dev. of Dep. Var.	0.395	9.201	0.387	0.366	8.541

Notes - *Doctor* - binary var. equal 1 if individual saw/talked to any doctor in past 12 months; *# Visits* - total number of doctor's office visits in past 12 months; *ER* - binary var. equal 1 if individual visited emergency room in past 12 months; *Saw Mental* - binary var. equal 1 if individual saw/talked to a medical professional (psychiatrist, psychologist, etc.) for mental or alcohol/drug problems in past 12 months; *# Mental Visits* - # of visits to professional for problems with mental health or drugs/alcohol (during past 12 months). Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are taken from the 2003-2015 waves of CHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), county fixed effects, and year fixed effects. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table 6: DACA and General Health Status, Mental Health (Entire U.S.: NHIS)

	(1) Health	(2) Poor Health	(3) Good Health	(4) Depressed	(5) Hopeless	(6) Effort	(7) K6 Scale	(8) Distress	(9) Hyperten.
DACA-Eligible * Post 2012	0.1188***	-0.0036***	0.0071	-0.0254	-0.0076	-0.0311	-0.2014	-0.0389	-0.0103
	(0.028)	(0.001)	(0.005)	(0.018)	(0.017)	(0.021)	(0.208)	(0.024)	(0.017)
Observations	583,085	583,085	583,085	246,199	246,172	246,032	245,701	245,701	249,479
R-squared	0.079	0.011	0.033	0.025	0.016	0.018	0.033	0.025	0.064
Mean of Dep. Var.	4.009	0.011	0.937	0.106	0.063	0.148	2.484	0.194	0.142
Std. Dev. of Dep. Var.	0.950	0.105	0.243	0.307	0.243	0.356	3.726	0.395	0.349

Notes - *Health* - self-reported general health status (categorical variable: 1 - poor, 2 - fair, 3 - good, 4 - very good, 5 - excellent); *Poor Health* - binary var. equal 1 if individual self-reported his/her general health status as poor (category 1); *Good Health* - binary var. equal 1 if individual self-reported his/her general health status as excellent, very good, or good (categories 5, 4, 3); *Depressed* - binary var. equal 1 if individual reported feeling sad or depressed such that "nothing could cheer them up" some/most/all of the time in past 30 days; *Hopeless* - binary var. equal 1 if individual reported feeling hopeless some/most/all of the time in past 30 days; *Effort* - binary var. equal 1 if individual reported feeling "everything was an effort" some/most/all of the time in past 30 days; *K6 Scale* - continuous measure of nonspecific psychological distress during the past 30 days using Kessler 6-Item (K6) Psychological Distress Scale (0-24; higher values represent higher levels of distress); *Distress* - binary var. equal 1 if individual experienced moderate or serious psychological distress in past 30 days (i.e. *K6 Scale* $>= 5$); *Hyperten.* - binary var. equal 1 if individual was ever told had hypertension/high blood pressure. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are taken from the 2000-2016 waves of NHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), year fixed effects, region fixed effects, and region-specific time trends. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table 7: DACA and General Health Status, Mental Health - Individuals in Poverty (Entire U.S.: NHIS)

	(1) Health	(2) Poor Health	(3) Good Health	(4) Depressed	(5) Hopeless	(6) Effort	(7) K6 Scale	(8) Distress	(9) Hyperten.
DACA-Eligible * Post 2012	0.1778***	-0.0011	0.0094	-0.0688**	-0.0639**	-0.0845**	-0.8849**	-0.0905**	-0.0445**
	(0.065)	(0.005)	(0.014)	(0.029)	(0.026)	(0.039)	(0.353)	(0.042)	(0.020)
Observations	57,449	57,449	57,449	32,371	32,361	32,338	32,277	32,277	32,827
R-squared	0.151	0.043	0.104	0.051	0.044	0.041	0.064	0.046	0.118
Mean of Dep. Var.	3.661	0.034	0.850	0.190	0.129	0.248	3.867	0.316	0.155
Std. Dev. of Dep. Var.	1.105	0.182	0.357	0.393	0.335	0.432	4.857	0.465	0.362

Notes - *Health* - self-reported general health status (categorical variable: 1 - poor, 2 - fair, 3 - good, 4 - very good, 5 - excellent); *Poor Health* - binary var. equal 1 if individual self-reported his/her general health status as poor (category 1); *Good Health* - binary var. equal 1 if individual self-reported his/her general health status as excellent, very good, or good (categories 5, 4, 3); *Depressed* - binary var. equal 1 if individual reported feeling sad or depressed such that "nothing could cheer them up" some/most/all of the time in past 30 days; *Hopeless* - binary var. equal 1 if individual reported feeling hopeless some/most/all of the time in past 30 days; *Effort* - binary var. equal 1 if individual reported feeling "everything was an effort" some/most/all of the time in past 30 days; *K6 Scale* - continuous measure of nonspecific psychological distress during the past 30 days using Kessler 6-Item (K6) Psychological Distress Scale (0-24; higher values represent higher levels of distress); *Distress* - binary var. equal 1 if individual experienced moderate or serious psychological distress in past 30 days (i.e. *K6 Scale* $>= 5$); *Hyperten.* - binary var. equal 1 if individual was ever told had hypertension/high blood pressure. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). This sample is further restricted to contain only individuals with family's before-tax income (from preceding calendar year) below U.S. Census Bureau's official poverty threshold. Data are taken from the 2000-2016 waves of NHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), year fixed effects, region fixed effects, and region-specific time trends. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table 8: DACA and General Health Status, Mental Health (California: CHIS)

