December 19, 2025

Submitted via www.regulations.gov

Kristi Noem
Secretary
Department of Homeland Security
2801 Nebraska Avenue NW
Washington, D.C. 20528

Re: "Public Charge Ground of Inadmissibility" Notice of Proposed Rulemaking; CIS No. 2836–25; DHS Docket No. USCIS–2025–0304

Dear Secretary Noem:

Thank you for the opportunity to submit comments on the Department of Homeland Security's (DHS or the Department) "Public Charge Ground of Inadmissibility" Notice of Proposed Rulemaking ("2025 Public Charge NPRM"), **The undersigned organizations oppose the NPRM and urge that DHS not finalize this regulation, as we believe it will cause enormous and permanent harm to individuals with serious, chronic illnesses, including U.S. citizens, their families, and the communities which they live.**

Our organizations represent millions of patients and consumers who face serious, acute, and chronic health conditions. Together, our organizations offer unique and important perspectives on what individuals and families need to prevent disease, cure illness, and manage their health. The diversity of our organizations and the populations we serve enables us to draw upon extensive knowledge and expertise that can be an invaluable resource to the Administration.

In March of 2017, our organizations came together to form the Partnership to Protect Coverage (PPC). Together, we agreed upon three overarching principles[1] to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) health care should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) health care should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) health care must be adequate, meaning healthcare coverage should cover treatments patients need.

U.S. immigration laws allow that individuals going through certain immigration processes can be denied permanent residence or visas if they are deemed to be potential "public charges," defined as individuals likely to become primarily dependent on certain public benefits. In 1999, over a century of public charge policy was compiled in a Field Guidance issued by the Immigration and Naturalization Service (INS; "1999 Field Guidance"). In 2019, DHS finalized and implemented regulations briefly changing the public charge standard, but in 2022, DHS issued regulations ("2022 Public Charge Rules") largely codifying the 1999 Field Guidance. For a quarter of a century, the 1999 Field Guidance has created clear, reliable, and reasonable public charge policy, consistent with a century of public charge policy prior to that as well as Congressional intent. This approach has also ensured consistent and continued access to health care and other services (such as the Supplemental Nutrition Assistance Program (SNAP) or housing assistance) for people living with chronic illnesses. The 2025 Public Charge NPRM would rescind the 2022 Public Charge Rule, and the entire foundation of over a century of public charge policy, replacing it with no effective policy, causing incredible uncertainty and permanent harm for millions of individuals and families living with serious, chronic health conditions.

The 2025 Public Charge NPRM will be harmful to Medicaid enrollees, individuals eligible for Medicaid, and other individuals, particularly those with chronic illnesses.

Impact on Coverage and Access

Current public charge policy is narrow and only considers past use of benefits that are cash assistance or institutional care. This is a sensible policy, since other benefits, such as health coverage, do not provide the income households need to survive. Health coverage is a supplemental benefit that does not obviate the need for families to support themselves, and in fact health care frequently enables families to support themselves. The 2025 Public Charge NPRM would undercut this policy, and instead (as described in the NPRM) allow all benefits, including Medicaid and CHIP, to be counted against immigrants in public charge determinations.

Expanding the applicable benefits set would have irreversible impacts on coverage and access to care. Individuals would realize that any use of health care coverage could be used against them in the future. This would create a disincentive to enroll or seek care, and many individuals would forego care, even medically necessary care. Maintaining a path to permanent residence is incredibly consequential to families with immigrants, and many families would avoid health care.

Consequences for Families and U.S. Citizens

It is critical to understand that this is a policy that will impact families. One quarter of U.S. citizen children have an immigrant parent.[2] The preponderance of "mixed status households," households

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[1] Partnership to Protect Coverage | Patient Advocacy | Consensus Healthcare Reform Principles

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

where members have different immigration statuses, means that entire families will avoid coverage or healthcare services to protect specific individuals within the family. As such, this policy will result in many U.S. citizens losing coverage (as well as lawfully present immigrants that are not impacted by the rule), in addition to the lawfully present immigrants who are targeted for used benefits they are legally eligible for. KFF estimates that 1.3 to 4 million people could disenroll from Medicaid or CHIP, and that nearly half of them would be U.S. citizen children–as many as 1.8 million U.S. citizen children.[3] The Department acknowledges this point in very general terms in the 2025 Public Charge NPRM, but does not calculate or analyze how pervasive this problem will be specifically for U.S. citizens. Therefore, the Department is offering flawed estimates of the impacts which undercount the population of people that could be impacted.[4]

