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Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

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VIA ELECTRONIC SUBMISSION

U.S. Citizenship and Immigration Services
Department of Homeland Security
5900 Capital Gateway Drive
Camp Springs, MD 20746

Attention: DHS Docket No. USCIS-2025-0304, RIN 1615-AD06
Notice of Proposed Rulemaking: Public Charge Ground of Inadmissibility

Dear Sir/Madam:

Thank you for the opportunity to comment on DHS Docket No. USCIS-2025-0304, "Public Charge Ground of Inadmissibility" (hereinafter referred to as "the NPRM").

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for children and families. As part of the McCourt School of Public Policy, CCF provides research, develops strategies, and offers solutions to improve the health of children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA).

Our comments include numerous citations to supporting research for the benefit of the Department of Homeland Security (DHS) and U.S. Citizenship and Immigration Services (USCIS) (hereinafter referred to collectively as "DHS"). We direct DHS to each of the studies cited and made available through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the formal administrative record on this NPRM for purposes of the Administrative Procedures Act.

I. Summary

The NPRM would eliminate a century of established policy, carefully calibrated to address policy issues and undefined terms in the law, without offering a reasoned policy alternative. In so doing, the NPRM would cause considerable harm to children and families, especially the one-in-four U.S. children who live in mixed status households (a household

with at least one noncitizen), the vast majority of whom are U.S. citizens.[1] The predictable harm that would stem from the NPRM includes considerable health insurance coverage losses, jeopardizing the well-being of millions of children, primarily citizen children, as outlined in detail below. The cost-benefit analysis (CBA) in the NPRM contains several methodological and conceptual flaws that undermine the validity of its conclusions. Research suggests that there will be much greater harm if the NPRM is finalized than the CBA lays out, primarily impacting U.S. citizen children. By rescinding the 2022 final rule Public Charge Ground of Inadmissibility" (hereinafter referred to as "the 2022 final rule"), the NPRM would undo longstanding public charge policy and undermine the reliance interests of immigrant families and their communities.[2] Families would be forced to make painful decisions as they try to predict how the rules may change in the future, including forgoing needed health coverage and other benefits for their U.S. citizen children out of confusion, fear, and an abundance of caution. There is no justification to put the health and well-being of so many children and families at risk, including U.S. citizen children.

DHS should withdraw the NPRM and leave the current regulations, as finalized in 2022, in effect.

II. Detailed Comments

A. The NPRM would eliminate decades of well-established public charge inadmissibility test guidelines.

By proposing to rescind the 2022 final rule, the NPRM would undo longstanding public charge policy.[3] The 2022 final rule codified over a century of public charge inadmissibility test guidelines. It did so by closely mirroring guidance issued in 1999 (known as the 1999 Field Guidance), which itself tracked decades of public charge policy.[4] Immigrant communities (and a wide range of health and social services stakeholders) have relied on these well-established standards as they navigate the lengthy process to immigrate to the U.S. or adjust their status to lawful permanent resident (LPR). The NPRM, on the other hand, proposes to rescind those rules, without offering a reasoned policy alternative. Individuals subject to public charge inadmissibility tests will be left confused, but the harms will extend far beyond those subject to public charge inadmissibility tests, as the NPRM itself recognizes (90 Fed. Reg. 52207, November 19, 2025).

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[1] D. Pillai, A. Pillai, and S. Artiga, "Children of Immigrants: Key Facts on Health Coverage and Care" (KFF: January 15, 2025), available at https://www.kff.org/racial-equity-and-health-policy/children-of-immigrants-key-facts-on-health-coverage-and-care/.

[2] "Public Charge Ground of Inadmissibility," *Federal Register* 87: 55472-55639 (September 9, 2022), available at https://www.federalregister.gov/documents/2022/09/09/2022-18867/public-charge-ground-of-inadmissibility.

[3] 87 *Fed. Reg.* 55472-55639 (September 9, 2022) op. cit.

[4] "Field Guidance on Deportability and Inadmissibility on Public Charge Grounds" *Federal Register* 64: 28689-28693 (March 26, 1999), available at https://www.federalregister.gov/documents/1999/05/26/99-13202/field-guidance-on-deportability-and-inadmissibility-on-public-charge-grounds.

