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December 18, 2025

Kristi Noem
Secretary of Homeland Security
Washington, D.C. 20528

Re: DHS Docket No. USCIS-2025-0304,
U.S. Citizenship and Immigration Services
Public Charge Ground of Inadmissibility

Dear Secretary Noem,

The National Health Law Program (NHeLP) writes in opposition to the Notice of proposed rulemaking from the Department of Homeland Security (DHS) regarding Public Charge Ground of Inadmissibility. For over 55 years, NHeLP has advocated, educated and litigated to preserve, protect and expand access to healthcare for low-income and underserved populations. We have continually worked to support immigrants' access to healthcare and thus submit these comments that strongly oppose DHS's proposed rule.

NHeLP urges DHS to withdraw the proposed rule, which would remove the current well-grounded regulations on public charge without replacing them. Most notably, this would leave huge questions where there are now clear guidelines about what programs can and cannot be considered in a public charge assessment, and that the use of benefits by family members not seeking adjustment will not be considered. This will create fear and uncertainty that will cause a "chilling effect" — the avoidance of applying for or receiving public benefits due to fear of jeopardizing their or their family member's access to legal immigration status — even beyond what has been previously seen. As the NPRM itself indicates, the proposed rule will make the nation and its communities, including U.S. citizen children, sicker and poorer.

As an organization dedicated to advocating for health care access, we cannot support a proposed rule that specifically identifies harm to individuals' health could "include:

- Worse health outcomes, such as increased prevalence of obesity and malnutrition (especially among pregnant or breastfeeding women, infants, and children), reduced prescription adherence, and increased use of emergency rooms for primary care due to delayed treatment.
- Higher prevalence of communicable diseases, including among U.S. citizens who are not vaccinated.
- Increased rates of uncompensated care, where treatments or services are not paid for by insurers or patients.
- Increased poverty, housing instability, reduced productivity, and lower educational attainment."[1]

This proposal is a threat to the nation's health and wellbeing, and to the just administration of immigration law, and DHS should abandon it.

I. Public charge is historically a narrow category

For more than a century, courts and agencies consistently interpreted the term public charge to encompass only individuals who are primarily dependent on the government to avoid destitution. The public charge law enacted in 1882 drew on older "poor laws" and was aimed to stop newly arrived immigrants from becoming entirely dependent on public support systems like poorhouses or almshouses.[2] In immigration cases, courts have recognized this consistent meaning of the term "public charge." For example, the Second Circuit held over a century ago that the term was meant "to exclude persons who were likely to become *occupants of almshouses* for want of means with which to support themselves in the future."[3] The Board of Immigration Appeals ("BIA") likewise held that the term "public charge" has an "ordinary meaning": "a money charge upon or an expense to the public for support and care, *the alien being destitute*," and recognized a critical distinction between benefits upon which an individual was primarily dependent and "supplementary benefits" provided by the government.[4]

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[1] DHS, *Notice of Proposed Rulemaking: Public Charge Ground of Inadmissibility*, 87 Fed. Reg. 55472 (Sept. 9, 2025), https://www.govinfo.gov/content/pkg/FR-2022-09-09/pdf/2022-18867.pdf (hereinafter 2025 NPRM).
[2] Torrie Hester, Hidetaka Hirota, Mary E. Mendoza, et al. "Historians' Comment on DHS Notice of Proposed Rule, Inadmissibility on Public Charge Grounds." October 2018 (Historians' Comment). https://www.ilcm.org/wp-content/uploads/2018/10/Historians-comment-FR-2018-21106.pdf.
[3] *Howe v. United States*, 247 F. 292, 294 (2d. Cir. 1917) (emphasis added).
[4] *Matter of Harutunian*, 14 I. & N. Dec. 583, 586 (BIA 1974) (emphasis added); *see also Matter of Perez*, 15 I. & N. Dec. 136, 137 (BIA 1974) (noting that past receipt of welfare benefits alone is not enough to render a noncitizen a public charge).

In 1996, Congress passed two laws, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA).[5] IIRIRA codified the public charge "totality of the circumstances" test, but neither law altered the term's longstanding meaning.

Following passage of those laws, the Immigration and Naturalization Service ("INS") endorsed the longstanding, historical interpretation of "public charge." Recognizing that IIRIRA and "recent welfare reform laws" had "sparked public confusion about the relationship between the receipt of . . . benefits and the meaning of 'public charge' under the immigration laws," INS published field guidance to clarify that relationship.[6] The guidance directed that "officers should not place any weight on the receipt of non-cash public benefits (other than institutionalization) or the receipt of cash benefits for purposes other than for income maintenance with respect to determinations of admissibility or eligibility for adjustment on public charge grounds."[7] By focusing on cash assistance for income maintenance, INS could "identify those who are primarily dependent on the government for subsistence without inhibiting access to noncash benefits that serve important public interests."[8] Following the promulgation of the 2019 rule, multiple courts affirmed that the term "public charge" has a well-established narrow meaning that does not extend to "supplemental" or other benefits not necessary for subsistence.[9]

DHS's interpretation in the NPRM extends far beyond this well-settled definition. DHS suggests that immigration officers should consider "any dependence on a means-tested public benefit . . . and not just receiving more than a designated public benefit for a specific period of time or being primarily dependent on public cash assistance for income maintenance or long-term institutionalization at government expense."[10] Elsewhere DHS goes even farther, suggesting that use of "any public resources, plays a critical role in the outcome of a public charge inadmissibility determination."[11] This approach simply cannot be squared with the statute.

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[5] Pub. L. No. 104-193, 110 Stat. 2105 (1996) (PRWORA); Pub. L. No. 104-208, 110 Stat. 3009–546 (1996).
[6] Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28,689 (May 26, 1999) ("1999 Field Guidance").
[7] *Id.*; *see also id.* at 28,692 ("It has *never* been Service policy that any receipt of services or benefits paid for in whole or in part from public funds renders an alien a public charge, or indicates that the alien is likely to become a public charge.") (emphasis added).
[8] *Id.* at 28,692.
[9] *See, e.g.*, *New York v. DHS*, 969 F.3d 42, 78 (2nd Cir. 2020); *City and Cnty. of San Francisco v. United States Citizenship and Immigration Services*, 981 F.3d 742, 759 (9th Cir. 2020); *Cook County v. Wolf*, 962 F.3d 208, 229, 246 (7th Cir. 2020).
[10] 90 Fed. Reg. 52185-86.
[11] *Id.* at 52,190.

II. The NPRM will dramatically expand the chilling effect

There is a robust body of evidence that documents that the chilling effects from public charge policy changes are significant and harmful to the health and well-being of immigrants and U.S. citizens.

Following the 2019 Public Charge rule, 15.6% of adults in all immigrant families, and 31% of adults in families that included one or more non-permanent residents, reported avoiding applying for non-cash benefits.[12] The chilling effect of the new proposed rule is likely to be even greater today because of lack of clarity of this proposed rule and the fears in immigrant communities due to the extensive threats they are experiencing. These fears reinforce each other, and research has found that experience with immigrant enforcement increases noncitizens' concerns about public charge. For example, knowing someone who has been deported, or being asked about citizenship status by law enforcement, has been found to increase concerns about accessing public benefits related to public charge.[13] A 2025 survey done by KFF and the New York Times showed that 22% of immigrants reported knowing someone who has been arrested, detained, or deported for immigration related reasons since January 2025. Additionally, 30% of respondents reported that they or someone they knew had limited participation in activities outside the home (*e.g.*, applying for public benefits, seeking medical care) due to concerns about drawing attention to their or a family member's immigration status.[14]

Evidence shows that chilling effects extend beyond those subject to the public charge rule. Thus, in addition to the harm to immigrants subject to public charge determinations, the proposed rule will cause harm to lawful permanent residents, refugees, and others who are not subject to public charge determinations.

For example, following enactment of PRWORA, children with immigrant parents disenrolled from Medicaid despite remaining eligible. Refugees withdrew from Medicaid and other public benefits at high rates despite being exempt from public charge. This led to treatment avoidance, delayed care, "underground" care use, and greater reliance on uncompensated

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[12] Hamutal Bernstein, Dulce Gonzalez, Michael Karpman, and Stephen Zuckerman, *Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019*, Urban Institute (2020), https://www.urban.org/research/publication/amid-confusion-over-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-2019.

[13] Lei Chen et al., *Immigrants' Enforcement Experiences and Concern about Accessing Public Benefits or Services*, 25 J. Immigr. & Minority Health 1077 (2023), https://doi.org/10.1007/s10903-023-01460-x.

[14] Shannon Schumacher et al., *KFF/New York Times 2025 Survey of Immigrants: Worries and Experiences Amid Increased Immigration Enforcement*, KFF (Nov. 18, 2025), https://www.kff.org/racial-equity-and-health-policy/kff-new-york-times-2025-survey-of-immigrants-worries-and-experiences-amid-increased-immigration-enforcement/.

care at safety-net providers.[15] With this Administration's interpretation of PRWORA, we will likely see effects as in 1994-1998:

- Use of food stamps fell by 60%;
- Use of Medicaid fell by 39%; and
- Use of TANF fell by 78%.[16]

This spillover effect is also experienced by Lawful Permanent Residents (LPRs), who are not subject to the public charge test after adjustment. Researchers at the Urban Institute have conducted a regular survey, the Well-Being and Basic Needs Survey (WBNS), which includes questions about whether adults in immigrant families (*i.e.*, in which the respondent or a family member living with them was not born in the U.S.) avoided participating in non-cash safety net programs because of green card concerns.[17] In 2019, the survey clearly indicated that the chilling effect influenced families: 6.7% of members of immigrant families in which all members of the family were U.S. citizens avoided non-cash benefits, and 16.7% of members in families in which all noncitizen members were permanent residents.[18]

The harm from spillover chilling effect is compounded by the proposed rule's removal of the current exemption that prevents benefit use from being considered if an individual later adjusts through another pathway (*e.g.*, a family-based pathway). Under the 2022 public charge rule, benefits used by refugees would never be counted. Under the proposed rule, DHS seems to suggest that a person who enters the U.S. as a refugee but later marries a U.S. citizen and seeks adjustment through the family pathway could have the use of those benefits considered against them. As a result, individuals are likely to forgo needed benefits to preserve future immigration options, as they cannot reliably predict which adjustment pathway they may ultimately pursue.

A. *The Harm to U.S. citizens outweighs the need for the NPRM*

Chilling effects are well-documented among U.S. citizen children in mixed-status households. Nineteen million, or one in four children, are U.S. citizens with a non-citizen parent.[19] The proposed rule will, therefore, result in significant reductions in citizens' access

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[15] Leighton Ku & Alyse Freilich, KFF, *Caring for Immigrants: Health Care Safety Nets in Lose Angeles, New York, Miami, and Houston 7 at 13-15 (2001),* https://aspe.hhs.gov/system/files/pdf/72701/report.pdf.

[16] Michael E. Fix and Jeffrey S. Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994–1997*, Urban Institute (1999),http://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform.

[17] Michael Karpman, Stephen Zuckerman & Dulce Gonzalez, *The Well-Being and Basic Needs Survey: A New Data Source for Monitoring the Health and Well-Being of Individuals and Families* (Aug. 28, 2018), https://www.urban.org/research/publication/well-being-and-basic-needs-survey.

[18] Hamutal Bernstein, Dulce Gonzalez, Michael Karpman, and Stephen Zuckerman, *supra* note 12.