	(1) Health	(2) Poor Health	(3) Good Health	(4) Depressed	(5) Hopeless	(6) Restless	(7) K6 Scale	(8) Distress	(9) Hyperten.
DACA-Eligible * Post 2012	0.3920**	0.0098	-0.0166	0.0190	0.0139	-0.0357	0.1003	-0.1035	0.0342
	(0.167)	(0.015)	(0.037)	(0.031)	(0.036)	(0.041)	(0.396)	(0.073)	(0.033)
Observations	106,247	106,247	106,247	85,731	85,731	85,731	85,776	85,731	106,247
R-squared	0.079	0.016	0.044	0.020	0.019	0.024	0.041	0.034	0.058
Mean of Dep. Var.	3.703	0.023	0.880	0.076	0.096	0.274	3.637	0.298	0.154
Std. Dev. of Dep. Var.	1.016	0.151	0.326	0.265	0.295	0.446	3.686	0.457	0.361

Notes - *Health* - self-reported general health status (categorical variable: 1 - poor, 2 - fair, 3 - good, 4 - very good, 5 - excellent); *Poor Health* - binary var. equal 1 if individual self-reported his/her general health status as poor (category 1); *Good Health* - binary var. equal 1 if individual self-reported his/her general health status as excellent, very good, or good (categories 5, 4, 3); *Depressed* - binary var. equal 1 if individual reported feeling sad or depressed such that "nothing could cheer them up" some/most/all of the time in past 30 days; *Hopeless* - binary var. equal 1 if individual reported feeling hopeless some/most/all of the time in past 30 days; *Restless* - binary var. equal 1 if individual reported feeling restless or anxious some/most/all of the time in past 30 days; *K6 Scale* - continuous measure of nonspecific psychological distress during the past 30 days using Kessler 6-Item (K6) Psychological Distress Scale (0-24; higher values represent higher levels of distress); *Distress* - binary var. equal 1 if individual experienced moderate or serious psychological distress in past 30 days (i.e. *K6 Scale* $>= 5$); *Hyperten.* - binary var. equal 1 if individual was ever told had hypertension/high blood pressure. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). Data are taken from the 2003-2015 waves of CHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), county fixed effects, and year fixed effects. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

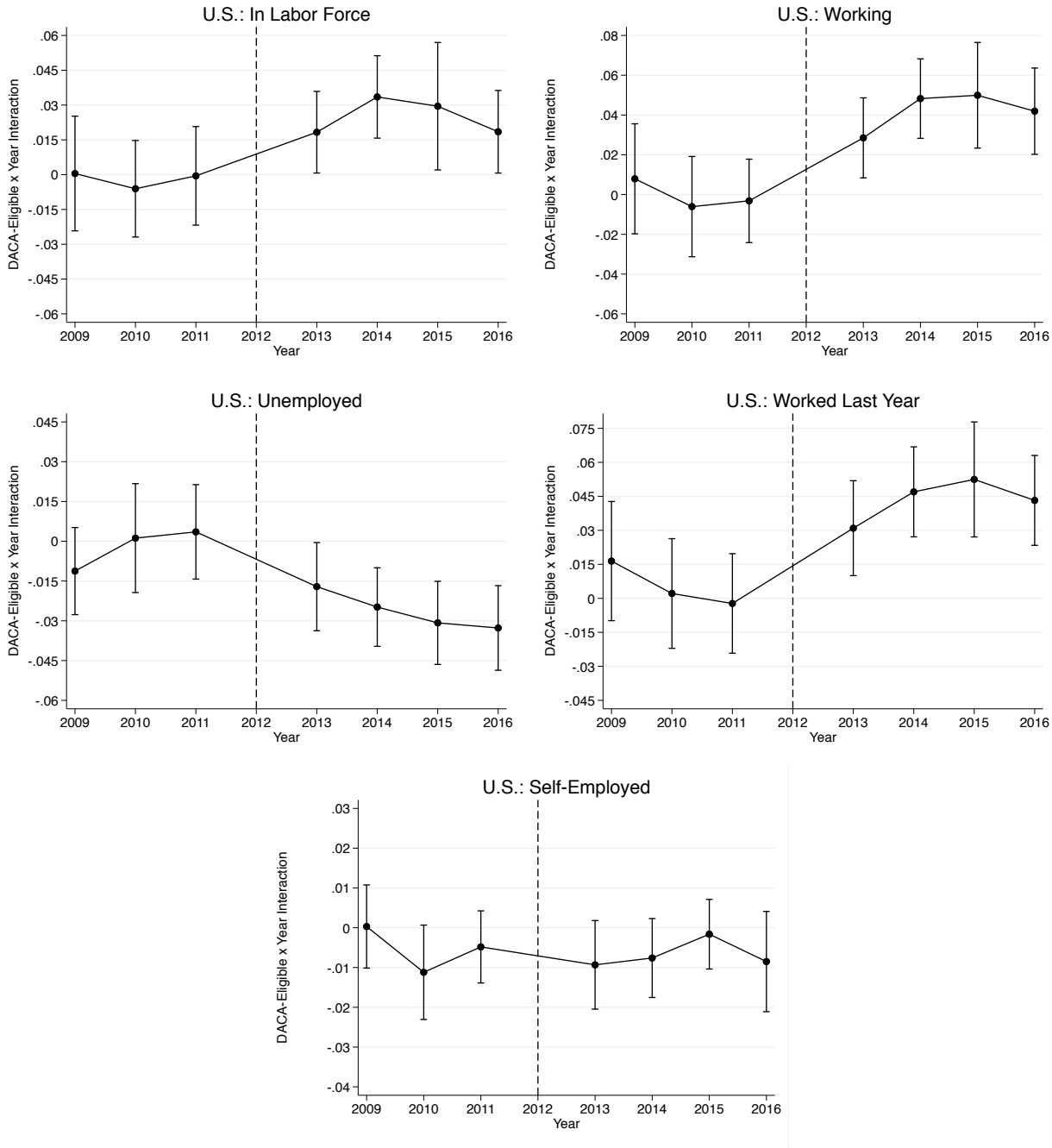
Table 9: DACA and General Health Status, Mental Health - Individuals in Poverty (California: CHIS)