B. Uncertainty and fear created by the rule will cause significant harm to children and families including citizen children.

1. The proposed rule will cause the child uninsured rate in the United States to rise as a consequence of the "chilling effect."

CCF monitors the rate and sources of children's coverage very closely. Each year, since 2011, CCF has released a widely cited annual report that analyzes data related to children's health insurance status from the Census Bureau's American Community Survey (ACS) for the U.S. overall and all 50 states and the District of Columbia.[5] Joan Alker has been the lead author on this report since its inception.

CCF has also been actively tracking Medicaid enrollment trends at the national and state levels, especially in the context of the end of the COVID-19 continuous coverage rules and the subsequent "unwinding" of enrollment protections. CCF maintains enrollment trackers that show monthly changes in total Medicaid enrollment and child Medicaid enrollment by state using Centers for Medicare & Medicaid Services (CMS) enrollment data and state-reported administrative data.[6] Years of tracking these data reveal a logical but often overlooked connection – when Medicaid and CHIP enrollment decline, the child uninsured rate goes up. Unfortunately, the rate of uninsured children is already on the rise, increasing from 5.1 percent in 2022 to 6 percent in 2024.[7]

It is indisputable that the NPRM will cause children to disenroll from Medicaid and CHIP. As discussed in more detail below, the methodology used by DHS to estimate these enrollment declines is flawed and results in a significant underestimate of the rule's true impact. However, the NPRM acknowledges the presence of a so-called "chilling effect," or disenrollment and forgone enrollment among a broader group of individuals living in immigrant families than those subject to public charge determinations, by writing: "the transfers estimated in this analysis relate predominantly to enrollment decisions made by those *who are not subject to the public charge ground of inadmissibility*" (90 Fed. Reg. 52208, November 19, 2025, emphasis added). Despite acknowledging the chilling effect, the NPRM makes scant mention of the fact that *citizen children* are the most likely to be harmed. Nevertheless, the NPRM establishes this important principle: **children, and primarily citizen children, will lose Medicaid and CHIP coverage as a consequence of its finalization.**

[5] Copies of all of our annual reports are available on our website at "Children's Health Coverage" (Georgetown University Center for Children and Families), available at https://ccf.georgetown.edu/subtopic/childrens-health-coverage/.

[6] Georgetown University Center For Children and Families, "What is happening with Medicaid renewals in each state?" available at https://ccf.georgetown.edu/2023/07/14/whats-happening-with-medicaid-renewals/; Georgetown University Center For Children and Families, "What is the impact of unwinding on Medicaid enrollment?" available at https://ccf.georgetown.edu/unwinding-enrollment-data/.

[7] J. Alker and Y. Yafimenka, "U.S. and State-by-State Child Health Coverage Trends" (Georgetown University Center for Children and Families: September 12, 2025), available at https://ccf.georgetown.edu/2025/09/12/u-s-and-state-by-state-child-health-coverage-trends/.

2. The impact of the rule could be severe, with the number of uninsured (primarily citizen) children in the U.S. increasing by more than 25 percent. This will lead to a range of social and economic harms that are completely overlooked in the proposed rule.

Recent analysis from KFF underscores that changes to public charge policy risk significant chilling effects that extend beyond the individuals directly subject to a public charge determination**.** Using ACS 2023 data, KFF estimates that about 13.4 million Medicaid/CHIP enrollees live in households with at least one noncitizen, including 5.9 million U.S. citizen children, who may experience decreased enrollment due to fear or misunderstanding of the rule. Under modeled disenrollment scenarios of 10 to 30 percent, between 1.3 and 4.0 million individuals could lose coverage, including from 600,000 up to 1.8 million citizen children.[8] In 2024 there were 4.6 million uninsured children in the United States.[9] If an additional 1.2 million citizen children become uninsured – the middle of KFF's estimated range based on a 20 percent disenrollment rate – that would *increase the number of uninsured children in the U.S. by more than 25 percent.*