[19] Drishti Pillai et al., KFF, *Children of Immigrants: Key Facts on Health Coverage and Care* (2025), https://www.kff.org/racial-equity-and-health-policy/children-of-immigrants-key-facts-on-health-coverage-and-care/.

to essential health care. For example, from 2016 to 2019, participation in programs such as Medicaid, CHIP, and the Supplemental Nutrition Assistance Program among citizen children with noncitizen household members declined at twice the rate of children in all U.S. citizen households, due to fear and uncertainty stemming from immigration policy changes.

Comprehensive reviews of PRWORA's immigrant eligibility restrictions likewise demonstrate that people who were not directly affected by eligibility changes still withdrew from public benefit programs.[20] Even lawfully present immigrants and all-citizen families often avoid accessing benefits for which they are eligible because of fears about immigration consequences or confusion around complex eligibility requirements.[21] Children with an immigrant mother were disenrolled from Medicaid, despite these children being unaffected by eligibility changes and remaining eligible for Medicaid coverage.[22] This effect was particularly pronounced for non-citizen children of lawfully present immigrants.[23]

Other studies identify significant reductions in insurance rates among citizen children of immigrants without LPR status compared to those with status.[24] In 2023, 11.7% of adults in immigrant families reported avoiding non-cash safety net programs due to green card concerns. Among immigrant families with children, that figure rose to 15.7%, double the rate of childless immigrant households.[25] If the proposed rule leads to disenrollment rates ranging from 10%-30%, nearly 600,000 to 1.8 million citizen children will be disenrolled from Medicaid or CHIP.[26]

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[20] Samantha Artiga and Drishti Pillai, *Expected Immigration Policies Under a Second Trump Administration and Their Health and Economic Implications*, KFF (November 21, 2024), https://www.kff.org/racial-equity-and-health-policy/issue-brief/expected-immigration-policies-under-a-second-trump-administration-and-their-health-and-economic-implications/. See also Randy Capps et al., *Anticipated "Chilling Effects" of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families,* Migration Policy Institute (Dec. 2020), https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real.

[21] Jeanne Batolova, Michael Fix and Mark Greenberg, *Chilling Effects: The Expected Public Charge Rule and Its Impact On Legal Immigrant Families' Public Benefits Use, Migration Policy Institute* (June 2018), https://www.migrationpolicy.org/sites/default/files/publications/ProposedPublicChargeRule-Final-Web.pdf.

[22] Neeraj Kaushal & Robert Kaestner, *Welfare Reform and health insurance of Immigrants*, 40 HEALTH SERVS. RES. 717 (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/pdf/hesr_00381.pdf.

[23] Ithai Zvi Lurie, *Welfare reform and the decline in the health-insurance coverage of children of non-permanent residents*, 27 J. HEALTH ECON. 786 (2008).

[24] https://www.sciencedirect.com/science/article/pii/S0167629607000999.

[25] Artiga, Samantha, Drishti Pillai, Sammy Cervantes, Akash Pillai & Matthew Rae, *Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment*, KFF (Dec. 2, 2025, updated Dec. 5, 2025) https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/).

[26] *Id*.

B. *Brightline rules are necessary to combat chilling effect*

Uncertainty about the scope of the public charge rule exacerbates chilling effects, deterring immigrants from accessing benefits for which they or their families are eligible. Prior experience shows that unclear rules create confusion for both the public and service providers, leading families to avoid programs even when they are eligible. [27] Interviews with immigrant families reveal reliance on media, or social networks for information, with few seeking professional advice, and many concluding that nonparticipation is safest.[28]

The 2022 public charge rule minimized some of the chilling effect by providing clear guidance: benefits received by family members would not count against an applicant, an only the receipt of, not the application, of public cash assistance (*e.g.*, TANF, and SSI) or long-term institutionalization would be considered. These bright-line standards supported access to essential programs while preserving the integrity of public charge determinations.[29]

C. *The rule as proposed will maximize chilling effect, especially among U.S. citizens*

The rejection of any clear specification of which public benefits could—and could not—be considered in a public charge assessment, including the assertion that the 2019 rule "straitjackets" officers, signals that DHS intends to disregard more than 140 years of precedent and invite consideration of any public benefit, used at any time, for any duration, by individuals with low incomes. In litigation challenging the 2019 final rule,[30] courts explicitly rejected such an approach. In *N.Y. v. DHS*, for example, the court noted that Congress did

> not anticipate abstention from all benefits use . . . . Had Congress thought that any benefits use was incompatible with self-sufficiency, it could have said so . . . . But it did not. We are thus left with an agency justification that is unmoored from the nuanced views of Congress.[31]

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[27] Greenberg, Feierstine & Voltolini, *One in Seven Adults in Immigrant Families Reported Avoiding Public Benefits Due to Chilling Effect*, Urban Inst., https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_8.pdf.

[28] Dulce Gonzalez & Hamutal Bernstein, *How Uncertainty Surrounding the Public Charge Rule Leads to Hardship for Immigrant Families*, Urban Inst., https://www.urban.org/urban-wire/how-uncertainty-surrounding-public-charge-rule-leads-hardship-immigrant-families.

[29] Public Charge Rule Ground of Inadmissibility, 87 Fed. Reg. 55472 (September 9, 2022) *(final rule)*.

[30] DHS, *Final Rule: Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. 41292 (Aug. 14, 2019), https://www.govinfo.gov/content/pkg/FR-2019-08-14/pdf/2019-17142.pdf (hereinafter 2019 Final Rule).

[31] New York v. United States Dep't of Homeland Sec., 969 F.3d 42, 82 (2d Cir. 2020).

By refusing to guide what benefits will and will not be considered, the Administration is consciously creating uncertainty that will predictably discourage immigrants and their U.S. citizen family members from accessing benefits for which they are lawfully eligible.

Throughout the NPRM, DHS employs multiple undefined terms: "means-tested public benefit," "public benefits," "public benefit programs," and "public resources" to describe the programs subject to consideration in a public charge assessment. This inconsistency exacerbates confusion and fuels the chilling effect. The regulatory language regarding bonds, the proposed revisions to Form I-485, and the paragraphs addressing the implications of removing 8 C.F.R. § 212.22 use the term "means-tested public benefit."[32] Elsewhere, the rule uses "public benefits" 165 times, "public benefit programs" 12 times, and "public resources" 13 times. In fact, the proposed rule states: "DHS proposes to eliminate these definitions that limit the benefits that are considered as part of the public charge inadmissibility determination."[33] In another, the NPRM suggests that "the receipt of any type of public benefits by a qualified alien is relevant and indeed critical to determine whether an alien is actually self-sufficient."[34] The logical result is profound uncertainty about DHS's actual intentions.

Given this uncertainty, immigration officials could deem a vast range of programs to be "public benefits" or "public resources," including programs not limited to people with low incomes. It is not plausible that DHS intends all such programs to count. However, the proposed rule provides no indication of which programs would be excluded and, in fact, expressly rejects the concept of doing so. By contrast, the 2019 final rule stated that its definition does not include benefits related exclusively to emergency response, immunization, education, or social services.[35] And

> DHS will not consider for purposes of public charge inadmissibility determination whether applicants for admission or adjustment of status are receiving food assistance through other programs, such as exclusively state-funded programs, food banks, and emergency services, nor will DHS discourage individuals from seeking such assistance.[36]

The NPRM's refusal to articulate comparable limits ensures that states, local governments, and enrollment assisters cannot offer definitive reassurance to immigrant families, including mixed-status families with U.S. citizen children, that programs are safe to use. The chilling effect is therefore both predictable and extensive.

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[32] Proposed Rule 90 Fed. Reg. 52168.
[33] *Id.*
[34] *Id.*
[35] Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41292 at 522 (August 14, 2019) (final rule).
[36] *Id.* at 527.

Even if it were clear that only "means-tested public benefit" programs would be considered, it would still be unclear exactly which programs DHS would consider. It might be plausible to guess that DHS is thinking of the programs covered as "Federal means-tested public benefits" under PRWORA, but DHS does not say so explicitly. Without clear guardrails, immigration officials would be free to devise their own definitions of "means-tested," raising concerns that numerous programs could be counted.

Moreover, even a clear definition would not resolve DHS's departure from the long-standing "primarily dependent" standard and its historical focus on cash assistance for subsistence and institutionalization for long-term care. These limitations reflected recognition that other benefits, including means-tested benefits, are supplemental.[37] For example, in many states, children in families whose incomes are above three times the federal poverty level qualify for Medicaid and CHIP, a recognition that these programs support children in working families.[38] As one judge observed in one of the 2019 lawsuits challenging the public charge final rule noted, expanding the inquiry to include such benefits reflects an "absolutist sense of self-sufficiency that no person in a modern society could satisfy."[39]

The uncertainty in the NPRM will result in a significant chilling effect by discouraging the use of lawful, supplemental programs intended to promote health, economic stability, and social well-being.

The proposal rescinds the 2022 policy without replacement language and instead promises future "policy and interpretive tools," creating opportunities for arbitrary and discriminatory decisions. Failure to define "means-tested public benefits" maximizes confusion for immigrants and those advising them. Excessive discretion remains with individual immigration officers, who cannot reasonably be expected to understand the details of hundreds or thousands of benefit programs.

As a result, people are left to guess what might count as a public benefit, leading to a wide range of benefits being avoided or immigration officers including consideration of programs that do not provide subsistence.

Moreover, DHS's vague assertion that it intends to gather data from benefits-granting agency will heighten avoidance behavior. It is unclear what benefits-granting agencies DHS plans to seek data from or whether DHS will request and receive information about the household members of U.S. citizen children who have applied for or enrolled in various

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[37] Department of Justice, *Field Guidance on Deportability and Inadmissibility o nPublic Charge Grounds*, 64 Fed. Reg. 28689 (Mar. 26, 1999), https://www.govinfo.gov/content/pkg/FR-1999-05-26/pdf/99-13202.pdf.

[38] KFF, *Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level*, January 2025, https://www.kff.org/affordable-care-act/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Upper%20Income%20Limit%22,%22sort%22:%22desc%22%7D.

[39] Cook Cnty., Illinois v. Wolf, 962 F.3d 208, 232 (7th Cir. 2020).

programs. That vagueness is likely to cause many immigrants to forgo services for their citizen children. As described above, studies have found that after proposed changes to the public charge rule, the share of children receiving public benefits, including Medicaid, fell twice as fast for U.S. citizen children in households with noncitizens as for those in households with citizens, and that the enactment of a state law empowering police to detain individuals who could not prove U.S. citizenship was associated with decreased use of routine health care.[40]

Service providers report that many immigrants back out midway through benefits enrollment if asked for additional documentation due to fears of exposure in public-charge determinations. One school administrator recounted a parent who, worried about public charge, chose not to provide her child's Social Security Number on a FAFSA application.[41] Even when accurate information about public charge criteria is available, immigrants often decide not to apply for or access benefits because policies could change. This reticence affects public health: children at state-run tuberculosis clinics, for instance, have declined to share information about household members, increasing the risk of community spread and driving immigrant communities further off-grid.[42]

Following years of anti-immigrant rhetoric and policy, fear and uncertainty about accessing safety-net programs have intensified.[43] In families with naturalized citizens, 9.5% of adults, and in families with green card holders, 16.2% of adults, reported avoiding noncash government benefits or other assistance in the past year because of immigration concerns.[44]

The proposed rule provides no clarity on dependent use of benefits, implicitly suggesting that benefits used by family members could be counted in public charge determinations. This lack of guidance will dramatically exacerbate the chilling effect on U.S. citizen children. The proposed rule removes the definition of "receipt of public benefits," which currently states that applying for or receiving benefits on behalf of family members does not count as

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[40] Russell B. Toomey et al., Impact of Arizona's SB 1070 Immigration Law on Utilization of Health Care and Public Assistance Among Mexican-Origin Adolescent Mothers and Their Mother Figures, 104 Am. J. Pub. Health S28(2014), https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2013.301655. Randy Capps et al., *The Public Charge Rule and Its Chilling Effect on Immigrant Families*, Migration Policy Institute , (Dec. 2020).