	(1) Health	(2) Poor Health	(3) Good Health	(4) Depressed	(5) Hopeless	(6) Restless	(7) K6 Scale	(8) Distress	(9) Hyperten.
DACA-Eligible * Post 2012	0.3255	0.0454	0.1016	-0.0325	-0.0791	-0.1777*	-1.6753	-0.2354*	-0.0600**
	(0.316)	(0.071)	(0.106)	(0.053)	(0.091)	(0.098)	(1.131)	(0.123)	(0.024)
Observations	12,060	12,060	12,060	10,176	10,176	10,176	10,188	10,176	12,060
R-squared	0.096	0.068	0.073	0.048	0.050	0.049	0.067	0.052	0.114
Mean of Dep. Var.	3.192	0.063	0.735	0.160	0.182	0.327	5.021	0.435	0.182
Std. Dev. of Dep. Var.	1.101	0.243	0.441	0.367	0.386	0.469	4.682	0.496	0.386

Notes - *Health* - self-reported general health status (categorical variable: 1 - poor, 2 - fair, 3 - good, 4 - very good, 5 - excellent); *Poor Health* - binary var. equal 1 if individual self-reported his/her general health status as poor (category 1); *Good Health* - binary var. equal 1 if individual self-reported his/her general health status as excellent, very good, or good (categories 5, 4, 3); *Depressed* - binary var. equal 1 if individual reported feeling sad or depressed such that "nothing could cheer them up" some/most/all of the time in past 30 days; *Hopeless* - binary var. equal 1 if individual reported feeling hopeless some/most/all of the time in past 30 days; *Restless* - binary var. equal 1 if individual reported feeling restless or anxious some/most/all of the time in past 30 days; *K6 Scale* - continuous measure of nonspecific psychological distress during the past 30 days using Kessler 6-Item (K6) Psychological Distress Scale (0-24; higher values represent higher levels of distress); *Distress* - binary var. equal 1 if individual experienced moderate or serious psychological distress in past 30 days (i.e. *K6 Scale* $>= 5$); *Hyperten.* - binary var. equal 1 if individual was ever told had hypertension/high blood pressure. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). This sample is further restricted to contain only individuals with family's before-tax income (from preceding calendar year) below U.S. Census Bureau's official poverty threshold. Data are taken from the 2003-2015 waves of CHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), county fixed effects, and year fixed effects. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

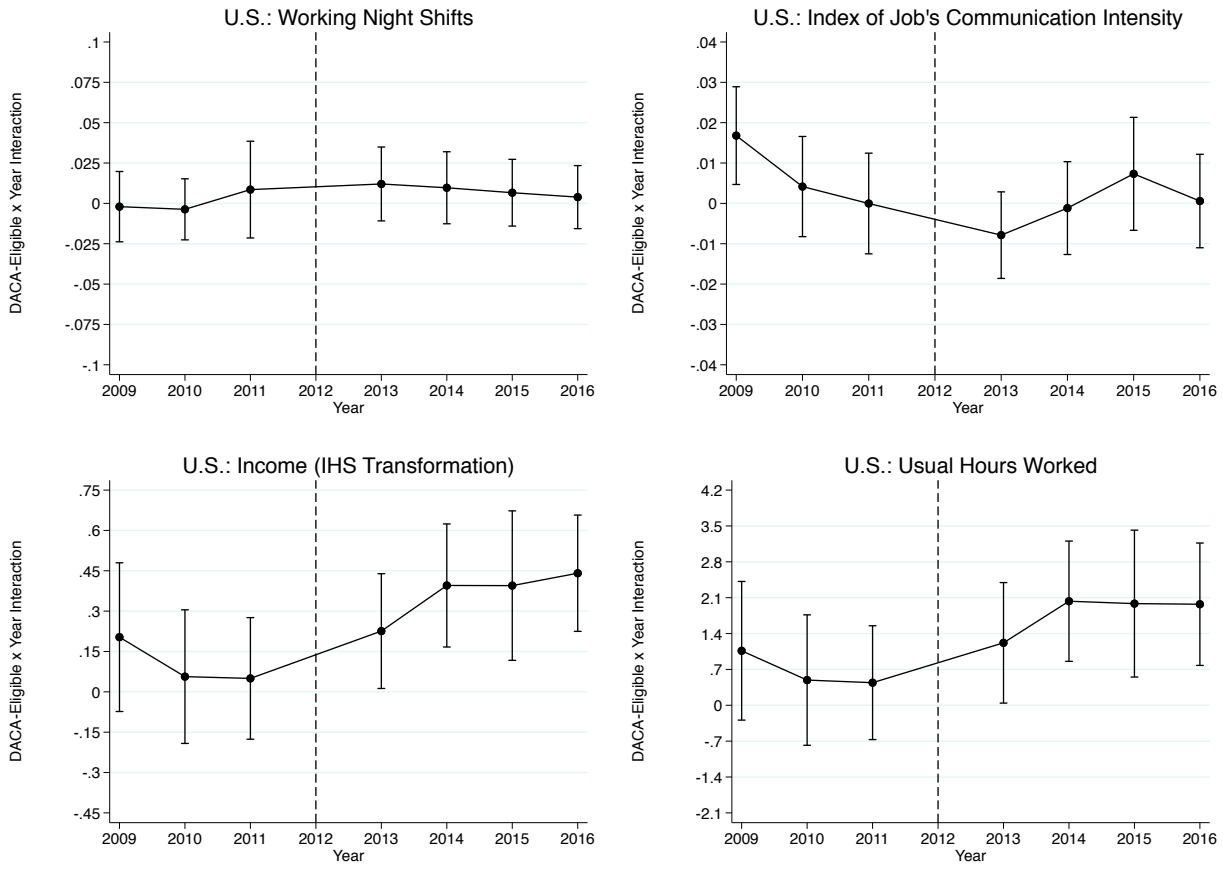
Appendix

Figure A.1: DACA and Labor Market Outcomes (U.S.)