Taking Medicaid away from eligible children is shortsighted from a national economic and fiscal perspective. The Congressional Budget Office (CBO) finds that Medicaid coverage during childhood has long-term economic and fiscal benefits for society and the U.S.'s fiscal and economic future, primarily by increasing adult earnings. CBO estimates that one additional year of childhood Medicaid enrollment raises adult earnings by about 0.5 percent on average, with larger gains for younger and lower-income children. These higher lifetime earnings generate additional federal tax revenue and reduce transfer payments. Using Treasury discount rates, the long-term fiscal gains average about $3,400 per child, offsetting nearly 200 percent of the upfront cost of providing an additional year of Medicaid (about $1,700 per child). In contrast, *policies reducing children's Medicaid coverage would lower future earnings and increase long-term deficits by $3,600 to $4,600 per child.* Most fiscal benefits accrue far in the future, taking 35-38 years to fully offset upfront program costs.[10]

3. The proposed rule fails to document the many harms that occur to children when they are uninsured in both the short and the long terms.

The NPRM acknowledges that it may cause families financial harm, but states that the benefits of the NPRM justify the impact on families: "DHS has determined that the rule may decrease disposable income and increase the poverty of certain families and children, including *U.S. citizen children*. DHS continues to believe that the benefits of the action justify the financial impact on the family." (90 Fed. Reg. 52221, November 19, 2025, emphasis

[8] S. Artiga et al., "Potential 'Chilling Effects' of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment" (KFF: December 2, 2025), available at https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/.
[9] Alker and Yafimenka, op. cit.
[10] E. Ash et al., "Exploring the Effects of Medicaid During Childhood on the Economy and the Budget" (Congressional Budget Office: November 2023), available at https://www.cbo.gov/system/files/2023-10/59231-Medicaid.pdf.

added.) This interpretation ignores the very far-reaching negative consequences that accrue to children, their family, and society at large when children are uninsured.

For most low and moderate wage working families, access to affordable health insurance for their children is simply out of reach if the child does not have access to Medicaid or CHIP. Family premiums for employer-sponsored insurance rose six percent in 2025 to a record high of $26,993 with workers contributing on average $6,850 annually.[11] Access to Medicaid and CHIP are essential given the paucity of affordable dependent coverage and the rising costs of health care.

For children, access to Medicaid confers a range of benefits that relate to improved health, educational and economic outcomes. These include lower rates of asthma,[12] better access to primary care and ability to fulfill prescriptions,[13] higher high school graduation rates, and improved health as adults.[14] These harms will primarily impact citizen children.

Finally, a rise in the number of uninsured children also increases burdens on providers who serve them including pediatricians and pediatric nurse practitioners, community health centers, pediatric specialists and hospital emergency and urgent care facilities. The NPRM acknowledges these impacts as "downstream effects" of the proposed rule, listing such harms as "worse health outcomes… increased use of emergency rooms… higher prevalence of communicable diseases… increased rates of uncompensated care… [and] lower revenues for healthcare providers participating in Medicaid…" without offering any benefits to counter them (90 Fed. Reg. 52218, November 19, 2025). Medicaid providers are already facing historic program cuts of more than $900 billion over ten years as a consequence of the passage of H.R. 1 earlier this year,[15] and this rule would only exacerbate those cuts.

C. The CBA presented in the NPRM to rescind the 2022 final rule contains several methodological and conceptual flaws that undermine the validity of its conclusions.

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[11] KFF, "Annual Family Premiums for Employer Coverage Rise 6% in 2025, Nearing $27,000, with Workers Paying $6,850 Toward Premiums Out of Their Paychecks" (KFF: October 22, 2025), available at https://www.kff.org/affordable-care-act/annual-family-premiums-for-employer-coverage-rise-6-in-2025-nearing-27000-with-workers-paying-6850-toward-premiums-out-of-their-paychecks/.

[12] O. Thompson, "The long-term health impacts of Medicaid and CHIP," *Journal of Health Economics*, 51 (January 2017):26-40, available at https://pubmed.ncbi.nlm.nih.gov/28040620/.

[13] E. Williams and R. Rudowitz, "Medicaid and Children's Health: 5 Issues to Watch Amid Recent Federal Changes" (KFF: October 15, 2025), available at https://www.kff.org/medicaid/medicaid-and-childrens-health-5-issues-to-watch-amid-recent-federal-changes/.