[41] Jonathan Beier & Essey Workie, *The Public-Charge Final Rule Is Far from the Last Word*, Migration Policy Institute (Sept. 2022), https://www.migrationpolicy.org/news/public-charge-final-rule-far-last-word.

[42] *Id*.

[43] Jennifer M. Haley, Genevieve M. Kenney, Hamutal Bernstein, and Dulce Gonzalez, *Many Immigrant Families with Children Continued to Avoid Public Benefits in 202, Despite Facing Hardships* (May 2021), https://www.urban.org/sites/default/files/publication/104279/many-immigrant-families-with-children-continued-avoiding-benefits-despite-hardships_0.pdf.

[44] Randy Capps et al., *supra* note 40.

"receipt." The preamble does not clarify whether family member benefit usage will be considered.[45]

According to KFF analysis of ACS data, approximately 13.4 million Medicaid or CHIP enrollees live in households with at least one noncitizen, including 5.9 million U.S. citizen children, who may be at risk for decreased enrollment. Beyond potential disenrollment, the proposed rule may also deter new enrollment among nearly 1.8 million uninsured individuals who are eligible for Medicaid or CHIP but not enrolled and who live in households with a noncitizen, including over 500,000 children. Similar patterns of chilling and disenrollment are likely across other health care programs.[46]

One in four children aged 18 and under in the U.S. has an immigrant parent, and the vast majority of these children are U.S. citizens. High uninsured rates among citizen children with a noncitizen parent, as well as among noncitizen children, reflect enrollment barriers such as fear, confusion, language access challenges, and eligibility restrictions for federally funded health coverage, including Medicaid and CHIP. These effects mirror those documented under the public charge rule: families often forgo benefits for citizen children due to uncertainty or fear that participation could jeopardize immigration status.[47] The rule, if enacted, will dramatically exacerbate these harms.

D. *Discretion of officers creates uncertainty and inconsistency*

The broad discretion afforded to immigration officers under the proposed rule risks widely divergent outcomes for similar cases. Moving away from a bright-line primary dependence standard increases officer discretion and the potential for arbitrary or discriminatory decisions.

Moreover, leaving public charge decisions to the sole discretion of immigration officers without clear regulatory guidance could lead to biased and discriminatory decisions. For instance, racial bias has been documented in other federal programs that rely on individual adjudicator discretion.[48]

E. *Vaguely referencing data sharing exacerbates chilling effect*

[45] 8 C.F.R. Parts 103 and 212.
[46] Artiga et al., *supra* note 25.
[47] KFF, *Children of Immigrants: Key Facts on Health Coverage and Care* (Jan. 15, 2025, updated Apr. 10, 2025), https://www.kff.org/racial-equity-and-health-policy/children-of-immigrants-key-facts-on-health-coverage-and-care/.
[48] Sanford F. Schram et al., Deciding to Discipline: Race, Choice, and Punishment in the Frontlines of Welfare Reform, 74 Am. Sociological Rev. 398, 414-15 (June 2009) (finding caseworkers are more likely to sanction African American TANF participants for noncompliance with program requirements than white participants). https://journals.sagepub.com/doi/10.1177/000312240907400304.

DHS's proposed data-sharing practices under the proposed rule further amplify fear and confusion among immigrant families, deterring use of health coverage and public benefits.[49] The rule indicates that DHS anticipates integrating immigration records with federal benefit-granting agencies and using these data to develop tools to guide public charge determinations.[50]

DHS has already obtained data from the IRS,[51] SSA,[52] and state SNAP[53] and Medicaid agencies[54] without required privacy safeguards and with documented accuracy issues. Using flawed or incomplete data in public-charge determinations, with no meaningful appeal opportunities, creates a substantial risk of erroneous outcomes for immigrants and their families. Frequent regulatory changes contribute to confusion, undermine trust, and promote avoidance behavior. The proposed rule notes that DHS intends to issue sub-regulatory guidance following a final rule, suggesting that guidance may be dynamic or responsive over time. Immigrants and service providers cannot reliably anticipate what benefit use will count, leaving families to make high-stakes decisions with limited information.

Survey data from 2022 underscores these effects. According to the Urban Institute, a quarter of mixed-status families avoided applying for noncash benefits due to concerns about green card applications, even when those benefits were irrelevant under the 2022 rule.[55] Constant shifts in rules make it difficult or impossible for immigrants to understand what affects green card or other immigration outcomes, deterring eligible individuals from accessing critical programs and services without improving their long-term immigration status.

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[49] Amicus Brief of the National Health Law Program and Partners, California v. U.S. Dep't of Health & Human Servs., No. 3:25-cv-05536-VC (N.D. Cal. Dec. 3, 2025), available at https://healthlaw.org/resource/amicus-california-v-u-s-department-of-health-and-human-services-u-s-district-court-northern-district-of-california/.

[50] Proposed Rule § 90 Fed. Reg. 52168.

[51] CENTER FOR TAXPAYER RIGHTS v. INTERNAL REVENUE SERVICE, 1:25-cv-00457, (D.D.C.), https://www.courtlistener.com/docket/69646607/center-for-taxpayer-rights-v-internal-revenue-service/.

[52] Social Security Administration, Privacy Act of 1974, System of Records, 90 Fed. Reg. 50879, November 11, 2025. https://www.federalregister.gov/documents/2025/11/12/2025-19849/privacy-act-of-1974-system-of-records.

[53] State of California v. United States Department of Agriculture, 3:25-cv-06310, (N.D. Cal.). https://www.courtlistener.com/docket/70945300/state-of-california-v-united-states-department-of-agriculture/.

[54] State of California v. U.S. Department of Health and Human Services 3:25-cv-05536 (N.D. Cal.). https://clearinghouse.net/case/46754/.

[55] Dulce Gonzalez & Hamutal Bernstein, *One in Four Adults in Mixed-Status Families Did Not Participate in Safety Net Programs in 2022 Because of Green Card Concerns*, Urban Inst. (Aug. 17, 2023),https://www.urban.org/sites/default/files/2023-08/One%20in%20Four%20Adults%20in%20Mixed-Status%20Families%20Did%20Not%20Participate%20in%20Safety%20Net%20Programs%20in%202022%20Because%20of%20Green%20Card%20Concerns.pdf.

III. The NPRM should not be retroactive

The proposed rule does not specify whether public charge determinations will consider the use of past benefits. DHS stated in both the 2018 notice of proposed rulemaking and the 2019 final rule that public charge determinations would be forward-looking. Omitting a clear statement in this proposal suggests the rule could apply retroactively which raises serious reliance and fairness concerns. Research shows that many individuals rely on updated public charge guidance and adjust their behavior in accordance with new rules.[56]

A. *Individuals reasonably relied on past public charge rules and enrolled in certain programs accordingly*

Many immigrants reasonably relied on previous iterations of the public charge rule, like those promulgated in 2019 and 2022. Yet DHS may consider the use of certain benefits under this proposed rule that were not considered under previous rules — for example, the 2019 rule did not consider the use of state or local benefits, and the 2022 rule did not consider benefit use by family members. Many immigrants relied on DHS's guidance, believing compliance with the rules would not negatively affect their adjustment of status in the future.

A 2021 survey of mixed-status immigrant households found that half of the respondents were likely to apply for public assistance after they were informed about the 2022 public charge rule.[57] DHS itself acknowledged that its previous public charge guidance, specifically the 2022 rule, "engendered reliance interests."[58] This proposed rule, however, did not quantify the vast numbers of people who have relied on all its previous public charge guidance. In doing so, DHS failed to adequately account for the significant reliance interests at stake.

Reliance on DHS guidance and use of past benefits cannot be undone. And the number of immigrants who relied on previous guidance is substantial. Roughly 2.5 million non-citizen immigrants meet Medicaid and CHIP income and immigration eligibility criteria.[59] This figure

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[56] *See* Amer. Immigr. Council, *The Ghost of Public Charge Keeps Scaring Immigrant Families Away From Public Benefits* (2023), https://www.americanimmigrationcouncil.org/blog/public-charge-keeps-scaring-immigrant-families-away-from-public-benefits/#:~:text=In%20the%20first%20wave%20of,the%20chilling%20effect%20is%20concerning (finding that a persistent chilling effect exists, but some households did increase benefit use after the 2022 rule took effect).

[57] Protecting Immigrant Families, *Immigrant Mixed Status Families Toplines Summary* (2025), https://pifcoalition.org/resources/library/immigrant-mixed-status-families-toplines-summary/.

[58] 2025 NPRM at p. 52193.

[59] Samantha Artiga et al., KFF, *5 Key Facts About Immigrants and Medicaid* (2025), https://www.kff.org/racial-equity-and-health-policy/5-key-facts-about-immigrants-and-medicaid/#:~:text=23%25)%20and%20eligible%20noncitizen,of%20Medicaid%20and%20CHIP%20

includes millions of lawfully present children and pregnant persons who are entitled to Medicaid under the Children's Health Insurance Program Reauthorization Act (CHIPRA) and may be subject to the public charge test.[60] More broadly, around 13.5 million Medicaid enrollees live in a household with at least one non-citizen member.[61]

Reliance interests extend beyond Medicaid and CHIP. Around 1.5 million individuals relied on some form of state-only funded coverage.[62] Around half a million non-citizen, non-LPR immigrants, like refugees and DACA recipients, were eligible for Marketplace coverage and premium tax credits in 2024 and 2025.[63] Additionally, hundreds of thousands of lawfully present immigrants impacted by the public charge rule made use of public services through FQHCs, Title X, Title XX, or a variety of other options.[64]

Lastly, state and local governments also relied on DHS's previous public charge guidance. For example, California health agencies estimated that, throughout 2018 and 2019, around $2.5 million was spent on communication, outreach, and public education efforts.[65] Addressing the 2019 rule, California agencies explained that:

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enrollees; Valerie Lacarte et al., Migration Policy Inst., *Medicaid Access and Participation: A Data Profile of Eligible and Ineligible Immigrant Adults* (2021).

[60] *See generally* Georgetown Univ. Health Policy Inst., *Summary of The Children's Health Insurance Program Reauthorization Act of 2007*, (2007), https://ccf.georgetown.edu/wp-content/uploads/2012/03/Federal%20schip%20policy_summary%20of%20the%20chipra.pdf (estimating that prior to its enactment, CHIPRA would expand coverage to millions of uninsured children).

[61] Samantha Artiga et al., KFF, *Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment* (2025), https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/#:~:text=In%202021%2C%20the%20Biden%20administration,the%20proposed%20rule%20is%20finalized.

[62] CBO, *Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act*, Pub. 61463, p. 7 (2025). *See also* Valarie Lacarte et al., Migration Policy Inst., *Medicaid Access and Participation: A Data Profile of Eligible and Ineligible Immigrant Adults* (2021), https://www.migrationpolicy.org/research/medicaid-immigrant-adults.

[63] *See* Drishti Pillai et al., KFF, *1.4 Million Lawfully Present Immigrants are Expected to Lose Health Coverage due to the 2025 Tax and Budget Law* (2025), https://www.kff.org/immigrant-health/1-4-million-lawfully-present-immigrants-are-expected-to-lose-health-coverage-due-to-the-2025-tax-and-budget-law/#:~:text=The%20CBO%20estimates%20that%20this,$176%20million%20as%20of%202034; KFF, *Key Facts on Health Coverage of Immigrants* (2025), https://www.kff.org/racial-equity-and-health-policy/key-facts-on-health-coverage-of-immigrants/.