Furthermore, in 2026, new Medicaid and CHIP eligibility standards for immigrants will go into place that restricts coverage to only three groups of immigrants (Legal Permanent Residents, certain Cuban and Haitian entrants, and Compact of Free Association (COFA) migrants). The Department's public charge policy does not impact Legal Permanent Residents. This means that the only groups that could use Medicaid without fear of it impacting a visa application will be a subset of Cuban, Haitian, and COFA migrants– and only the sub-subset of that group which later initiate an immigration process subject to public charge review. This target population of this major change in rules is such a tiny fraction of the immigrant population but may cause 1.8 million citizens who are children, to lose their health coverage.[5]

The policy will have an outsized impact on U.S. citizens and immigrant communities because of the confusion and uncertainty it will provoke. Long-standing policy, including the 1999 Field Guidance and the 2022 Final Rule, draws a bright line to exempt Medicaid services from public charge determination (except some institutional care), to provide clarity and predictability to allow families to make informed decisions. In contrast, the 2025 NPRM broad inclusion of benefits will make families perceive risk everywhere and thus avoid care. According to KFF, three in ten immigrants report that they or a family member have limited their participation in activities outside the home since January 2025 due to concerns about drawing attention to immigration status.[6]

This "chilling effect" was evident in 2019 and the surrounding years when DHS proposed and implemented regulations briefly changing the public charge standard. Although the 2019 regulations provided clearer criteria than the new 2025 NPRM, the resulting uncertainty of those changes significantly reduced coverage and care – even for U.S. citizens. In the years leading up to 2019, use of Medicaid and other public benefits by U.S. citizen children declined more than twice as fast in

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[3] 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/

[4] *Id.*

[5] 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/

[6] Drishti Pillai et al. *KFF/New York Times 2025 Survey of Immigrants: Health and Health Care Experiences During the Second Trump Administration*. KFF, 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/

households with noncitizens (down 20%) as compared to those with only citizens (down 8%).[7] That rate of decline for U.S. citizen children in households with noncitizens (down 18%) more closely resembled the overall rates of decline for non-citizens themselves (down 20%) than citizens (down only 8%).[8]

Based on survey data, in 2019, 15.6 percent of adults in immigrant families, and 31 percent of adults in families where at least one member was not a permanent resident, reported avoiding applying for non-cash benefits, including Medicaid.[9] Of the adults avoiding non-cash benefits because of "green card concerns," nearly half reported avoiding Medicaid or CHIP.[10] The chilling effect even substantially impacted families that would be entirely unimpacted by the 2019 rule; for example, 16.7 percent of families in which all noncitizen members were already permanent residents.[11] The chilling effect was twice as strong for families with children, and 76.8 percent of adults in immigrant families with children did not understand that children's enrollment is not a factor in their parents' public charge determinations.[12]

Evidence consistently shows that health insurance improves health and reduces mortality.[13] Uninsured individuals have worse access to care and affordability and are more likely to not seek medical care until their health deteriorates, requiring more costly intervention and emergency care.[14] Similar findings have been identified specifically for immigrant children.[15] Reducing insurance also impacts non-health issues, such as employment,[16] and Medicaid investments in children leads to four-fold savings for the government.[17]

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[7] Jeanne Batalova, Randy Capps, Michael Fix, *Anticipated 'Chilling Effects' of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families*, Migration Policy Institute, December 21, 2020. https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real.

[8] *Id*.

[9] 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

[10] *Id*.

[11] *Id.*

[12] Jennifer M. Haley, Genevieve M. Kenney, Hamutal Bernstein, and Dulce Gonzalez, *One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019*, Urban Institute, 2020. https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019

[13] Helen Levy and Thomas C. Buchmueller, "The Impact of Health Insurance on Mortality." Annual Review of Public Health, Volume 46, 2025 (2025): 541–50. https://doi.org/10.1146/annurev-publhealth-061022-042335.