[14] A summary of peer-reviewed literature is available at E. Park, J. Alker, and A. Corcoran, "Jeopardizing A Sound Investment: Why Short-term Cuts to Medicaid During Pregnancy and Childhood Could Result in Long Term Harm" (The Commonwealth Fund: December 2020), available at https://www.commonwealthfund.org/sites/default/files/2020-12/Park_Medicaid_short_term_cuts_long-term-effects_ib_v2.pdf.

[15] Congressional Budget Office, "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline" (Congressional Budget Office: July 21, 2025), available at https://www.cbo.gov/publication/61570.

1. DHS highlights reduced public benefits program spending but does not analyze what families would lose as a result, even though those losses are economically meaningful and would fall heavily on low-income families, including those with citizen children.

DHS emphasizes reductions in Medicaid, SNAP and other public benefit payments as major "impacts" of the proposed rule. Under the standard economic practice and OMB Circular A-4, reductions in transfer payments do not by themselves represent net social benefits or costs and should be accompanied by an assessment of their distributional effects. However, the rule does not attempt to quantify household welfare loss, health impacts, increased uncompensated care or child poverty effects, even though DHS acknowledges these harms qualitatively elsewhere. The CBA therefore presents an incomplete and potentially misleading picture of the NPRM's true economic consequences treating lower enrollment and lower spending on low-income families as a positive effect of the rule without assessing the associated losses to low-income families, including those with U.S. citizen children.[16]

2. DHS's approach to estimate the number of immigrants who receive public benefits is not statistically valid and produces unreliable estimates.

Specifically, the methodology assumes random distribution of beneficiaries across households, equates person-level immigrant shares with household-level probabilities and treats all members of immigrant households as foreign-born benefit recipients, none of which is statistically or demographically valid. The resulting estimate does not reflect actual immigrant benefit participation. A more appropriate approach would rely on person- or household-level microdata to directly identify households with immigrant members and observed receipt of public benefits, rather than applying population averages and scaling assumptions.

[16] Office of Management and Budget, "Circular A-4" (Office of Management and Budget: September 17, 2003), available at https://obamawhitehouse.archives.gov/node/15644. OMB Circular A-4 (2003) states that "Transfer payments are monetary payments from one group to another that do not affect total resources available to society" and therefore "You should not include transfers in the estimates of the benefits and costs of a regulation. Instead, address them in a separate discussion of the regulation's distributional effects."

3. While DHS includes a wide range of potential disenrollment rates (3.3, 10.3 and 17.3 percent) and acknowledges substantial uncertainty around these estimates, the analysis relies on program-wide assumptions that may underestimate forgone enrollment.

Recent evidence indicates that chilling effects may be larger than DHS's scenarios suggest, particularly among mixed-status families and other groups not fully captured in the underlying modeling. Survey evidence from the Urban Institute and KFF/New York Times documents widespread and growing avoidance of health and other safety net programs due to immigration-related fears. Between 2023 and 2025, the number of parents who avoided applying for benefit programs (health, food, housing) for fear of drawing attention to their or family members' immigration status rose from 11 to 18 percent and from 27 to 46 percent among likely undocumented immigrants. Nearly one in five parents (17 percent) have stopped participating in such programs as of January 2025. Similarly, the Urban Institute estimates show that nearly one quarter of adults in mixed-status families avoided programs such as Medicaid, SNAP, or housing assistance, fearing it could jeopardize their green card applications, with avoidance rates among adults in immigrant families with children roughly double those without children (15.7 vs. 7.5 percent). This evidence suggests that DHS's modeled disenrollment rates underestimate the magnitude and distribution of chilling effects associated with the proposed rule.[17,18]

4. DHS excludes Medicaid child enrollment from the modeled disenrollment base (see notes in Table VI.8 and footnote 170, 90 Fed. Reg. 52209-52211, November 19, 2025) and understates forgone Medicaid enrollment and associated long-term social costs.