[64] *See* HHS, OPA Bulletin, *2024 Title X Family Planning Annual Report: Title X Providers Continue to Rebuild and Grow* (2024). *See also* HHS, *SSBG Fact Sheet* (2024), https://acf.gov/ocs/fact-sheet/ssbg-fact-sheet; Nat'l Immigr. Forum, *Fact Sheet: Immigrants and Public Benefits* (2018), https://forumtogether.org/wp-content/uploads/2018/08/Immigrants-and-Public-Benefits-FINALupdated.pdf.

[65] Cal. Health and Human Serv., *Advance Notice of Proposed Rulemaking: "Public Charge Ground of Inadmissibility"* (2021), https:\www.chhs.ca.gov\wp-content\uploads\2021\10\CalHHS-Public-Charge-Comment-Letter-October-2021.pdf.

> [R]equiring consideration of past receipt of public benefits significantly increase administrative workload, state costs, and county costs while also creating an insurmountable public messaging issue.[66]

In 2020 and 2021, Illinois health agencies devoted $2.1 million toward "community education and individual and family counseling on the 2019 public charge rule."[67] Other state agencies have also commented on the financial burdens of relying on and explaining constantly changing public charge rules.[68]

B. *It is fundamentally unfair to punish individuals for relying on government rules to adjust their behavior*

It is fundamentally unfair to punish the vast number of individuals who relied on DHS's guidance.[69] The millions of immigrants who relied on DHS's guidance cannot undo their past benefit use. Their ability to trust and rely on federal rules is critical in an ever-changing political landscape. A forward-facing public charge rule is more likely to advance that goal. A retroactive rule — one that treats previously compliant behavior as non-compliant — erodes public trust and undermines the administration's credibility.

As noted, millions of immigrants relied on the government's guidance and cannot reverse their conduct. Their previously compliant behavior is at risk of being punished by this administration.

It is extremely concerning that DHS failed to include a clear statement in its proposed rule that any changes to public charge policy would only be forward-looking. A retroactive rule sets unfair and contradictory precedent where DHS punishes individuals' benefits use during a time when its own policy stated that use of such benefits would not have adverse immigration consequences. A forward-looking rule would avoid these pitfalls and at least it would not worsen an already confounding area of public policy.

IV. Health care utilization should not count toward public charge.

All people use health care and basic health care is neither intended nor sufficient to provide sustenance. Health care use is not an indicator of self-sufficiency (or lack thereof) and DHS's characterization of health care use as a negative factor is inconsistent with several

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[66] *Id.*
[67] Ill. Dep't of Human Serv., *Comment on ANPRM, ID: USCIS-2021-0013-0195* (2021).
[68] *See, e.g.*, City of New York, *Comment on ANPRM, ID: USCIS-2021-0013-0153* (2021); Dep't of Vt. Health Access, *Comment on ANPRM, ID: USCIS-2021-0013-0121* (2021).
[69] *See generally* U.S. Const. art. I, § 9, cl. 3 (*ex post facto* principles and are broadly relevant for administrative rule making).

states' beliefs and policy choices.[70] Moreover, empirical evidence shows complicated links between health care use and income (which DHS often uses as a proxy for self-sufficiency) and, if anything, higher income earners visit providers more often and engage in preventative more frequently than individuals with lower incomes.[71] DHS's expansive policies are untenable. Even the more narrow 2019 rule, if applied to U.S. citizens, would have found the majority of them at risk of becoming a public charge.[72] Adding more unreliable factors to the analysis makes the test even less functional. Thus, DHS should not consider health care utilization in its public charge determinations.

Even if self-sufficiency was the standard for public charge determinations, ample evidence shows that many individuals who use health care regularly or have serious conditions are self-sufficient.[73] Health care utilization is complex and determined by the need for care, quality of care, and access to care among a myriad of other factors.[74] This includes intensive care where utilization is more closely associated with availability than other factors such as self-sufficiency or lack thereof.[75] It is simply not possible to draw conclusions about self-sufficiency based on an individual's health care utilization.

These findings are more apparent when applied to U.S. citizens. Nearly every U.S. citizen has used some form of public health care in their lifetime. Tens of millions of U.S. citizens received health coverage through the Marketplace in recent years, and the vast majority received federal premium subsidies.[76] Hundreds of millions of U.S. citizens received

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[70] *See, e.g.*, Mark Barna, *State lawmakers leading new charge for single-payer care.* 53 THE NATION'S HEALTH 4, (2023); Maine AllCare, *Rep. Ro Khanna and Sen. Ed Markey reintroduce the State-Based Universal Health Care Act* (2025), https://maineallcare.org/rep-ro-khanna-and-sen-ed-markey-reintroduce-the-state-based-universal-health-care-act/; Off. of the Governor of the State of N.M., *New Mexico is first state in nation to offer universal child care* (2025), https://www.governor.state.nm.us/2025/09/08/new-mexico-is-first-state-in-nation-to-offer-universal-child-care/; Washington State Health Care Authority, *Universal Health Care Commission*, https://www.hca.wa.gov/about-hca/who-we-are/universal-health-care-commission (last visited Dec. 15, 2025).

[71] Serdar Ozkan, *Income differences and health disparities: Roles of preventive vs. curative medicine*, 150 J. OF MONETARY ECON. 103698 (2025); Steven Wolf et al., Ctr. On Budget and Policy Priorities, *How Are Income and Health Linked to Longevity* (2015), https://www.cbpp.org/sites/default/files/atoms/files/5-30-19pov.pdf.

[72] Danilo Trisi, Ctr. on Budget and Policy Priorities, *Trump Administration's Overbroad Public Charge Definition Could Deny Those Without Substantial Means a Chance to Come to or Stay in the U.S.* (2019), https://www.cbpp.org/sites/default/files/atoms/files/5-30-19pov.pdf.

[73] *See* National Academies of Sciences, Engineering, and Medicine, *Health-Care Utilization as a Proxy in Disability Determination* (2018), https://pubmed.ncbi.nlm.nih.gov/29782136/.

[74] *Id.*

[75] *See* Genevieve Kanter et al., *Income Disparities In Access To Critical Care Services*, 39 HEALTH AFFAIRS 8 (2000).

[76] Am. Hospital Assoc., *Fact Sheet: One Big Beautiful Bill Act Would Significantly Reduce Availability of Coverage in the Health Insurance Marketplaces* (2025), https://www.aha.org/system/files/media/file/2025/06/Fact-Sheet-One-Big-Beautiful-Bill-Act-Would-Significantly-Reduce-Availability-of-Coverage.pdf.

federally funded vaccinations for COVID-19 since 2021.[77] In sum, an individuals' use of a public health services is so broad, and bears no correlation to self-sufficiency, that it should not be used as a criteria in public charge determinations.

V. Medicaid should not count toward public charge

A. Medicaid use is not indicative of a lack of self-sufficiency

While we disagree that self-sufficiency is the appropriate legal standard for the public charge determination, even under DHS's interpretation, there is no basis to include receipt of Medicaid. Receipt of Medicaid is not evidence of a lack of self-sufficiency.

In *New York v. U.S. Department of Homeland Security* (2020), the Second Circuit expressly rejected DHS's assertion that Medicaid use was evidence of a lack of self-sufficiency and characterized the claim as "dubious."[78] The court recognized that access to health insurance in the United States is largely shaped by structural labor market conditions rather than individual choice or effort.[79]

Indeed, access to private health insurance is primarily determined by employment-based factors beyond an individual's control — namely, whether an employer offers coverage.[80] Many Medicaid enrollees work for businesses that are not required to provide health insurance.[81] Medicaid, therefore, serves as an essential coverage bridge for individuals who are already working but cannot access employer-sponsored insurance.

Rather than demonstrating a lack of self-sufficiency, extensive data show that most adult Medicaid enrollees are part of the workforce. Studies consistently find that approximately 60% of Medicaid beneficiaries who are not children, older adults, or people with disabilities, are employed.[82] According to KFF's 2025 update on Medicaid and work, in 2023 most adult Medicaid enrollees under age 65 were actively working, and many of those who were not employed were students, family caregivers, or individuals with serious health conditions.[83] This directly undermines the depiction of Medicaid recipients as lacking self-sufficiency.

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[77] *See* Hussain Lalani et al., *US Taxpayers Heavily Funded the Discovery of COVID-19 Vaccines* 111 PUBMED 3 (2021); USAFacts, *US Coronavirus vaccine tracker* https://usafacts.org/visualizations/covid-vaccine-tracker-states/ (last visited Dec. 11, 2025).
[78] *New York v. United States Dep't of Homeland Sec*., 969 F.3d 42, 84 (2d Cir. 2020).
[79] *Id*. at 84-85.
[80] *Id.* at 84 (2d Cir. 2020) (citing National Housing Law Project Amicus Br. at 22 (noting that roughly 40% of employed Medicaid beneficiaries work for small businesses, many of which are not legally required to provide health insurance)).
[81] *Id*.
[82] *Id.* at 85 (2d Cir. 2020) (citing Public Justice Center Amicus Br. at 20 [citing Rachel Garfield et al., KFF, Understanding the Intersection of Medicaid and Work: What Does the Data Say? 2 (2019)]).
[83] Jennifer Tolbert et al., KFF, *Understanding the Intersection of Medicaid and Work: An Update* (May 30, 2025), https://www.kff.org/medicaid/understanding-the-intersection-of-medicaid-and-work-an-update/.

Several research organizations have found that receipt of Medicaid is far from evidence of a lack of self-sufficiency. Instead, they have found that Medicaid enables individuals to prioritize their health, to work and remain productive, and to be financially stable.

Medicaid is, above all, a safeguard against unmet health care needs.[84] It allows enrollees to access essential preventive services,[85] acute care,[86] prescription drugs,[87] and long-term services and supports.[88] By ensuring access to care, Medicaid allows individuals to manage chronic conditions,[89] avoid preventable medical crises,[90] and thereby maintain the functional capacity necessary for employment[91] and caregiving.[92] Without reliable access to health care, workers are more likely to miss work due to untreated illness, experience disability, or exit the workforce altogether. Medicaid, therefore, directly promotes economic

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[84] Madeline Guth, Rachel Garfield & Robin Rudowitz, KFF, *The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020* (Mar. 17, 2020), https://www.kff.org/affordable-care-act/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/#:~:text=Coverage:%20Studies%20show%20that%20Medicaid,gains%2C%20and%20overall%20economic%20growth ("Medicaid expansion has improved access to care, utilization of services, the affordability of care, and financial security among the low-income population.").

[85] Leighton Ku, Julia Paradise, & Victoria Thompson, KFF, *Data Note: Medicaid's Role in Providing Access to Preventive Care for Adults* (May 17, 2027), https://www.kff.org/medicaid/data-note-medicaids-role-in-providing-access-to-preventive-care-for-adults/#:~:text=Looking%20Ahead,including%20preventive%20care%20for%20adults.

[86] Alice Burns et al., KFF, *10 Things to Know About Medicaid*, (Feb. 18, 2025), https://www.kff.org/medicaid/10-things-to-know-about-medicaid/#:~:text=7.,is%20both%20limited%20and%20mixed (Medicaid MCOs provide comprehensive acute care).

[87] KFF, *Medicaid's Prescription Drug Benefit: Key Facts* (May 1, 2019), https://www.kff.org/medicaid/medicaids-prescription-drug-benefit-key-facts/#:~:text=Medicaid%20provides%20health%20coverage%20for,pharmacy%20benefits%20in%20different%20ways.