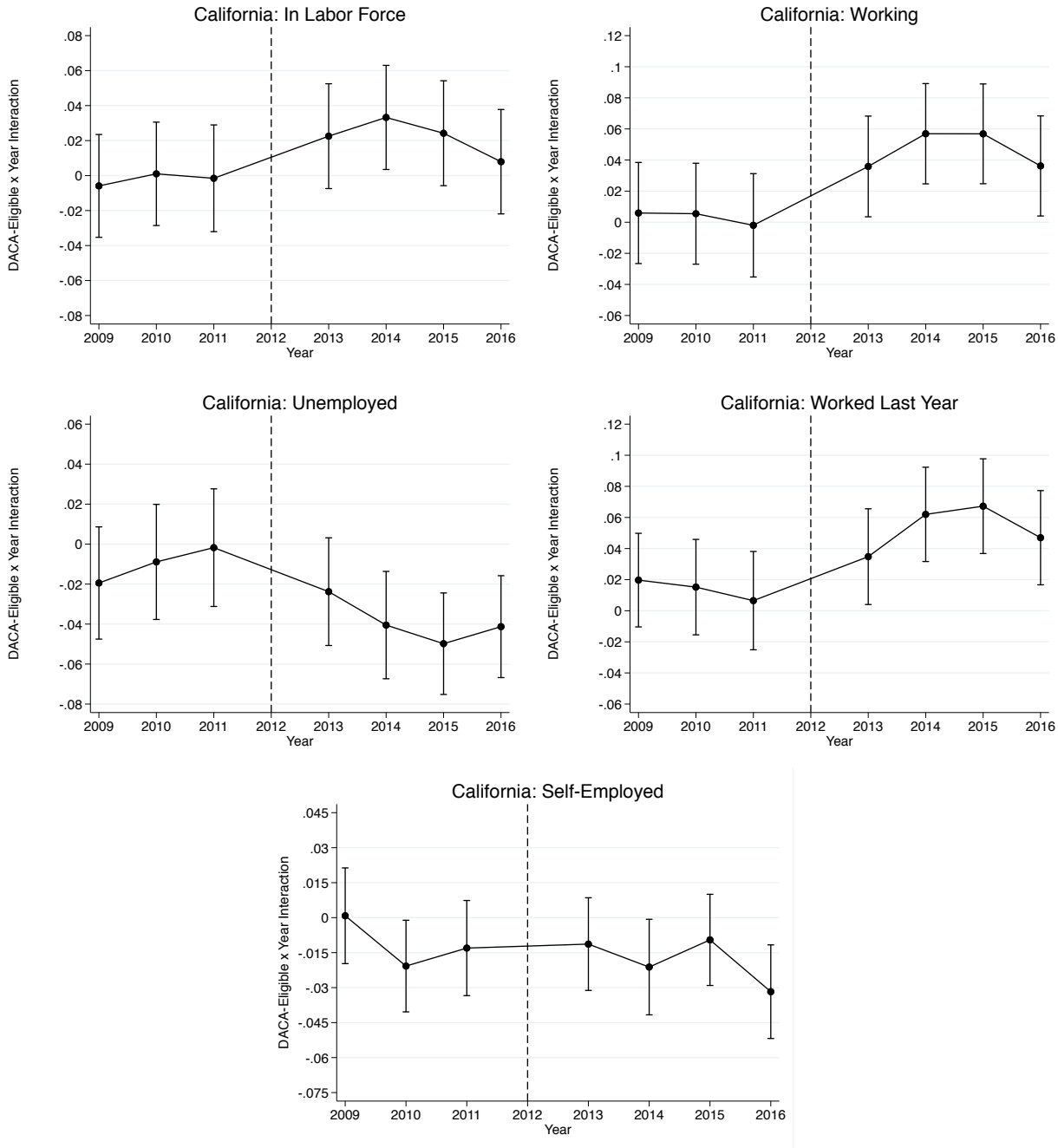
Notes - The figure plots the coefficients obtained estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graphs. Following dependent variables were used in the regressions (left-to-right, starting with the uppermost row): *In Labor Force* - binary var. equal 1 if individual currently participates in the labor force; *Working* - binary var. equal 1 if individual is currently working; *Unemployed* - binary var. equal 1 if individual is currently unemployed; *Worked Last Year* - binary var. equal 1 if individual had worked at all for profit, pay, or as an unpaid family worker during previous 12 months; *Self-Employed* - binary var. equal 1 if individual is currently self-employed. All estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2005-2016 waves of ACS. Regressions control for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), state fixed effects, year fixed effects, and state-specific time trends. Standard errors are clustered at state-year level.

Figure A.2: DACA and Labor Market Outcomes/Working Conditions (U.S.)