The analysis only considers adult Medicaid disenrollment and then scales these to households. This approach omits Medicaid enrollees among U.S.-citizen children in mixed-status families enrolled who have a high documented chilling effect and does not account for important structural differences between adults and children. Children are more likely to be eligible for and enrolled in Medicaid/CHIP due to higher income thresholds, and they are far more likely to be U.S. citizens even in households with noncitizen adults. The median state income eligibility level for children in Medicaid and CHIP is 255 percent of the

[17] D. Pillai et al., "KFF/New York Times 2025 Survey of Immigrants: Health and Health Care Experiences During the Second Trump Administration" (KFF: November 18, 2025), available at https://www.kff.org/immigrant-health/kff-new-york-times-2025-survey-of-immigrants-health-and-health-care-experiences-during-the-second-trump-administration/.

[18] D. Gonzalez et al., "Mixed-Status Families and Immigrant Families with Children Continued Avoiding Safety Net Programs in 2023" (Urban Institute: August 7, 2024), available at https://www.urban.org/research/publication/mixed-status-families-and-immigrant-families-children-continued-avoiding.

federal poverty level whereas for adults it is 138 percent of the poverty level (for states that have adopted the ACA's Medicaid expansion) and considerably lower (29 percent of the poverty level) in the ten states that have not.[19] One in four children lives in a mixed-status family and the vast majority of these children are citizens. Only 3 percent are noncitizen children. Therefore, the analysis understates forgone Medicaid enrollment, which would largely impact U.S. citizen children and associated long-term social costs.[20,21]

5. The CBA quantifies fiscal transfer reductions but treats downstream harms such as adverse public health outcomes, community-level economic instability, and disproportionate effects on U.S.-citizen children in mixed-status households only qualitatively, despite the availability of empirical data.

DHS acknowledges that prior public charge policies generated measurable administrative costs, including churn-related reprocessing, translation needs and caseworker training, yet these costs are excluded from the quantified analysis. At the same time, because Medicaid and SNAP eligibility changes under H.R. 1[22] are occurring simultaneously, DHS cannot isolate the causal effect of the proposed rule, adding additional uncertainty. These omissions potentially lead to an asymmetrical and underestimated assessment of the true social and administrative costs of this rule.

6. The CBA applies inconsistent valuation approaches across public benefit programs.

DHS uses median per-capita costs to estimate Medicaid impacts and average annual per-recipient payments for other programs, without explaining why CHIP, despite comparable state-level variation, is not treated similarly. Additionally, table VI.10 appears to rely on a more precise disenrollment rate (10.29 percent) than the rounded 10.3 percent figure presented in the text, suggesting internal rounding discrepancies (90 Fed. Reg. 52214, November 19, 2025). DHS further applies a uniform 59 percent FMAP to both Medicaid and

[19] See Appendix Tables 1 and 5 at T. Brooks et al., "Medicaid and CHIP Eligibility, Enrollment and Renewal Policies as States Resume Routine Operations" (KFF and the Georgetown University Center for Children and Families: April 1, 2025), available at 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.
[20] J. Haley et al., "Assessing Health Care Access among Medicaid/CHIP-Enrolled Children: A National Chartbook, 2016–19" (Urban Institute: April 6, 2023), available at https://www.urban.org/research/publication/assessing-health-care-access-among-medicaidchip-enrolled-children.
[21] S. Artiga et al., op. cit.
[22] "H.R. 1 - An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14." P.L. 119-21, 139 *Stat* 72 (2025), available at https://www.congress.gov/bill/119th-congress/house-bill/1/text.

CHIP, even though CHIP's federal matching rate is substantially higher under statute. This approach likely distorts the distribution of costs between the federal government and state governments and introduces bias into the estimated reductions in transfer payments.

7. DHS misinterprets the KFF estimate by describing affected individuals as "alien" Medicaid and CHIP enrollees.

The original KFF analysis refers to "noncitizens or citizens living in a family with a noncitizen," meaning the estimate includes U.S.-citizen children in mixed-status households who are not aliens under the Immigration and Nationality Act definition. This mischaracterization narrows the group and obscures the documented chilling effects on eligible U.S.-citizen children. Moreover, the hyperlink DHS provided in footnote 163 does not contain this estimate, the figure is located in the separate KFF analysis cited in footnote 162.[23,24,25]

D. The NPRM would create an unworkable system for people seeking admission to the U.S. or adjustment of status to LPR.

1. The NPRM is poorly targeted because very few immigrants are eligible for Medicaid/CHIP, especially following implementation of new eligibility restrictions in 2026, and yet hundreds of thousands to millions of people will lose health coverage.