[88] Priya Chiadambaram & Alice Burns, KFF, *10 Things About Long-Term Services and Supports (LTSS)* (Jul. 8, 2024), https://www.kff.org/medicaid/10-things-about-long-term-services-and-supports-ltss/.

[89] Heather Saunders, Alice Burns, & Robin Rudowitz, KFF, *5 Key Facts About Medicaid Coverage for Adults with Chronic Conditions* (Apr. 10, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-adults-with-chronic-conditions/#:~:text=2.%20Medicaid%20facilitates%20access%20to%20care%20for%20people%20with%20chronic%20conditions.

[90] Leighton Ku, Julia Paradise, & Victoria Thompson, *supra* note 85.

[91] Stephani Becker & Stephanie Altman, Shriver Center on Poverty Law, *Five Things You Should Know About Medicaid* (Feb. 8, 2018), https://www.povertylaw.org/article/five-things-you-should-know-about-medicaid/#:~:text=Medicaid%20makes%20work%20possible.&text=By%20ensuring%20that%20low%2Dincome,income%20from%20securing%20gainful%20employment ("By ensuring that low-income men and women have access to critical healthcare, Medicaid helps people stay healthy and pursue work.").

[92] Alice Burns et al., KFF, *How do Medicaid Home Care Programs Support Family Caregivers?* (Jan. 13, 2025) https://www.kff.org/medicaid/how-do-medicaid-home-care-programs-support-family-caregivers/.

participation by stabilizing health and preserving work capacity.[93] By contrast, loss of coverage exposes families to untreated illness and catastrophic medical expenses that impair their ability to work consistently.[94] Medicaid makes it easier for people to work and to keep working.[95] Overall, Medicaid ensures enrollees can live healthier and more productive lives.[96]

Medicaid also improves the financial stability of low-income individuals and families.[97] By lifting them from the substantial burden of unpredictable and catastrophic medical expenses that would otherwise destabilize their finances, housing, transportation, education, and/or employment. Without this burden individuals can achieve financial stability.

DHS itself has previously acknowledged that restricting access to Medicaid leads to worse health outcomes, increased use of emergency departments, higher prevalence of communicable diseases, and increased uncompensated care.[98] But the proposed rule significantly underestimates the severity of these harms. These effects not only damage individual health but also impose substantial strain on hospitals, safety-net providers, and state and local health systems.[99]

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[93] Stephani Becker and Stephanie Altman, *supra* note 91.
[94] *See generally* Madeline Guth, Rachel Garfield & Robin Rudowitz, *supra* note 84.
[95] Aubrianna Osorio, Georgetown Univ. McCourt School of Public Pol'y Center for Children and Families, *Research Update: It's Simple – Medicaid Helps People Work* (May 22, 2023), https://ccf.georgetown.edu/2023/05/22/research-update-its-simple-medicaid-helps-people-work/.
[96] Am. Hospital Ass'n, *Fact Sheet: Medicaid* (Feb. 2025), https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid; *See also* Benjamin D. Sommers et al., *Health Insurance Coverage and Health – What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586 (2017), https://www.nejm.org/doi/pdf/10.1056/NEJMsb1706645; Katherine Baicker et al., *The Oregon Experiment — Effects of Medicaid on Clinical Outcomes*. 368 NEW ENG. J. MED. 1713 (2013), https://www.nejm.org/doi/pdf/10.1056/NEJMsa1212321 ("[Medicaid] did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.").
[97] Brigham Walker et al., The Commonwealth Fund, *How Medicaid Protects Beneficiaries from Financial Stress — and How It Could Do More* (Feb. 21, 2024), https://www.commonwealthfund.org/blog/2024/how-medicaid-protects-beneficiaries-financial-stress-and-how-it-could-do-more#:~:text=Medicaid's%20Financial%20Protection,cannot%20balance%20bill%20in%20Medicaid.
[98] Samantha Artiga et al., KFF, *Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment* (Dec. 2, 2025), https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/?utm_campaign=KFF%3A%20Medicaid&utm_medium=email&_hsenc=p2ANqtz-9XKc6k4s90kP7UMHs2MPDelXPgtSFnjNbPf4eSKiG2XMG28HlAvC4NLhjW84JCXg5j6ZXtt_Voz3EFgS8RUPJ4gZs3Qg&_hsmi=392676305&utm_content=392676305&utm_source=hs_email [hereinafter "Artiga et al."].
[99] Randy Haught et al., The Commonwealth Fund, *Federal Cuts to Medicaid Could End Medicaid Expansion and Affect Hospitals in Nearly Every State* (May 22, 2025),

Medicaid is an effective tool to keep individuals from financial turmoil, put them on the road to economic well-being,[100] and save them from health care spending.[101] The improved financial security Medicaid provides allows households to devote resources to other items such as food, housing, transportation, and education.[102] Research consistently shows that Medicaid coverage is associated with lower medical debt, fewer bills sent to collections, reduced bankruptcy risk, and improved credit scores.[103]

By contrast, policies that deter Medicaid enrollment increase poverty, housing instability, and financial distress.[104] DHS underestimates the extent to which the proposed rule is likely to lead to increased poverty, housing instability, reduced productivity, and lower educational attainment. These outcomes would be catastrophic for immigrant and mixed-status families and would also destabilize household finances and reduce revenues for health care providers.

The record is clear: Medicaid strengthens self-sufficiency. Medicaid use cannot rationally be treated as evidence of a lack of self-sufficiency and should not be counted in public charge determinations.

B. ***There is no need to review Medicaid use in public charge determinations because most Medicaid is generally unavailable to individuals subject to the public charge test***

There is little to no legal or practical justification for considering Medicaid in public charge determinations because, as a matter of law, Medicaid is generally unavailable to individuals who are subject to the public charge test.[105] This is particularly true following the changes enacted under the One Big Beautiful Bill Act (OBBBA).[106] As a result, reviewing Medicaid use does not meaningfully advance the stated aims of public charge enforcement. Instead,

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https://www.commonwealthfund.org/publications/issue-briefs/2025/may/federal-cuts-medicaid-could-end-medicaid-expansion-affect-hospitals.

[100] Karina Wagnerman, Georgetown Univ. McCourt School of Public Pol'y Center for Child. and Families, *Medicaid Coverage Improves Financial Security* (Dec. 6, 2016), https://ccf.georgetown.edu/2016/12/06/medicaid-coverage-improves-financial-security/#:~:text=A%202013%20study%20in%20the,having%20problems%20paying%20medical%20bills; Luojia Hu et al., *The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing*, 163 J. OF PUBLIC ECON. 99-112 (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC6208351/.

[101] Melissa Majerol, Jennifer Tolbert, & Anthony Damico, KFF, *Health Care Spending Among Low-Income Households with and without Medicaid* (Feb. 4, 2016), https://www.kff.org/medicaid/health-care-spending-among-low-income-households-with-and-without-medicaid/.

[102] *Id.*

[103] Aaron E. Carroll, *Medicaid as a Safeguard for Financial Health*, 321(2) JAMA 135 –136. https://jamanetwork.com/journals/jama/fullarticle/2720716.

[104] Artiga et al, *supra* note 98.

[105] Manatt Health, *Public charge final Rule: Frequently asked Questions*, STATE HEALTH & VALUE STRATEGIES 9 (Oct. 2019), https://www.shvs.org/wp-content/uploads/2019/10/Public-Charge-FAQ-FINAL.pdf.

[106] One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 152 (2025).

it creates significant harmful consequences for individuals who are eligible for Medicaid but exempt from public charge and are nonetheless chilled from accessing health care (see discussion of the chilling effect supra).

Public charge applies only to a narrow group of immigrants, primarily individuals applying for a visa, those seeking admission to the United States, and those applying for adjustment of status to lawful permanent residence.[107]

Those exempt from public charge include U.S. citizens, lawful permanent residents after admission, refugees, asylees, VAWA self-petitioners, Special Immigrant Juveniles, survivors of trafficking (T visas), survivors of crime (U visas), and other humanitarian immigrants.[108]

Meanwhile, full-scope Medicaid for non-pregnant adults is generally restricted to U.S. citizens and now only a limited subset of lawfully present immigrants who meet income requirements and, in most cases, have satisfied the federal five-year waiting period.[109] Because these legal eligibility frameworks are fundamentally misaligned, most immigrants who remain subject to public charge — that is those sponsored by a family member — are legally ineligible for full-scope Medicaid coverage. DHS's treatment of Medicaid as a public charge factor functions primarily as a deterrent to families accessing health care for which they are fully entitled.

Starting October 2026, OBBBA will further tighten Medicaid eligibility and impose new coverage restrictions, including additional limitations on certain lawfully present immigrants and new federal work requirements for some non-disabled adults enrolled through Medicaid expansion — requirements that would not apply to the many adults who qualify for Medicaid through other eligibility categories.[110] These changes further reduce the remaining practical overlap between Medicaid eligibility for non-pregnant adults and public charge applicability.

Allowing immigration officials to consider all Medicaid use will not meaningfully affect the public charge determinations DHS ultimately makes because few immigrants who are actually subject to the public charge test are eligible for Medicaid or CHIP in the first place. Instead, the primary effect of this policy will be to deter individuals who are not subject to public charge but are eligible for Medicaid from enrolling in or maintaining coverage.

Historically, confusion and fear surrounding public charge rules have caused widespread disenrollment from public benefits among eligible immigrant families, children, and pregnant

[107] 8 U.S.C. § 1182(a)(4). *See* Inadmissibility on Public Charge Grounds, 87 Fed. Reg. 55472, 55528 – 29 (Sept. 9, 2022). *See also* USCIS Policy Manual, Vol. 8, Pt. G, Ch. 1.
[108] *See* 8 U.S.C. §§ 1182(a)(4)(E), (d)(13) – (14); 8 C.F.R. § 212.23(a); DHS, *Final Rule: Public Charge Ground of Inadmissibility*, 87 Fed. Reg. 55472, 55495 – 55503 (Sept. 9, 2022).
[109] *See* 42 U.S.C. § 1396a(a)(10)(A); 8 U.S.C. §§ 1612(a), 1613; 42 C.F.R. § 435.406.
[110] One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 152 (2025).

people, even when no legal immigration consequences existed.[111] Permitting DHS to review *any* Medicaid use will predictably perpetuate and exacerbate this chilling effect — this is confirmed by the documented chilling effects from the 2019 rule.[112]

DHS's own estimates project that approximately 460,000 individuals would disenroll from Medicaid and CHIP as a result of this policy.[113] However, independent analyses, including by KFF, demonstrate that the population actually affected by these chilling effects reaches into the millions — and that the vast majority of those harmed are not subject to public charge at all.[114]

The resulting harm from disenrolling is substantial. Deterrence from Medicaid is associated with delayed access to care, untreated chronic conditions, increased emergency department utilization, worse maternal and child health outcomes, and higher long-term public costs.[115] It also destabilizes household finances and workforce participation by exposing families to catastrophic medical expenses and untreated illness.[116] Evidence from

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[111] Artiga et al.; Claudia Schlosberg & Dinah Wiley, Nat'l Health Law Prog. and Nat'l Immigr. Law Center, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care* (May 22, 1998), https://www.oregonadvocates.org/geo/search/download.67362/; Michael E. Fix & Jeffrey S. Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform*, URB. INST. 1-2, 5 (1999), https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and- Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf. Michael E. Fix & Jeffrey S. Passel, *The Scope and Impact of Welfare Reform's Immigrant Provisions,* URB. INST. (January 2002), https://www.urban.org/sites/default/files/publication/60346/410412-Scope-and-Impact-of-Welfare-Reform-s-Immigrant-Provisions-The.PDF.