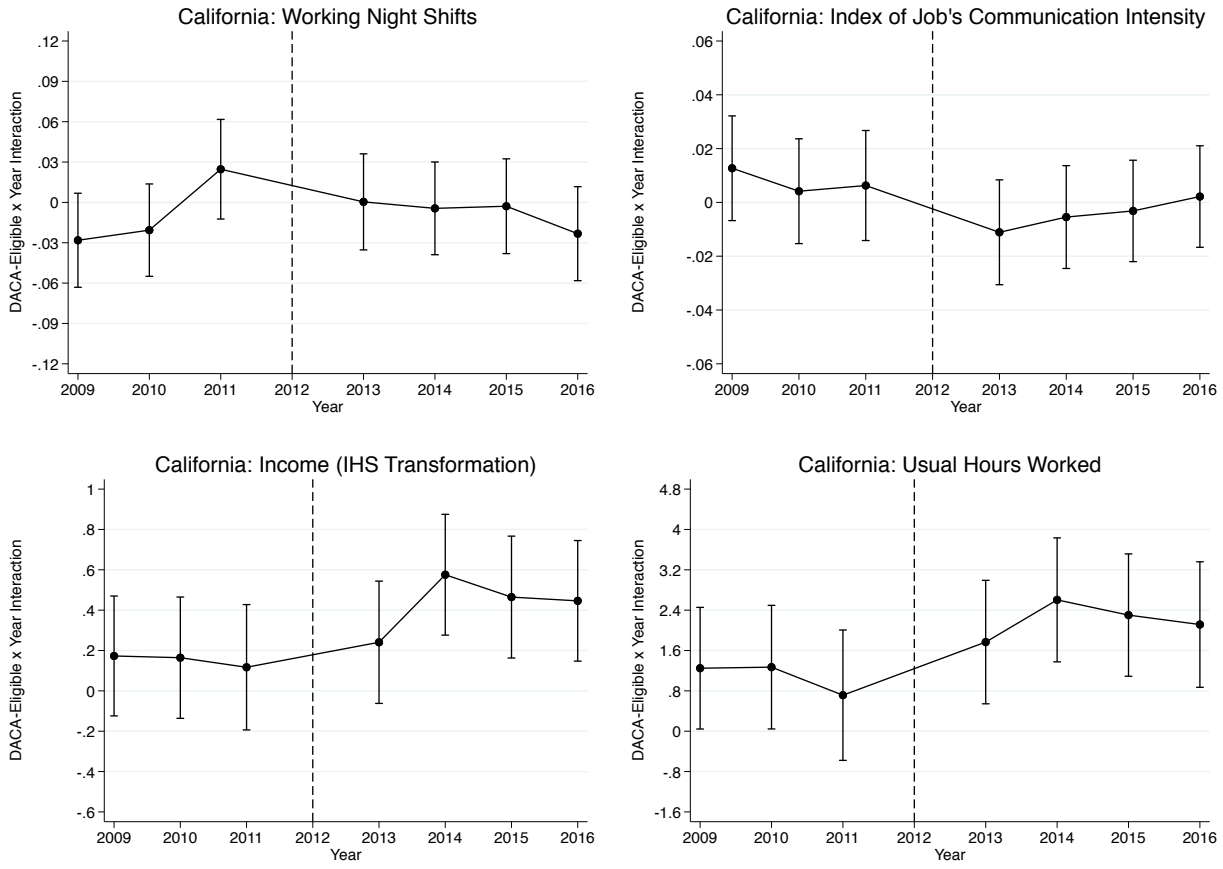
Notes - The figure plots the coefficients obtained estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graphs. Following dependent variables were used in the regressions (left-to-right, starting with the uppermost row): *Working Night Shifts* - binary var. equal 1 if individual is currently working night shifts (i.e. individual departs for work between 6pm and 6am); *Index of Job's Communication Intensity* - index of communication skill intensity of occupation (0-100; see Peri and Sparber (2009) for more details); *Income (IHS Transformation)* - inverse hyperbolic sine (IHS) transformation of individual's total pre-tax personal income (or losses) from all sources for the previous 12 months; *Usual Hours Worked* - number of hours per week respondent usually worked in past 12 months. All estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2005-2016 waves of ACS. Regressions control for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), state fixed effects, year fixed effects, and state-specific time trends. Standard errors are clustered at state-year level.

Figure A.3: DACA and Labor Market Outcomes (California)



Notes - The figure plots the coefficients obtained estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graph. Following dependent variables were used in the regressions (left-to-right, starting with the uppermost row): *In Labor Force* - binary var. equal 1 if individual currently participates in the labor force; *Working* - binary var. equal 1 if individual is currently working; *Unemployed* - binary var. equal 1 if individual is currently unemployed; *Worked Last Year* - binary var. equal 1 if individual had worked at all for profit, pay, or as an unpaid family worker during previous 12 months; *Self-Employed* - binary var. equal 1 if individual is currently self-employed. All estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2005-2016 waves of ACS. Regression controls for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), PUMA fixed effects, and year fixed. Standard errors are heteroskedasticity-robust.

Figure A.4: DACA and Labor Market Outcomes/Working Conditions (California)



Notes - The figure plots the coefficients obtained estimating Eq.(1) with the variable $Elig_{it}$ interacted with a binary variable for each year (2012 is the omitted interaction). 95% confidence limits of the interaction estimates are included in the graph. Following dependent variables were used in the regressions (left-to-right, starting with the uppermost row): *Working Night Shifts* - binary var. equal 1 if individual is currently working night shifts (i.e. individual departs for work between 6pm and 6am); *Index of Job's Communication Intensity* - index of communication skill intensity of occupation (0-100; see Peri and Sparber (2009) for more details); *Income (IHS Transformation)* - inverse hyperbolic sine (IHS) transformation of individual's total pre-tax personal income (or losses) from all sources for the previous 12 months; *Usual Hours Worked* - number of hours per week respondent usually worked in past 12 months. All estimates are derived from a sample of non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2005-2016 waves of ACS. Regression controls for DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), PUMA fixed effects, and year fixed. Standard errors are heteroskedasticity-robust.