[14] K. Robin Yabroff, Jingxuan Zhao, Michael T. Halpern, et al. "Health Insurance Disruptions and Care Access and Affordability in the U.S." American Journal of Preventive Medicine 61, no. 1 (2021): 3–12. https://doi.org/10.1016/j.amepre.2021.02.014.

[15] Christine Percheski and Sharon Bzostek, "Public Health Insurance and Health Care Utilization for Children in Immigrant Families," *Maternal and Child Health Journal* 21, 2017. https://link.springer.com/article/10.1007/s10995-017-2331-y.

[16] Larisa Antonisse and Rachel Garfield, *The Relationship Between Work and Health: Findings from a Literature Review*, KFF, August 7, 2018. https://www.kff.org/medicaid/the-relationship-between-work-and-health-findings-from-a-literature-review/.

[17] Janet Currie & Anna Chorniy, Medicaid and Child Health Insurance Program Improve Child Health and Reduce Poverty But Face Threats, 21(8) Academic Pediatrics S146-53 (2021). https://pubmed.ncbi.nlm.nih.gov/34740422.

The 2025 NPRM threatens to reverse these gains, creating confusion and disruptions that disproportionately harm individuals with serious, chronic illness that we represent. Individuals with chronic illnesses need stable and continuous health care supports to manage their health conditions and achieve optimal health. For example:

- For cancer patients who are mid-treatment, a loss of health care coverage, even if brief, could seriously jeopardize their chance of survival and can be devastating to cancer patients and their families. Mostly recently, the link between disruptions in Medicaid coverage and worsened health outcomes was established among Medicaid-insured children and adolescents with blood cancers. The lack of continuous Medicaid coverage was associated with advanced-stage diagnosis of lymphoma,[18] and poorer survival.[19]
- Delays in the diagnosis or treatment of multiple sclerosis can lead to irreversible damage to the central nervous system, resulting in disease progression and worse prognoses.
- With consistent access to treatment, HIV is a manageable chronic illness and cannot be transmitted to others. But if treatment is interrupted, people with HIV face worsening health, dangerous opportunistic infections, disability, and death. And when people with HIV have detectable viral loads, they may inadvertently transmit HIV to others.
- For a person with cystic fibrosis (CF), delays care or specialized treatment, infections and exacerbations caused by CF can result in irreversible lung damage, respiratory failure, and hospitalization.

These are just a few examples of how disruptions in care for individuals with serious, chronic illness can often lead to permanent, irreversible negative health outcomes.

Unfair Standards and Misaligned Policy

We believe it is unfair and potentially unlawful to punish individuals, as the rule suggests, for *past use* of health care (and other) programs, when using those programs at the time was legal and the individuals reasonably relied on agency policy that it would *not* impact public charge determinations. This is particularly true for individuals with chronic illness who, when using preventive and other disease management services, are following the recommended guidelines of clinicians, patient advocacy organizations, and public patient education campaigns, which urge families to comply with cost-effective preventive treatments. Even the 2018 NPRM and ultimate 2019 Public Charge Final Rule excluded consideration of benefits that were not relevant prior to the effective date of the rule.[20] The 2019 rule clarified that it would not consider past benefits received while an immigrant was in an exempt immigration status or the recipient of a waiver of public charge inadmissibility. These omissions are unreasonable and will jeopardize the health and stability of people with chronic conditions.

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[18] Xinyue Zhang, Sharon M. Castellino, K. Robin Yabroff, Wendy Stock, Shasha Bai, Ann C. Mertens, Joseph Lipscomb, Xu Ji, Health Insurance Continuity Is Associated with Stage at Diagnosis Among Children, Adolescents, and Young Adults Newly Diagnosed with Lymphoma, Blood, Volume 142, Supplement 1, 2023, Page 2390, ISSN 0006-4971, https://doi.org/10.1182/blood-2023-179559.

[19] Ji X, et al. Lacking Health Insurance Continuity Is Associated with Worse Survival Among Children, Adolescents, and Young Adults Newly Diagnosed with Blood Cancer. Abstract presented at AcademyHealth Annual Research Meeting, June 25, 2023.
https://academyhealth.confex.com/academyhealth/2023arm/meetingapp.cgi/Paper/58242

[20] Department of Homeland Security. *Inadmissibility on Public Charge Grounds. August 14, 2019, 84* Federal Register 41292, 41318 (2019 Final Rule). https://www.federalregister.gov/d/2019-17142/p-627.