[112] Hamutal Bernstein et al., Urb. Inst., *Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019* (2020), https://www.urban.org/research/publication/amid-confusion-over-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-2019; Jennifer M. Haley et al., Urb. Inst., *One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019* (2020), https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019; Dulce Gonzalez et al., Urb. Inst., *Mixed-Status Families and Immigrant Families with Children Continued Avoiding Safety Net Programs in 2023* (2024), https://www.urban.org/research/publication/mixed-status-families-and-immigrant-families-children-continued-avoiding; Drishti Pillai et al., KFF, *KFF/New York Times 2025 Survey of Immigrants: Health and Health Care Experiences During the Second Trump Administration* (2025), https://www.kff.org/immigrant-health/kff-new-york-times-2025-survey-of-immigrants-health-and-health-care-experiences-during-the-second-trump-administration/; Jeanne Batalova, Randy Capps, & Michael Fix, Migration Pol'y Inst., *Anticipated 'Chilling Effects' of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families* (December 21, 2020), https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real; *New Data Reveal Stark Decreases in SNAP Participation Among U.S. Citizen Children Living With a Non-Citizen,* FOOD RESEARCH & ACTION CENTER (2021), https://frac.org/wp-content/uploads/SNAP-Participation-Among-U.S.-Citizen-Children.pdf.

[113] Artiga et al, *supra* note 98.

[114] Artiga et al, *supra* note 98.

[115] Jennifer Tolbert et al., KFF, *Key Facts about the Uninsured Population* (Dec. 18, 2024), https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/; Artiga et al.

[116] *Id*.

prior public charge policies further shows that these coverage losses are driven primarily by fear and confusion about immigration consequences — not by actual changes in legal eligibility for Medicaid or CHIP.[117]

C. Coverage for prenatal care is not evidence of public charge

As described above, Medicaid coverage is available for lawfully residing children and pregnant immigrants, if states select the option.[118] Because the definition of "lawfully residing" is broader than the groups otherwise eligible for Medicaid, these are the primary groups who will be impacted by DHS's decision to permit counting Medicaid in a public charge determination.

But Medicaid use by children and pregnant immigrants should not be considered in a public charge determination. Pregnancy requires medical care regardless of income, immigration status, or employment. Prenatal care is medically necessary to safeguard both maternal and infant health,[119] and access to such care reflects medical need, not economic dependence. The use of prenatal care coverage supports pregnant people and the health of their children.

Federal and state Medicaid programs recognize the medical necessity of prenatal care by setting income eligibility limits for pregnant individuals substantially higher than for non-pregnant adults,[120] often exceeding 200% of the federal poverty level.[121] This elevated threshold reflects a deliberate policy choice to ensure broad access to prenatal services, given their critical importance to public health.

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[117] Artiga et al, *supra* note 98.; *See also* Lei Chen et al., *Immigrants' Enforcement Experiences and Concern about Accessing Public Benefits or Services*, 25 *J. OF IMMIGR. AND MINORITY HEALTH* 1077 – 84 (2023), https://doi.org/10.1007/s10903-023-01460-x.

[118] 42 U.S.C. § 1396b(v)(4).

[119] Mohammed Nasser Albarqi, *The Impact of Prenatal Care on the Prevention of Neonatal Outcomes: A Systematic Review and Meta-Analysis of Global Health Interventions*, 13 HEALTHCARE 1076 (May 6, 2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC12071573/#B1-healthcare-13-01076; *See also* Cristina Novoa, Center for Am. Progress, *Ensuring Healthy Births Through Prenatal Support* (Jan, 31 2020), https://www.americanprogress.org/article/ensuring-healthy-births-prenatal-support/; HHS Office on Women's Health, *Prenatal care*, https://womenshealth.gov/a-z-topics/prenatal-care (last visited Dec. 14, 2025).

[120] Usha Ranji et al., KFF, *5 Key Facts About Medicaid and Pregnancy* (May 29, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-pregnancy/.

[121] Tricia Brooks et al., KFF, *Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations* (Apr. 1, 2025), https://www.kff.org/medicaid/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-following-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/#3d220ed2-e1fa-4ae8-a42f-61ffeb0936fe ("the median eligibility limit for pregnancy coverage in Medicaid and CHIP increased from 210% to 213% of the federal poverty level (FPL)…").

Medicaid is a central pillar of prenatal and childbirth care in the United States. Medicaid finances 40% of all births nationwide and nearly 50% in rural communities.[122] This demonstrates that Medicaid-funded prenatal and delivery care is widespread. This makes it a foundation component of maternal health in the U.S.

The importance of prenatal Medicaid coverage is well documented.[123] As a result, Medicaid expansion is associated with increased use of prenatal services.[124]

Medicaid access during pregnancy is also associated with improved birth outcomes,[125] including lower infant mortality,[126] fewer low-birthweight births,[127] improved maternal health,[128] and better long-term child health.[129] Medicaid's role is especially significant for low-income women and women of color, who face disproportionate risks of maternal morbidity and mortality.[130]

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[122] Am. Hospital Ass'n, *supra* note 96; *See also* Georgetown Univ. Health Pol'y Inst. Center for Child. and Families, *Women Depend on Medicaid Across the Lifespan,* https://ccf.georgetown.edu/2025/06/24/women-depend-on-medicaid-across-the-lifespan/#9ca85804-2477-4916-8d13-aa04fe24fc23 (last visited Dec. 14, 2025); KFF, *Births Financed by Medicaid by Metropolitan Status*, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Dec. 14, 2025).

[123] Adam Searing & Donna Cohen Ross, *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies,* GEORGETOWN UNIV. HEALTH POL'Y INST. CENTER FOR CHILD. AND FAMILIES (2019), https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health_FINAL-1.pdf; *See also* Sarah Ines Ramirez, *Prenatal Care: An Evidence-Based Approach*, 108 AM. FAM. PHYSICIAN 139 – 150, https://www.aafp.org/pubs/afp/issues/2023/0800/prenatal-care.html#abstract.

[124] Ranji et al., *supra* note 120; Madeline Guth & Karen Diep, KFF, *What Does the Recent Literature Say About Medicaid Expansion?: Impacts on Sexual and Reproductive Health* (Jun. 29, 2023), https://www.kff.org/affordable-care-act/what-does-the-recent-literature-say-about-medicaid-expansion-impacts-on-sexual-and-reproductive-health/.

[125] Ranji et al., *supra* note 120.

[126] Chintan B. Bhatt & Consuelo M. Beck-Sague*, Medicaid Expansion and Infant Mortality in the United States*, 108 AM. J. PUBLIC HEALTH 565-567 (Apr. 2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC5844390/.

[127] Ranji et al., *supra* note 120.

[128] *Id*.

[129] *Medicaid Matters for Young Child. and their Families*, Georgetown Univ. McCourt School of Public Pol'y Center for Child. and Families, https://ccf.georgetown.edu/2025/06/03/medicaid-matters-for-young-children-and-their-families/ (last visited Dec. 14, 2025); Sarah Miller & Laura R. Wherry, *The Long-Term Effects of Early Life Medicaid Coverage,* HEALTH POL'Y SCHOLARS AND HEALTH & SOCIETY SCHOLARS PROGRAMS AT THE UNIV. OF MICHIGAN (Aug. 20, 2015), https://websites.umich.edu/~mille/MillerWherry_Prenatal2015.pdf.

[130] Andy Schneider et al., Georgetown Univ. McCourt School of Public Pol'y Center for Child. and Families, *Medicaid Managed Care, Maternal Mortality Review Committees, and Maternal Health: A 12-State Scan* (Oct. 16, 2023) https://ccf.georgetown.edu/2023/10/16/medicaid-managed-care-maternal-mortality-review-committees-and-maternal-health-a-12-state-scan/#:~:text=the%20Full%20Report-,Introduction,Indian%20and%20Alaska%20Native%20women.

On the other hand, a lack of prenatal care is associated with increased maternal complications,[131] higher infant mortality,[132] greater rates of preterm birth,[133] and preventable long-term health consequences for both parent and child.[134] Denying or deterring access to prenatal care therefore imposes both immediate and generational harms.

These harms are not speculative. Despite the availability of Medicaid and CHIP, from 2009 to 2010, 40% of mothers surveyed across 30 states reported delaying prenatal care due to lack of money or insurance coverage.[135] Barriers to care are especially acute for immigrant women of reproductive age, 34% of whom are uninsured.[136] Policies that deter or restrict access to prenatal care and related assistance for immigrant mothers risk worsening maternal morbidity and mortality and undermining infant health at birth. The consequences extend well beyond pregnancy, as inadequate prenatal care is associated with lasting adverse health outcomes for children, with effects that can persist for decades and diminish a future generation's opportunity to thrive in tangible and entirely preventable ways.[137]

The 2019 Public Charge Final Rule recognized these realities. DHS expressly exempted Medicaid benefits received for pregnancy-related services, acknowledging that prenatal care serves an essential public health function and should not be treated as evidence of

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[131] Emily J. Gregory & Emily DeFranco, *Risk Factors Affecting Rising Rate of No Prenatal Care in US Births Between 2012 – 2016,* 135 AM. J. OF OBSTETRICS AND GYNECOLOGY *36S* (May 2020), https://journals.lww.com/greenjournal/abstract/2020/05001/risk_factors_affecting_rising_rate_of_no_prenatal.122.aspx.

[132] Guttmacher Inst., *Neonatal Death Risk: Effect of Prenatal Care Is Most Evident After Term Birth* (Sept. 1, 2002), https://www.guttmacher.org/journals/psrh/2002/09/neonatal-death-risk-effect-prenatal-care-most-evident-after-term-birth.

[133] Anthony M Vintzileos et al., *The impact of prenatal care in the United States on preterm births in the presence and absence of antenatal high-risk conditions*, 187 AM. J. OF OBSTETRICS AND GYNECOLOGY *1254-7,* https://pubmed.ncbi.nlm.nih.gov/12439515/.

[134] Cristina Novoa, Center for Am. Progress, *Ensuring Healthy Births Through Prenatal Support* (Jan. 31, 2020), https://www.americanprogress.org/article/ensuring-healthy-births-prenatal-support/; Inst. of Medicine (US) Comm. on the Consequences of Uninsurance, *Health Insurance is a Family Matter* (2002), https://www.ncbi.nlm.nih.gov/books/NBK221019/ ("Before birth, good prenatal care also provides opportunities to ensure the best possible health for both mother and child.").

[135] KFF, *Proposed Changes to "Public Charge" Policies for Immigrants: Implications for Health Coverage* (2018), http://files.kff.org/attachment/Issue-Brief-Proposed-Changes-to-Public- Charge-Policies-for-Immigrants-Implications-for-Health-Coverage.

[136] Guttmacher Inst., *Gains in Insurance Coverage for Reproductive-Age Women at a Crossroads* (Dec. 4, 2018), https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads.

[137] Sharon Parrot, Shelby Gonzales, & Liz Schott, *Trump "Public Charge" Rule Would Prove Particularly Harsh for Pregnant Women and Children*, CTR. ON BUDGET AND POL'Y PRIORITIES (2018), https://www.cbpp.org/sites/default/files/atoms/files/5-1-18pov2.pdf.

dependency. DHS itself confirmed that prenatal Medicaid use cannot rationally be equated with public charge.[138] DHS offers no explanation for a different view now.

DHS's refusal to exclude Medicaid-funded prenatal care is disconnected from the public charge test and will result in significant harm.