Table A.1: The Effects of DACA on Health Insurance Coverage (Residual Method)

	(1) Any Coverage	(2) Medicaid	(3) Any Private	(4) Employer-Sponsored	(5) Indiv. Purchased
Panel A: Entire U.S.					
DACA-Eligible * Post 2012	0.0261***	0.0112*	0.0147**	0.0057	0.0080**
	(0.008)	(0.006)	(0.006)	(0.006)	(0.004)
Observations	382,069	382,069	382,069	382,069	382,069
R-squared	0.226	0.083	0.252	0.189	0.096
Mean of Dep. Var.	0.640	0.085	0.559	0.437	0.138
Std. Dev. of Dep. Var.	0.480	0.279	0.496	0.496	0.345
Panel B: California & New York					
DACA-Eligible * Post 2012	0.0422***	0.0264***	0.0134*	0.0103	0.0018
	(0.007)	(0.006)	(0.007)	(0.007)	(0.004)
Observations	125,317	125,317	125,317	125,317	125,317
R-squared	0.196	0.112	0.262	0.209	0.124
Mean of Dep. Var.	0.659	0.144	0.521	0.409	0.127
Std. Dev. of Dep. Var.	0.474	0.351	0.500	0.492	0.333
Panel C: Entire U.S. (except California and New York)					
DACA-Eligible * Post 2012	0.0195**	0.0019	0.0185***	0.0073	0.0109**
	(0.008)	(0.004)	(0.007)	(0.007)	(0.004)
Observations	256,752	256,752	256,752	256,752	256,752
R-squared	0.257	0.063	0.270	0.199	0.103
Mean of Dep. Var.	0.631	0.056	0.578	0.451	0.143
Std. Dev. of Dep. Var.	0.482	0.231	0.494	0.498	0.350

Notes - *Any Coverage* - binary var. equal 1 if individual currently with health insurance coverage; *Medicaid* - binary var. equal 1 if individual currently on Medicaid; *Any Private* - binary var. equal 1 if individual currently with private health insurance (i.e. via employer/union or purchased directly from insurer); *Employer-Sponsored* - binary var. equal 1 if individual currently with health insurance via employer or union; *Indiv. Purchased* - binary var. equal 1 if individual currently with health insurance purchased directly from insurer. Standard errors in parentheses, heteroskedasticity-robust (Panel B), and clustered at state-year level (Panels A and C). Estimates in all columns are derived from a sample of (likely) unauthorized immigrants ages 18-35 with at least a high school diploma (or equivalent). Data comes from the 2008-2016 waves of ACS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, age of entering U.S., education attainment), year fixed effects, and state-specific time trends. In addition, all columns in Panels A and C control for state fixed effects, while all columns in Panel B control for PUMA fixed effects. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table A.2: DACA and Health Care Access/Use - Individuals in Poverty (Entire U.S.: NHIS)

	(1) Usual	(2) Doctor	(3) # Visits	(4) Care 10+	(5) Hosp. Night	(6) ER	(7) Saw Special	(8) Saw Eye	(9) Saw Mental
DACA-Eligible * Post 2012	0.0868	-0.0795	-0.0390	0.0293	0.0097	-0.0427	-0.0009	-0.0219	-0.0080
	(0.058)	(0.064)	(0.221)	(0.018)	(0.019)	(0.040)	(0.022)	(0.051)	(0.019)
Observations	32,610	32,381	32,381	57,405	57,448	32,472	32,488	32,510	32,508
R-squared	0.066	0.073	0.080	0.044	0.024	0.044	0.034	0.049	0.050
Mean of Dep. Var.	0.739	0.735	2.326	0.113	0.096	0.293	0.172	0.258	0.130
Std. Dev. of Dep. Var.	0.439	0.441	2.347	0.316	0.295	0.455	0.377	0.438	0.336

Notes - *Usual* - binary var. equal 1 if individual has usual place to go to when sick or needing health advice; *Doctor* - binary var. equal 1 if individual saw/talked to any doctor in past 12 months; *# Visits* - total number of doctor's office visits in past 12 months; *Care 10+* - binary var. equal 1 if individual received medical care 10+ times in past 12 months; *Hosp. Night* - binary var. equal 1 if individual was in a hospital overnight in past 12 months; *ER* - binary var. equal 1 if individual visited emergency room in past 12 months; *Saw Special* - binary var. equal 1 if individual saw/talked to medical specialist in past 12 months; *Saw Eye* - binary var. equal 1 if individual saw/talked to eye doctor in past 12 months; *Saw Mental* - binary var. equal 1 if individual saw/talked to a mental health professional (psychiatrist, psychologist, etc.) in past 12 months. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). This sample is further restricted to contain only individuals with family's before-tax income (from preceding calendar year) below U.S. Census Bureau's official poverty threshold. Data are taken from the 2000-2016 waves of NHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), year fixed effects, region fixed effects, and region-specific time trends. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table A.3: DACA and Health Care Access/Use - Individuals in Poverty (California: CHIS)