We also object to two additional features of the 2025 NPRM. First, the NPRM suggests that the final rule will reverse the current policy which only considers the recipient of benefits and does not consider family members' use of benefits. The new rule would therefore punish some individuals for other family members' use of benefits. Such a policy will substantially worsen the disruption to enrollment and health care for mixed status families, and for example, result in many children not enrolling in or using care, out of fear of impacts on their family members. Such a policy will be particularly harmful to the families with chronic illnesses that we represent.

Second, the 2025 NPRM also proposes to overturn the long-standing definition of public charge, which impacts only individuals who are found to be "primarily dependent" on public benefits. Instead, the rule would apply to any use of public benefits. In the first instance, this is problematic because, if all benefits can be considered in a profoundly subjective calculation, there is no clear or predictable standard for families to base their behavior around. More importantly, it also completely disregards the reality of life for low- and middle-class families in this country. Nearly half of children in the U.S. are covered by Medicaid and CHIP. These families are not "public charges." They are largely working families that rely on public benefits that supplement their earned incomes. For example, in many states, children in families with incomes greater than three times the federal poverty level are eligible for Medicaid and CHIP, and in all but one state children over twice the poverty level are covered.[21] Three times the poverty level for a family of four is $96,450;[22] this is indisputably coverage designed to support working families. Furthermore, health care, unlike cash assistance, does not pay the rent. In fact, for many individuals with chronic health conditions, health care services allow them to maintain a level of functionality that enables them to work. The long-standing policy focusing only on primary dependence is the only standard that is reasonable, particularly for the individuals we represent.

The 2025 Public Charge NPRM Undermines Effective Public Charge Standards

Lack of Clear Standards and Guidance

The 2025 Public Charge NPRM is deeply flawed and poses significant risks to enrollees, particularly those with chronic illness. Public charge policy has always required clear, predictable standards, yet DHS's proposal dismantles more than a century of consistent policy—including 25 years of effective formal rules—without providing a workable alternative. In contrast, the 2022 Final Rule currently in effect reflects a carefully constructed approach, developed through an exhaustive notice-and-comment process and refined based on broad stakeholder input.

Once the NPRM is effective, there will be no standards in place (except for limited provisions related to bonds). This is unacceptable. Families will have no idea what consequences attach to the critical health care decisions they need to make. Our organizations will have no basis to advise communities with serious, or complex chronic illness on how and when to seek care and other supports. Immigration officers will have no standards to help them implement the public charge policy. As the 2025 NPRM itself

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[21] KFF, "Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level," 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.

[22] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)," https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf.

notes, the lack of standards prior to 1999 led to great dissatisfaction with impacts on health care and other social services. As explained by the INS in 1999:

> [T]he Service has been contacted by many State and local officials, Members of Congress, immigrant assistance organizations, and health care providers who are unable to give reliable guidance to their constituents and clients on this issue. According to Federal and State benefit granting agencies, this growing confusion is creating significant, negative public health consequences across the country. This situation is becoming particularly acute with respect to the provision of emergency and other medical assistance, children's immunizations, and basic nutrition programs, as well as the treatment of communicable diseases. Immigrants' fears of obtaining these necessary medical and other benefits are not only causing them considerable harm, but are also jeopardizing the general public. … Concern over the public charge issue is further preventing aliens from applying for available supplemental benefits, such as child care and transportation vouchers, that are designed to aid individuals in gaining and maintaining employment. In short, the absence of a clear public charge definition is undermining the Government's policies of increasing access to health care and helping people to become self-sufficient.[23]

DHS's present action would upend the carefully crafted policy that has brought stability over the last 25 years, returning the country to the state of chaos and confusion that was purposefully addressed through policy guidance in 1999.