D. Coverage of children's health care is not evidence of public charge

Children are not, and should not be, expected to be self-sufficient or to be part of the workforce. They are legal and economic dependents, and their health, development, and well-being necessarily rely on their families and public systems of care. Treating a child's receipt of Medicaid as evidence of future dependency or lack of self-sufficiency is, therefore, fundamentally illogical.

Public charge policies that chill access to children's health coverage cause widespread and well-documented harm. Reduced participation in health coverage and other assistance programs directly undermines the health and financial stability of immigrant families and threatens the growth and healthy development of their children. Following prior public charge rule changes, many immigrant families, including families with U.S. citizen children, declined assistance and services for which they were fully eligible, including critical health coverage and care.[139]

Based on the KFF analysis of American Community Survey data, approximately 13.4 million Medicaid or CHIP enrollees live in a household with at least one noncitizen, including 5.9 million U.S. citizen children.[140] As a result, policies that deter immigrant families from enrolling in Medicaid disproportionately harm children.

Extensive research demonstrates that Medicaid coverage in childhood is associated with improved long-term health,[141] higher educational attainment,[142] increased earnings,[143] and

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[138] DHS, *Final Rule: Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. 41292, 41302 – 03 (Aug. 14, 2019) (excluding pregnancy-related Medicaid from public charge consideration), https://www.govinfo.gov/content/pkg/FR-2019-08-14/pdf/2019-17142.pdf.

[139] Samantha Artiga, KFF, *Changes to Public Charge Regulations Will Likely Lead More Immigrant Families to Avoid Health Care and Assistance Programs* (Nov. 18, 2025), https://www.kff.org/quick-take/changes-to-public-charge-regulations-will-likely-lead-more-immigrant-families-to-avoid-health-care-and-assistance-programs/.

[140] Artiga et al, *supra* note 98.

[141] Laura R. Wherry et al., *Childhood Medicaid Coverage and Later-Life Health Care Utilization*, 100 THE REV. OF ECON. AND STAT. 287-302 (2018), https://www.nber.org/system/files/working_papers/w20929/w20929.pdf ("This evidence suggests that health interventions in the pre-teen and early teen years for disadvantaged populations can provide long-term health benefits.").

[142] Sarah R. Cohodes et al., *The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions*, 51 J. OF HUMAN RESOURCES 727 – 759 (Aug. 2016), https://jhr.uwpress.org/content/51/3/727.short.

[143] Edwin Park, Georgetown Univ. McCourt School of Public Pol'y Center for Child. and Families, *New CBO Study Explores the Long-Term Fiscal Benefits of Medicaid Coverage in Childhood* (Nov.

greater tax contributions in adulthood.[144] Childhood Medicaid eligibility is also associated with lower rates of chronic disease,[145] reduced mortality, and fewer hospitalizations later in life.[146] These long-term gains directly contradict any suggestion that childhood Medicaid use signals future economic dependence.

Regular access to health care in childhood is also medically essential.[147] Medicaid provides children with access to routine well-child visits, immunizations, developmental screenings, mental health services, and early interventions for physical and developmental conditions.[148] These services are critical to identifying health needs early, preventing avoidable medical issues, and avoiding lifelong impairment and high-cost emergency care.

Deterring families from enrolling children in Medicaid due to fears of public charge has significant and predictable public health consequences.[149] Loss of coverage among children leads to delayed diagnosis, increased emergency room use, worsening of preventable conditions, and higher long-term health system costs.[150]

These harms are especially severe for low-income children and children of color, who already face disproportionate health risks.[151] Other national survey data show that nearly

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16, 2023), https://ccf.georgetown.edu/2023/11/16/new-cbo-study-explores-the-long-term-fiscal-benefits-of-medicaid-coverage-in-childhood/.

[144] Matt Broaddus, Center on Budget and Pol'y Priorities, *Medicaid-Eligible Children Grow Up to Earn More and Pay More in Taxes* (Jan. 21, 2015), https://www.cbpp.org/blog/medicaid-eligible-children-grow-up-to-earn-more-and-pay-more-in-taxes; David W. Brown, Amanda E. Kowalski, & Ithai Z. Lurie, *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts? COWLES FOUNDATION DISCUSSION PAPERS* (2015), https://elischolar.library.yale.edu/cowles-discussion-paper-series/2396.

[145] Michel H. Boudreaux, Ezra Golberstein, & Donna D. McAlpine, *The Long-term Impacts of Medicaid Exposure in Early Childhood: Evidence from the Program's Origin*, 45 J. OF HEALTH ECON. 161-75 (2016); Laura R. Wherry et al., *Childhood Medicaid Coverage and Later-Life Health Care Utilization*, 100 THE REV. OF ECON. AND STAT. 287-302 (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC6497159/.

[146] Burns et al., *supra* note 86.

[147] *See generally* Glenn Flores et al., *The health and healthcare impact of providing insurance coverage to uninsured children: A prospective observational study*, 17 BMC PUBLIC HEALTH (2017), https://link.springer.com/article/10.1186/s12889-017-4363-z.

[148] Medicaid.gov, *Early and Periodic Screening, Diagnostic, and Treatment*, https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment (last visited Dec. 14, 2015).

[149] Artiga et al, *supra* note 98.

[150] *See generally* Abuko Estrada, First Focus on Child., *Prescription for Disaster: the Impact of Proposed Medicaid and CHIP Cuts on Children's Health* (Mar. 17, 2025), https://firstfocus.org/update/prescription-for-disaster-the-impact-of-proposed-medicaid-and-chip-cuts-on-childrens-health/#:~:text=Even%20short%20gaps%20in%20coverage,requirements%20imposed%20on%20their%20parents.

[151] Ismael Cid-Martinez, Kyle K. Moore, & Adewale A. Maye, Econ. Pol'y Inst., *Cuts to Medicaid will disproportionately hurt people of color and children* (Apr. 2, 2025), https://www.epi.org/blog/medicaid-cuts-will-disproportionately-hurt-people-of-color-and-children/; Unidos US, *Medicaid Cuts Would Rip Away Health Coverage from Millions of assans*,

one in four adults in mixed-status families and more than one in seven adults in immigrant families with children avoided safety-net programs in 2023 due to immigration-related fears alone.[152]

Coverage for children through Medicaid and CHIP cannot rationally be treated as evidence of public charge. It is a foundational investment in children's health, development, and future economic self-sufficiency.

E. Emergency Medicaid is not evidence of public charge

Emergency health care is, by its nature, unpredictable and extraordinarily expensive. Almost no individual, regardless of income, maintains sufficient liquid resources to cover the full cost of emergency treatment out of pocket.[153] Emergency Medicaid[154] exists to cover these unpredictable, life-threatening events and reflects the realities of the U.S. health care system. Its use is not evidence of dependency or reliance on public benefits; it is evidence of medical necessity.

Emergency Medicaid use is primarily a function of exclusion from other public programs, not a choice to rely on government assistance.[155] Many immigrants work in jobs that do not offer employer-sponsored insurance.[156] Federal law strictly limits Emergency Medicaid to the treatment of emergency medical conditions for individuals who are otherwise ineligible for full-scope Medicaid due to their immigration status.[157] Individuals who receive Emergency Medicaid are categorically barred from comprehensive Medicaid coverage and most other federal public benefits.[158] With OBBBA's further restriction of immigrant eligibility

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Disproportionately Harming People of Color (Mar. 13, 2025), https://unidosus.org/publications/medicaid-cuts-would-rip-away-health-coverage-from-millions-of-americans-disproportionately-harming-people-of-color/.

[152] *Id*.

[153] *See generally* Board of Governors of the Federal Reserve System, *Economic Well-Being of U.S. Households in 2023* (May 2024), https://www.federalreserve.gov/publications/2024-economic-well-being-of-us-households-in-2023-expenses.htm.

[154] 42 U.S.C. § 1396b(v).

[155] Fabricio J. Alarcon, *The Migrant Crisis and Access to Health Care*, 8 DEL. J. OF PUBLIC HEALTH 20-25 (Oct. 28, 2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9621574/#:~:text=Undocumented%20immigrants%20are%20considered%20%E2%80%9Cnon,those%20related%20to%20immigration%20status; Leonardo Cuello, Georgetown Univ. McCourt School of Public Pol'y Center for Child. and Families, *The Truth About Medicaid Coverage for Immigrants – and the Looming Threats* (May 21, 2025), https://ccf.georgetown.edu/2025/05/21/the-truth-about-medicaid-coverage-for-immigrants-and-the-looming-threats/#:~:text=The%20reimbursement%20covers%20only%20treatment,status%20using%20only%20state%20dollars.

[156] KFF, *Key Facts on Health Coverage of Immigrants* (Jan. 15, 2025), https://www.kff.org/racial-equity-and-health-policy/key-facts-on-health-coverage-of-immigrants/.

[157] 42 U.S.C. § 1396b(v).

[158] Evelyne P. Baumrucker & Abigail F. Kolker, Cong. Research Service, *Noncitizen Eligibility for Medicaid and CHIP* (March 10, 2025), https://www.congress.gov/crs-product/IF11912.

for full-scope Medicaid, Emergency Medicaid will become even more important. Emergency Medicaid, therefore, serves as the sole remaining safety net for life-threatening conditions for people who are otherwise excluded from the public benefits system altogether.

Deterring individuals from seeking emergency medical care would have severe and far-reaching public health consequences. Fear of immigration consequences and public charge enforcement would cause people to delay or avoid lifesaving treatment, leading to increased mortality, worsened chronic illness, greater spread of communicable diseases, and higher long-term health system costs.[159] Emergency Medicaid is also a critical funding source for hospitals that are legally obligated under the Emergency Medical Treatment and Labor Act (EMTALA) to provide stabilizing emergency care regardless of a patient's ability to pay.[160] If individuals are deterred from seeking care or coverage, hospitals will be left without reimbursement for mandated services, placing significant financial strain on already-burdened safety-net providers.[161]

Federal law itself reflects the government's compelling interest in ensuring access to emergency medical treatment, as embodied in EMTALA's mandate for emergency care.[162] Penalizing or chilling the use of Emergency Medicaid, therefore, directly undermines both public health and clear congressional intent.

The use of Emergency Medicaid cannot be treated as evidence of public charge. It reflects systemic exclusion from comprehensive coverage and the medical necessity of emergency treatment, not dependence. Penalizing emergency coverage would endanger lives, weaken hospitals, and miss the fundamental purpose of both Emergency Medicaid and federal emergency care law.

VI. Other health programs that serve immigrants

DHS references PRWORA repeatedly, but does not specify whether it intends to incorporate the definitions of public benefits that several other federal agencies have issued, and which have recently been expanded (and challenged in ongoing litigation). DHS's proposal to offer no clear prohibition on considering various programs, however, suggests that any number of programs may be included.[163] Several of these programs

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[159] Artiga et al, *supra* note 98.
[160] 42 U.S.C. § 1395dd.
[161] Emily Badger, Alicia Parlapiano, & Margot Sanger-Katz, N.Y. Times, W*hen the G.O.P. Medicaid Cuts Arrive, These Hospitals Will Be Hit Hardest* (Nov. 18, 2025), https://www.nytimes.com/2025/11/18/upshot/urban-hospitals-medicaid-cuts.html.
[162] 42 U.S.C. § 1395dd; Joseph Zibulewsky, *The Emergency Medical Treatment and Active Labor Act (EMTALA): what it is and what it means for physicians*, 14 BAYLOR UNIV. MEDICAL CENTER PROCEEDINGS 339-46 (2001), https://pmc.ncbi.nlm.nih.gov/articles/PMC1305897/#:~:text=The%20law's%20initial%20intent%20was,or%20stability%20for%20the%20transfer.
[163] *See* Dep't of Agriculture, Personal Responsibility and Work Opportunity Reconciliation Act

exists specifically to serve immigrants or underserved populations. By design, they serve areas in need of health care providers or health insurance. Use of these programs or coverage is not an indicator of lack of self-sufficiency or independence — it simply means no other options are readily available in that area.