	(1) Usual	(2) Doctor	(3) # Visits	(4) ER	(5) Saw Mental	(6) # Mental Visits
DACA-Eligible * Post 2012	0.0318	-0.1637	2.0765	-0.0827	0.0375	0.2156
	(0.131)	(0.119)	(3.207)	(0.123)	(0.082)	(1.205)
Observations	12,060	12,060	12,060	10,188	8,548	8,548
R-squared	0.086	0.083	0.045	0.066	0.089	0.037
Mean of Dep. Var.	0.743	0.746	4.772	0.255	0.194	2.537
Std. Dev. of Dep. Var.	0.437	0.435	12.74	0.436	0.396	12.08

Notes - *Usual* - binary var. equal 1 if individual has usual place to go to when sick or needing health advice; *Doctor* - binary var. equal 1 if individual saw/talked to any doctor in past 12 months; *# Visits* - total number of doctor's office visits in past 12 months; *ER* - binary var. equal 1 if individual visited emergency room in past 12 months; *Saw Mental* - binary var. equal 1 if individual saw/talked to a medical professional (psychiatrist, psychologist, etc.) for mental or alcohol/drug problems in past 12 months; *# Mental Visits* - # of visits to professional for problems with mental health or drugs/alcohol (during past 12 months). Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens and citizens ages 18-50 with at least a high school diploma (or equivalent). This sample is further restricted to contain only individuals with family's before-tax income (from preceding calendar year) below U.S. Census Bureau's official poverty threshold. Data are taken from the 2003-2015 waves of CHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment), county fixed effects, and year fixed effects. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table A.4: DACA and Health Care Access, Affordability (NHIS: all non-citizens, 18-35, with HS degree or equivalent)

	(1) Usual	(2) Any Care Delay	(3) Special. Not Afford.
DACA-Eligible * Post 2012	0.0343	-0.0173	-0.0430*
	(0.034)	(0.012)	(0.026)
Observations	13,074	31,650	4,998
R-squared	0.093	0.029	0.030
Mean of Dep. Var.	0.618	0.145	0.048
Std. Dev. of Dep. Var.	0.486	0.352	0.214

Notes - *Usual* - binary var. equal 1 if individual has usual place to go to when sick or needing health advice; *Any Care Delay* - binary var. equal 1 if any member of respondent's family delayed seeking medical care due to cost (in past 12 months). *Special. Not Afford.* - binary var. equal 1 if individual needed but couldn't afford specialist (in past 12 months). Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2000-2016 waves of NHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment, # years in U.S.), year fixed effects, region fixed effects, and region-specific time trends. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table A.5: DACA and Health Care Access (CHIS: all non-citizens, 18-35, with HS degree or equivalent)

	(1) Usual	(2) Personal MD
DACA-Eligible * Post 2012	0.0586	0.0141
	(0.053)	(0.074)
Observations	6,010	1,691
R-squared	0.111	0.234
Mean of Dep. Var.	0.695	0.380
Std. Dev. of Dep. Var.	0.460	0.485

Notes - *Usual* - binary var. equal 1 if individual has usual place to go to when sick or needing health advice; *Personal MD* - binary var. equal 1 if individual has personal doctor as main medical provider. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2003-2015 waves of CHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment, age at entering U.S.), county fixed effects, and year fixed effects. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table A.6: DACA and Health Care Use (NHIS: all non-citizens, 18-35, with HS degree or equivalent)

	(1) Doctor	(2) # Visits	(3) Care 10+	(4) Hosp. Night	(5) ER	(6) Saw Special	(7) Saw Eye	(8) Saw Mental
DACA-Eligible * Post 2012	0.0248	0.0777	-0.0043	0.0073	-0.0051	-0.0167	0.0075	0.0191*
	(0.034)	(0.117)	(0.007)	(0.008)	(0.024)	(0.017)	(0.028)	(0.010)
Observations	12,990	12,990	31,633	31,659	13,022	13,023	13,029	13,029
R-squared	0.113	0.121	0.019	0.044	0.018	0.029	0.052	0.015
Mean of Dep. Var.	0.610	1.505	0.042	0.061	0.136	0.098	0.176	0.028
Std. Dev. of Dep. Var.	0.488	1.846	0.201	0.240	0.343	0.298	0.381	0.163

Notes - *Doctor* - binary var. equal 1 if individual saw/talked to any doctor in past 12 months; *# Visits* - total number of doctor's office visits in past 12 months; *Care 10+* - binary var. equal 1 if individual received medical care 10+ times in past 12 months; *Hosp. Night* - binary var. equal 1 if individual was in a hospital overnight in past 12 months; *ER* - binary var. equal 1 if individual visited emergency room in past 12 months; *Saw Special* - binary var. equal 1 if individual saw/talked to medical specialist in past 12 months; *Saw Eye* - binary var. equal 1 if individual saw/talked to eye doctor in past 12 months; *Saw Mental* - binary var. equal 1 if individual saw/talked to a mental health professional (psychiatrist, psychologist, etc.) in past 12 months. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2000-2016 waves of NHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment, # years in U.S.), year fixed effects, region fixed effects, and region-specific time trends. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table A.7: DACA and Health Care Use (CHIS: all non-citizens, 18-35, with HS degree or equivalent)

	(1) Doctor	(2) # Visits	(3) ER	(4) Saw Mental	(5) # Mental Visits
DACA-Eligible * Post 2012	-0.0239	0.8294	-0.0337	0.0379	0.9387*
	(0.054)	(0.865)	(0.046)	(0.029)	(0.511)
Observations	6,010	6,010	4,661	3,583	3,583
R-squared	0.101	0.091	0.069	0.060	0.051
Mean of Dep. Var.	0.694	2.830	0.144	0.072	0.504
Std. Dev. of Dep. Var.	0.461	5.053	0.351	0.259	3.189