Under current law, only "qualified immigrants" are eligible for Medicaid/CHIP, and many such immigrants are subject to a five-year waiting period prior to gaining eligibility. However, H.R. 1 included new eligibility restrictions that will take effect on October 1, 2026. Under H.R. 1, only three categories of immigrants will be eligible for Medicaid/CHIP: (1) LPRs, (2) certain Cuban/Haitian migrants, and (3) people from the Marshall Islands, Federated States of Micronesia (FSM), and Palau who live in the U.S. under the Compact of

[23] "Public Charge Ground of Inadmissibility," *Federal Register* 90: 52168-52224 (November 19, 2025), available at https://www.federalregister.gov/documents/2025/11/19/2025-20278/public-charge-ground-of-inadmissibility (page 52209): "These fears led to significant disenrollment, with an estimated 2.0 to 4.7 million alien Medicaid and CHIP enrollees opting out (disenrollment rates of 15 percent to 35 percent). Many families reported confusion about the 2022 rule changes or concerns about future changes to the public charge rule, prompting them to forgo services."

[24] D. Pillai and S. Artiga, "2022 Changes to the Public Charge Inadmissibility Rule and the Implications for Health Care" (KFF: May 5, 2022), available at https://www.kff.org/racial-equity-and-health-policy/2022-changes-to-the-public-charge-inadmissibility-rule-and-the-implications-for-health-care/: "Prior KFF analysis estimated that the rule could lead to disenrollment of between 2.0 to 4.7 million Medicaid and CHIP enrollees who are noncitizens or citizens living in a family with a noncitizen if the rule led to disenrollment rates ranging from 15% to 35%."

[25] *8 U.S.C. § 1101*, available at https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title8-section1101&num=0&edition=prelim.

Free Association (often referred to as COFA migrants).[26] The first group, LPRs, is the largest but LPRs are not subject to the public charge test of inadmissibility. The next two groups, Cuban, Haitian, and COFA migrants may be eligible for Medicaid/CHIP and subject to a public charge test of inadmissibility. The only other groups potentially impacted are lawfully residing children and pregnant women eligible for Medicaid/CHIP at state option (through either the ICHIA/CHIPRA 214 option or the CHIP FCEP option).[27] Though estimates of the size of the population eligible for Medicaid/CHIP and subject to a public charge test of inadmissibility are not available, it is clearly small. And yet, the impact of the NPRM is large – potentially increasing the number of uninsured children by 25 percent as explained above. *This underscores that the NPRM is overly broad and poorly targeted.*

2. The NPRM would remove needed guardrails, creating an unworkable system prone to inconsistency.

Under the rules finalized in 2022, immigration officers must consider whether an applicant is likely to become a public charge under the totality of the circumstances test. DHS considers the statutory factors (age; health; family status; assets, resources, and financial status; and education and skills), the affidavit of support (when required), and current and/or past use of cash assistance or long-term institutional care at government expense. This test allows for officer discretion to weigh each of the clearly defined factors to assess whether the applicant is likely at any time to become primarily dependent on the government for subsistence. All of the components are considered together and no single component can dictate the outcome (except if a required affidavit of support is missing or insufficient).[28] Under the NPRM, the statutory factors would remain, along with consideration of the affidavit of support (when required), but all guidance around whether and how to consider current or past use of benefits is removed in favor of complete officer discretion. Immigration officers, who are not experts in benefit programs, could consider any and all benefit use including federal, state, and local programs regardless of how long such benefits were used, when, or what level of support they provided.