Federally Qualified Health Centers (FQHCs), for example, are intended to fill care gaps by operating in underserved areas. Their statutory purpose includes serving a "medically underserved population comprised of migratory and seasonal agricultural workers, the homeless . . . ."[164] FQHCs exist in areas where immigrant workers are unable to access due to eligibility restrictions, or where employer sponsored insurance is not offered.

FQHCs utilization is not a reliable indicator of self-sufficiency. FQHCs serve a larger audience that relies on access to care due to our fragmented health care system.[165] Often, FQHCs provide mostly primary care with limited ancillary services — these basic services are used by everyone and have no bearing on an individual's subsistence on the government. Including FQHC use in public charge determinations would also disproportionately punish those in underserved areas, especially rural areas, where all patients — citizens and non-citizens — have limited options.[166] FQHC utilization is supported by the fact that these entities provide high-quality, low-cost care. Their growing popularity and expansion have been propelled by their comprehensive, community-based model.[167] They can adapt their services to meet community needs and are often the only source of dental, mental health, and substance abuse care.[168]

DHS would undercut this vital function if FQHC utilization were included in public charge determinations and deterred immigrants and their family members from utilizing these

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of 1996 (PRWORA); Interpretation of "Federal Public Benefit," 90 Fed. Reg. 30,621 (July 10, 2025); Dep't of Education, Clarification of Federal Public Benefits Under the Personal Responsibility and Work Opportunity Reconciliation Act, 90 Fed. Reg. 30,896 (July 11, 2025); Dep't of Health and Human Servs., Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of "Federal Public Benefit," 90 Fed. Reg. 31,232 (July 14, 2025); Dep't of Justice, Revised Specification Pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 90 Fed. Reg. 32,023 (July 16, 2025).

[164] 42 U.S.C. § 254b(a)(1).

[165] *See* Lia Scalzo, *How Federally Qualified Health Centers Transform Access to Care* (2025), https://insights.ibx.com/how-federally-qualified-health-centers-transform-access-to-care/#:~:text=Many%20factors%20make%20it%20hard,in%20closing%20these%20care%20gaps.

[166] Celli Horstman et al., Commonwealth Fund., *Community Health Centers' Progress and Challenges in Meeting Patients' Essential Primary Care Needs* (2024); Nat'l Assoc. of Comm. Health Centers, *America's Health Centers: By the Numbers*, https://www.nachc.org/resource/americas-health-centers-by-the-numbers/ (last visited Dec. 12, 2025) (finding that over 20% of rural Americans get care from FQHCs).

[167] Sara Rosenbaum and Feygele Jacobs, *How Medicaid Built Community Health Centers And Health Centers Returned The Favor* (2025), https://www.healthaffairs.org/content/forefront/medicaid-built-community-health-centers-and-health-centers-returned-favor.

[168] *Id.*

programs. It undermines FQHCs' express statutory purpose. And it does not serve DHS's goal of weighing factors of self-sufficiency because FQHC utilization has no bearing on self-sufficiency.

Other state and local health programs, such as vaccination programs, could also be included in public charge determinations under this Administration's misapplication of PRWORA. Similar to FHQCs, vaccine testing and treatment of communicable disease is required under statute and made available to individuals regardless of immigration status. This is particularly important for vaccines and communicable diseases because universal access promotes prevention and treatment and is more likely to achieve the goal of population-based immunity.[169] Rescinding prior public charge regulations could lead to individuals avoiding vaccination, which has far-reaching effects that extend well-beyond the immigrant population.[170]

Revising the public charge test to permit consideration of other health programs could result in chilling of immigrants' use of premium tax credits (PTCs). Like the other programs mentioned above, inclusion of PTCs in public charge determinations would result in a counterintuitive outcome. Many lawfully present immigrants are not eligible for PTCs, and they are no more, or less, self-sufficient than those who are eligible. Use of PTCs is a measure of eligibility for the benefit. It should not be conflated with lack of self-reliance or destitution. The vast majority of Marketplace enrollees receive some form of premium tax credit — and no specific conclusions can be drawn on such broad and incidental subsets of a population.[171]

VI. Cost-benefit analysis does not address widespread impact of the NPRM

The proposed rule includes an economic impact analysis, which predicts that approximately 447,000 people will disenroll or forgo enrollment in SNAP, 364,000 in Medicaid, 64,000 in Supplemental Security Income (SSI), 59,000 in CHIP and 16,000 in cash assistance under Temporary Assistance for Needy Families (TANF). However, as harmful as this impact would be, it is likely a significant understatement of the harm.

DHS's primary estimates of the chilling effect are based on a 10.3% chilling effect. This is not based on any specific estimate of chilling effect but is rather the mathematical midpoint between a 3.3% estimate that is based on the share of all noncitizens who adjust status

[169] CDC, *Immunity Types*, https://www.cdc.gov/vaccines/basics/immunity-types.html (last visited Dec. 12, 2025).
[170] *See* CDC, *Diseases that Vaccines Help Protect Against*, https://www.cdc.gov/vaccines-children/diseases/index.html (last visited Dec. 12, 2025).
[171] KFF, *Estimated Total Premium Tax Credits Received by Marketplace Enrollees* (2025), https://www.kff.org/affordable-care-act/state-indicator/average-monthly-advance-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

each year (*e.g*. assumes no chilling effect on anyone who is not adjusting in that calendar year) and a 17.3% estimate that purports to be derived from the Urban Institute and KFF studies.[172] However, DHS does not show their math for this calculation, which appears to include results for all-citizen immigrant households. Moreover, this combines results from the period when the 2019 rule was in effect and from the period when the 2022 rule was in effect. Based on the studies cited above, disenrollment rates from 10-30% are more plausible, with 20% as a midpoint estimate. These are the rates used in a new KFF estimate of the chilling effect on Medicaid and CHIP.[173]

Moreover, as the KFF analysis points out, DHS's estimate of the population to which this chilling rate should be applied is demonstrably too low. DHS estimates that 3.5 million Medicaid enrollees and 570,000 CHIP enrollees lived in a household with at least one person who is not a citizen.[174] KFF's analysis of American Community Survey data finds that there are actually about 13.4 million Medicaid or CHIP enrollees living in a household with at least one noncitizen. In addition, there are nearly 1.8 million uninsured individuals in a household with at least one noncitizen who are eligible for Medicaid or CHIP but not enrolled and could be deterred from applying.[175]

Finally, DHS does not even attempt to measure the harms from disenrollments from the wide range of programs that will experience chilling effects. Thus, its estimates are dramatically discounting the actual harm from this proposed rule.

VII. Harms from the rule do not outweigh purported benefits

The chilling effect of public charge will only worsen hunger, unmet health care needs, health outcomes, poverty, homelessness, and other serious problems. And as we have noted throughout, the harms attach beyond immigrant communities, impacting citizen children in mixed status households as well as other individuals and communities.

Executive Order 13563 directs agencies to propose or adopt a regulation only upon a reasoned determination that its benefits justify its costs; the regulation is tailored to impose the least burden on society, consistent with achieving the regulatory objectives; and in choosing among alternative regulatory approaches, the agency has selected those

[172] 2025 Proposed Rule, https://www.federalregister.gov/d/2025-20278/p-480.
[173] Samantha Artiga, Drishti Pillai, Sammy Cervantes, Akash Pillai and Matthew Raie, *Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment*, KFF, 2025. https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/.
[174] 2025 Proposed Rule, Table VI.10, https://www.federalregister.gov/d/2025-20278/page-522
[175] Artiga et al, *supra* note 173.

approaches that maximize net benefits.[176] The proposed rule fails to meet these requirements.

DHS is well aware of the chilling effect of the public charge rules. As explained in the preamble to the 2022 final rule:

> The 2019 Final Rule was associated with widespread indirect effects, primarily with respect to those who were not subject to the 2019 Final Rule in the first place, such as U.S.-citizen children in mixed-status households, longtime lawful permanent residents who are only subject to the public charge ground of inadmissibility in limited circumstances, and noncitizens in a humanitarian status who would be exempt from the public charge ground of inadmissibility in the context of adjustment of status.[177]

Indeed, these chilling effects are recognized in the current proposed rule, in the discussion of likely costs of the rule. Specifically, DHS acknowledges that "elimination of certain definitions may lead to public confusion or misunderstanding of the proposed rule, which could result in decreased participation in public benefit programs by individuals who are not subject to the public charge ground of inadmissibility."[178]

The proposed rule will also lead to harms including:

- "Lower revenues for healthcare providers participating in Medicaid.
- Reduced income for companies manufacturing medical supplies or pharmaceuticals.
- Decreased sales for grocery retailers participating in SNAP.
- Economic impacts on agricultural producers supplying SNAP-eligible foods.
- Financial strain on landlords participating in federally funded housing programs."[179]

At the same time, DHS maintains that this is not the "intent" of the regulation and therefore suggests that it has no obligation to minimize these harms. Similarly, in the 2019 final rule, DHS acknowledged the likely chilling effect of the policy on groups not subject to a public charge determination but stated that disenrolling or forgoing enrollment would be "unwarranted" and therefore "DHS will not alter this rule to account for such unwarranted choices."[180]

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[176] *Improving Regulation and Regulatory Review*, Executive Order 13563, January 21, 2011. https://www.federalregister.gov/documents/2011/01/21/2011-1385/improving-regulation-and-regulatory-review.
[177] DHS, Final Rule: Public Charge Ground of Inadmissibility, 87 Fed. Reg. 55472 (Sept. 9, 2022), https://www.federalregister.gov/d/2022-18867/p-1414.
[178] 2025 NPRM, https://www.federalregister.gov/d/2025-20278/p-453.
[179] 2025 NPRM, https://www.federalregister.gov/d/2025-20278/p-529.
[180] 2019 Final Rule, https://www.federalregister.gov/d/2019-17142/p-535.

Given the great uncertainty created by the proposed rule about which benefits are safe to use, and whether family members' use of benefits can be held against an applicant for status, families are likely to take a cautious view and avoid using benefits that could possibly count against them. Such a choice cannot reasonably be described as "irrational," "unpredictable" or "unwarranted." Therefore, DHS must take the likelihood of such choices into account.

Even if deterring immigrants and their families from benefits is not the intent, DHS is required to show that it cannot achieve the goal of implementing its statutory requirements in an alternative way that causes less harm. The proposed rule makes no attempt to do so.

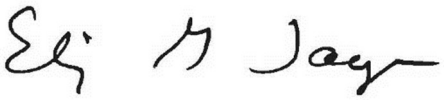
Conclusion

For all the foregoing reasons, DHS should immediately withdraw its current proposal and instead dedicate its efforts to advancing policies consistent with statute and case law that strengthen — rather than undermine — the ability of immigrants to support themselves and their families.

Further, we would like our comment, including any articles, studies, or other supporting materials that we have included in our comment as an active link in the text or in footnotes, to be included as part of the formal administrative record for the proposed rule for the purposes of the federal Administrative Procedure Act. Please let us know if DHS is unable for any reason to meet our request and include our linked materials, so we will have the chance to otherwise submit copies of the supporting documents into the record.

If you have any questions about anything in the comments or the materials, please contact Sarah Grusin, Senior Attorney, grusin@healthlaw.org.

Sincerely,



Elizabeth G. Taylor
Executive Director