Notes - *Doctor* - binary var. equal 1 if individual saw/talked to any doctor in past 12 months; *# Visits* - total number of doctor's office visits in past 12 months; *ER* - binary var. equal 1 if individual visited emergency room in past 12 months; *Saw Mental* - binary var. equal 1 if individual saw/talked to a medical professional (psychiatrist, psychologist, etc.) for mental or alcohol/drug problems in past 12 months; *# Mental Visits* - # of visits to professional for problems with mental health or drugs/alcohol (during past 12 months). Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2003-2015 waves of CHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment, age at entering U.S.), county fixed effects, and year fixed effects. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table A.8: DACA and General Health Status, Mental Health (NHIS: all non-citizens, 18-35, with HS degree or equivalent)

	(1) Health	(2) Poor Health	(3) Good Health	(4) Depressed	(5) Hopeless	(6) Effort	(7) K6 Scale	(8) Distress	(9) Hyperten.
DACA-Eligible * Post 2012	0.0826***	-0.0001	0.0024	-0.0183	0.0031	-0.0261	-0.1321	-0.0330	0.0004
	(0.031)	(0.001)	(0.006)	(0.020)	(0.018)	(0.022)	(0.226)	(0.026)	(0.019)
Observations	31,662	31,662	31,662	12,999	12,988	12,982	12,962	12,962	13,157
R-squared	0.039	0.003	0.012	0.016	0.013	0.017	0.026	0.022	0.015
Mean of Dep. Var.	4.119	0.003	0.968	0.102	0.053	0.105	1.900	0.150	0.047
Std. Dev. of Dep. Var.	0.878	0.056	0.175	0.302	0.223	0.306	3.137	0.358	0.213

Notes - *Health* - self-reported general health status (categorical variable: 1 - poor, 2 - fair, 3 - good, 4 - very good, 5 - excellent); *Poor Health* - binary var. equal 1 if individual self-reported his/her general health status as poor (category 1); *Good Health* - binary var. equal 1 if individual self-reported his/her general health status as excellent, very good, or good (categories 5, 4, 3); *Depressed* - binary var. equal 1 if individual reported feeling sad or depressed such that "nothing could cheer them up" some/most/all of the time in past 30 days; *Hopeless* - binary var. equal 1 if individual reported feeling hopeless some/most/all of the time in past 30 days; *Effort* - binary var. equal 1 if individual reported feeling "everything was an effort" some/most/all of the time in past 30 days; *K6 Scale* - continuous measure of nonspecific psychological distress during the past 30 days using Kessler 6-Item (K6) Psychological Distress Scale (0-24; higher values represent higher levels of distress); *Distress* - binary var. equal 1 if individual experienced moderate or serious psychological distress in past 30 days (i.e. *K6 Scale* $>= 5$); *Hyperten.* - binary var. equal 1 if individual was ever told had hypertension/high blood pressure. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2000-2016 waves of NHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment, # years in U.S.), year fixed effects, region fixed effects, and region-specific time trends. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.

Table A.9: DACA and General Health Status, Mental Health (CHIS: all non-citizens, 18-35, with HS degree or equivalent)

	(1) Health	(2) Poor Health	(3) Good Health	(4) Depressed	(5) Hopeless	(6) Restless	(7) K6 Scale	(8) Distress	(9) Hyperten.
DACA-Eligible * Post 2012	0.3117*	0.0155	-0.0438	0.0301	0.0377	0.0001	0.3795	-0.1005	0.0492
	(0.173)	(0.014)	(0.042)	(0.035)	(0.039)	(0.047)	(0.413)	(0.076)	(0.034)
Observations	6,010	6,010	6,010	4,661	4,661	4,661	4,661	4,661	6,010
R-squared	0.142	0.053	0.082	0.052	0.049	0.061	0.086	0.079	0.051
Mean of Dep. Var.	3.554	0.013	0.857	0.098	0.122	0.213	3.686	0.318	0.068
Std. Dev. of Dep. Var.	1.001	0.112	0.350	0.297	0.327	0.409	3.460	0.466	0.252

Notes - *Health* - self-reported general health status (categorical variable: 1 - poor, 2 - fair, 3 - good, 4 - very good, 5 - excellent); *Poor Health* - binary var. equal 1 if individual self-reported his/her general health status as poor (category 1); *Good Health* - binary var. equal 1 if individual self-reported his/her general health status as excellent, very good, or good (categories 5, 4, 3); *Depressed* - binary var. equal 1 if individual reported feeling sad or depressed such that "nothing could cheer them up" some/most/all of the time in past 30 days; *Hopeless* - binary var. equal 1 if individual reported feeling hopeless some/most/all of the time in past 30 days; *Restless* - binary var. equal 1 if individual reported feeling restless or anxious some/most/all of the time in past 30 days; *K6 Scale* - continuous measure of nonspecific psychological distress during the past 30 days using Kessler 6-Item (K6) Psychological Distress Scale (0-24; higher values represent higher levels of distress); *Distress* - binary var. equal 1 if individual experienced moderate or serious psychological distress in past 30 days (i.e. *K6 Scale* $>= 5$); *Hyperten.* - binary var. equal 1 if individual was ever told had hypertension/high blood pressure. Robust standard errors in parentheses. Estimates in all columns are derived from a sample of all non-citizens ages 18-35 with at least a high school diploma (or equivalent). Data are taken from the 2003-2015 waves of CHIS. All regressions control for Post-DACA implementation dummy, DACA eligibility dummy, demographic characteristics (sex, race, ethnicity, marital status), DACA eligibility criteria dummies (age, education attainment, age at entering U.S.), county fixed effects, and year fixed effects. *** Significant at the 1% level. ** Significant at the 5% level. * Significant at the 10% level.