DHS writes that rescinding the 2022 final rule, "would allow DHS to more accurately, precisely, and reliably assess public charge inadmissibility," when in fact, the opposite is true (90 Fed. Reg. 52195, November 19, 2025). *Such wide discretion creates the opportunity for bias to influence decision making and the risk of different outcomes for similarly situated*

[26] "H.R. 1 - An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14." P.L. 119-21, Sec. 71109, 139 *Stat* 72 (2025), available at https://www.congress.gov/bill/119th-congress/house-bill/1/text.
[27] See Appendix Tables 3 and 4 at T. Brooks et al. op. cit..
[28] K. Whitener, "Restoring the Public Charge Policy" (Georgetown University Center for Children and Families: October 2022), available at https://ccf.georgetown.edu/wp-content/uploads/2022/10/Public-Charge-Final.pdf.

individuals with the same history of benefit use. This kind of inconsistency would make it impossible for applicants to learn the rules and comply, leading instead to broad avoidance of benefit programs, among a much larger group of people than those subject to the test, out of an abundance of caution. As noted above, avoiding benefit programs such as Medicaid and CHIP has lifelong, harmful consequences, especially for children.

3. The NPRM unreasonably proposes rescinding key definitions and replacing them with subregulatory guidance at a future date, circumventing the notice and comment rulemaking process and in blatant disregard for the reliance interests of applicants.

The current public charge rules include the following definition: "*likely at any time to become a public charge* means likely at any time to become primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or long-term institutionalization at government expense."[29] The *primarily dependent* standard is important because it distinguishes supplemental benefit use from true dependence on the government for subsistence. In 2018-2019 when the first Trump Administration proposed and finalized sweeping changes to public charge rules[30] that would have expanded the list of benefits considered (among other changes), researchers found that about half of all U.S.-born citizens would likely be deemed a public charge if the new definition were applied to them.[31] This reflects the reality that even highly productive, working families need help making ends meet in today's economy. The NPRM would allow for even broader benefit use considerations than the 2019 final rule, even though such benefit use does not actually indicate dependence. The long-standing policy focusing only on *primary dependence* is the only standard that is reasonable.

Moreover, the NPRM says that, "DHS intends, after the removal of these regulations, to formulate appropriate *policy and interpretive tools* that will guide public charge inadmissibility determinations…" (90 Fed. Reg. 52169, November 19, 2025, emphasis added), alluding to plans to issue subregulatory guidance on public charge determinations without giving the public the opportunity to comment. Among the policy changes from

[29] 42 *C.F.R.* §212.21(a) (2022).
[30] "Inadmissibility on Public Charge Grounds," *Federal Register* 83: 51114-51296 (October 10, 2018), available at https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds; "Inadmissibility on Public Charge Grounds," *Federal Register* 84: 41292-41508 (August 14, 2019), available at https://www.federalregister.gov/documents/2019/08/14/2019-17142/inadmissibility-on-public-charge-grounds.
[31] D. Trisi, "Administration's Public Charge Rules Would Close the Door to U.S. to Immigrants Without Substantial Means" (Center on Budget and Policy Priorities: November 11, 2019), available at https://www.cbpp.org/research/immigration/administrations-public-charge-rules-would-close-the-door-to-us-to-immigrants.

rescinding the 2022 final rule and the foreshadowed guidance there are four particularly harmful concepts, allowing consideration of: (1) benefit applications, (2) benefits used by family members, (3) benefits used while in an exempt category if later applying for adjustment of status via a nonexempt category, and (4) benefits used prior to finalization of new rules. Each of these are discussed in greater detail below, and each would seriously undermine the reliance interest of individuals subject to public charge inadmissibility tests and their family members.

By proposing to rescind the 2022 final rules, DHS explicitly argues in favor of removing the provision that excluded application for an approval or certification to receive public benefits in the future (90 Fed. Reg. 52189-90 regarding rescinding 8 CFR 212.22(a)(3), November 19, 2025). Application for a public benefit simply does not make a person a public charge. People may apply for benefit programs inadvertently; in fact, until recently, certain Medicaid applicants were required to apply for other benefit programs for which they may be eligible (a requirement which mirrored a similar condition for receipt of Supplemental Security Income benefits).[32] *It is a mistake to equate applying for benefits to becoming a public charge.*

Similarly, by proposing to rescind the definition of *receipt* at 8 CFR 212.21(d), DHS also argues in favor of removing clear guidelines that excluded from consideration benefits used by family members. As described above, children are more likely to be eligible for and enrolled in Medicaid and CHIP because the income eligibility levels are higher than for adults, and children are more likely to be citizens, even if they live in a mixed status household. Allowing for consideration of use of Medicaid and CHIP by citizen children when determining the admissibility/adjustment of status of their parents would logically result in parents opting out of Medicaid and CHIP, which would make it harder for those citizen children to get the healthcare services they need in the short term and result in lower economic output for society as a whole in the long term.