Specifically, the 2025 NPRM claims that the 2022 Final Rule hindered "DHS's ability to make accurate, precise, and reliable determinations of whether certain aliens are likely at any time to become a public charge." In reality, eliminating regulatory standards will do the opposite – leaving officers without clear criteria will lead to decisions that are less accurate, precise, and reliable. It is not tenable to argue that removing uniform standards will increase consistency with standards. We are also concerned that without clear criteria, officers may lapse into considering improper and even discriminatory factors when making public charge assessments. Moreover, the proposed rule would remove the requirement in the current regulations that officers include in their denial of admission a specific articulation of the reasons for the determination and the factors that were considered, a requirement which itself promotes accuracy, precision, and reliability in decisions. The proposed rule repeatedly emphasizes the importance of allowing immigration officers to make decisions based on their subjective opinions. However, the relevant statutory language references the opinion of the Attorney General at the time of application for admission or adjustment of status. This conflicts with the Department's stated intent for precision and reliability and the statutory framework.

Entirely eliminating the current system leaves families, health providers, state and local governments, and immigration officers with a slippery slope that could implicate an impossibly large array of government programs and functions. Even the 2019 Final Rule set outer limits on the reach of this policy, clarifying that the policy would not reach "benefits related exclusively to emergency response,

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[23] Department of Justice, *Inadmissibility and Deportability on Public Charge Grounds,* May 26, 1999. 64 Federal Register, 28676 (1999 NPRM). https://www.govinfo.gov/content/pkg/FR-1999-05-26/pdf/99-13188.pdf. (Note: the content of this proposed rule was the same as the field guidance, but it was never finalized as a rule.)

immunization, education, or social services."[24] The 2025 NPRM includes no such guardrail to prevent the policy from reaching every governmental function in this country.

Procedural and Practical Challenges
We are also concerned about DHS' plan, as stated in the NPRM, to issue future policy through subregulatory guidance rather than formal rulemaking, leaving no standard in place until then, and introducing new ones without public input. This approach may circumvent the Administrative Procedure Act requirements and prevents stakeholders from commenting on how these standards could affect families with serious, chronic conditions

Along with families, health care providers, and social services, our organizations have relied on long-settled public charge policy to advise patients for a quarter-century. The Department's proposed rule would, with great unfairness to families, upend the stable government policies that our organizations depend upon to do our job: help patients with chronic illnesses.

Ineffective Targeting
Finally, we believe that the Department should not finalize the 2025 Public Charge NPRM because the rule delivers almost no measurable benefit. Instead, it may cause permanent harm on families in the U.S. – including millions of citizens and lawfully present immigrants and up to 1.8 million U.S. citizen children. Considering the minimal set of immigrants eligible for Medicaid starting in 2026, and the subset of them that would actually be impacted by the public charge policy, this policy would have a negligible impact on the number of immigrants who cease to immigrate based on incentives. The stated objective of the new policy is to "ensur[e] self-sufficiency and minimiz[e] the incentive to immigrate based on the U.S. social safety net." As we have discussed earlier, use of health care services does not impede self-sufficiency, nor obviate the need for families to work, and in fact health care helps many families be self-sufficient.

Conclusion
As such, **we strongly urge the Department to withdraw the 2025 Public Charge NPRM.** If DHS proceeds with this regulation despite our recommendation, it must incorporate changes to mitigate significant risks it poses to families and individuals, including (1) excluding Medicaid and other health programs from consideration; (2) not considering past use of such benefits and not considering use of any benefits prior to implementation of the new rule; (3) not considering family member use of benefits, (4) not reversing the long-standing definition considering only evidence of primary dependence on public benefits; and (5) providing public notice and comment periods for any new substantive standards.

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Thank you for the opportunity to provide these comments. If you have any questions, please contact Theresa Alban at the Cystic Fibrosis Foundation at talban@cff.org.

Sincerely,

AiArthritis
American Cancer Society Cancer Action Network

[24] Department of Homeland Security, "*Inadmissibility on Public Charge Grounds," August 14, 2019, 84* Federal Register 41292, 41312, https://www.federalregister.gov/d/2019-17142/p-627.

American Heart Association
American Lung Association
Blood Cancer United, formerly The Leukemia & Lymphoma Society
Cancer Nation
Coalition for Hemophilia B
Cystic Fibrosis Foundation
Diabetes Patient Advocacy Coalition
Epilepsy Foundation of America
Family Voices National
Hemophilia Federation of America
Legal Action Center
Lutheran Services in America
March of Dimes
Muscular Dystrophy Association
National Bleeding Disorders Foundation
National Health Council
National Kidney Foundation
National Multiple Sclerosis Society
National Patient Advocate Foundation
Pulmonary Hypertension Association
The AIDS Institute