In response to comments about the policies regarding application for and receipt of public benefits by family members in the first Trump Administration, DHS wrote, "An alien does not receive a benefit merely by virtue of having applied or been certified for such benefit, and has not received a public benefit if the alien acted not on his or her own behalf but on

[32] See 42 *C.F.R.* 435.608 prior to adoption of the final rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," finalized April 2, 2024 with an effective date for removing the requirements at 42 *C.F.R.* 435.608 of June 2025, available at https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health.

behalf of another person" (84 Fed. Reg. 41334, August 14, 2019).[33] This remains true and yet the NPRM reverses course.

By proposing to rescind 8 CFR 212.22(d), the NPRM would allow consideration of benefits used while in an exempt category if the person is later applying for admission/adjustment of status under a nonexempt category (90 Fed. Reg. 52191, November 19, 2025). This is despite a clear policy to the contrary, finalized in 2022. In the preamble to the 2022 final rule, DHS wrote, "DHS does not believe that the rule requires any further clarification as the language in 8 CFR 212.22(d) is clear, precise, and absolute in stating that DHS will not consider any public benefits received by a noncitizen during periods in which the noncitizen was present in the United States in an immigration category that is exempt from the public charge ground of inadmissibility or for which the noncitizen received a waiver of public charge inadmissibility in a public charge inadmissibility determination. If benefits were received by a noncitizen when they were in one of the exempt categories or categories eligible for an inadmissibility waiver identified in 8 CFR 212.23, USCIS will not consider the benefits they received while in those categories." (87 Fed. Reg. 55574, September 9, 2022).[34] The NPRM would reverse course on this clearly articulated policy, and potentially retroactively as described below.

Finally, the NPRM also suggests that it would allow consideration of benefits used prior to finalization of new rules, meaning that people could be punished for benefit use during a time when such use was lawful and excluded from public charge determinations. In 2018-2019 when the first Trump Administration proposed and finalized sweeping changes to public charge rules, the rules clearly articulated a policy that the new rules would only be forward-looking (84 Fed. Reg. 41321, August 14, 2019).[35] By failing to provide similar assurances, the NPRM exposes people to unfair and potentially unlawful treatment by making the effective date of a new policy retroactive.

The combination of these policies is fundamentally unfair and absurd. People cannot be expected to comply with rules that have not been written.

III. Conclusion

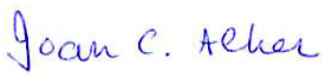
Rescinding the 2022 final rule as proposed by the NPRM would cause significant harm to children and families. The NPRM will undoubtedly cause Medicaid/CHIP enrollment declines, which in turn will increase the number of children without health coverage, jeopardizing their health and wellbeing into adulthood. The NPRM acknowledges these

[33] 84 *Fed. Reg.* 41292-41508 (August 14, 2019) op. cit.
[34] 87 *Fed. Reg.* 55472-55639 (September 9, 2022) op. cit.
[35] 84 *Fed. Reg.* 41292-41508 (August 14, 2019) op. cit.

harmful impacts in passing, but does not adequately address the fact that while the rule is purportedly about immigration status, these harms will fall squarely on U.S. citizen children. The CBA in the NPRM is flawed, grossly underestimating the true impact of the NPRM on Medicaid/CHIP enrollment and ignoring its impact on the health of U.S. citizen children. Rescinding the 2022 final rule without offering a replacement would create an unworkable system for people seeking admission to the U.S. or adjustment of status to LPR, undermining the trust and reliance interests of immigrant families and their communities. Therefore, DHS should withdraw the NPRM and allow the 2022 final rule on the public charge ground of inadmissibility to stand.

If you have any questions about our comments, please contact Joan Alker (joan.alker@georgetown.edu) or Kelly Whitener (kelly.whitener@georgetown.edu).

Sincerely,



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