December 19, 2025

Submitted electronically via regulations.gov

The Honorable Kristi Noem
Secretary of the U.S. Department of Homeland Security
Department of Homeland Security
2707 Martin Luther King Jr Ave., S.E.
Washington, DC 20528-0525

RE: American Public Health Association, Robert Wood Johnson Foundation, and Public Health Deans and Scholars' Comments on Department of Homeland Security "Public Charge Ground of Inadmissibility" (DHS Docket No. USCIS 2025-0304; RIN 1615-AD06)

Dear Secretary Noem:

The American Public Health Association (APHA) and the Robert Wood Johnson Foundation (RWJF), along with 65 public health and health policy deans, chairs, and scholars (in their individual capacities), file this comment on the Department of Homeland Security's (DHS) November 2025 Notice of Proposed Rulemaking (NPRM), which would rescind DHS' 2022 Final Public Charge Rule[1] without any replacement guidance and instead allow immigration officers discretion to consider any public benefit or factor in determining who is likely to become a "public charge."[2] If finalized as proposed, the NPRM would grant immigration officers virtually unchecked authority over public charge determinations, leading to inconsistent, inaccurate, and arbitrary decisions. Such an approach would have a serious chilling effect on use of essential health and public health services, including by legally present immigrants and U.S. citizens in mixed-status households. DHS has proposed this approach without sufficient regard to the significant adverse impact on individual and population health that will result. In addition, DHS' economic impact analysis is flawed and significantly understates the harms arising from the proposed rule. Finally, the proposed rule, if finalized, would violate the law. For these reasons, we urge DHS to withdraw its proposal and leave its 2022 Final Public Charge Rule in place.

APHA is a non-partisan, non-profit organization that champions the health of all people and all communities; strengthens the profession of public health; shares the latest research and information; promotes best practices; and advocates for public health issues and policies grounded in scientific research. APHA represents more than 23,000 individual members and has 52 state and regional affiliates. APHA's membership also includes organizational members, including groups interested in health, state and local health departments, and health-related

[1] 8 C.F.R. § 212.20-§212.23.
[2] 90 *Fed. Reg.* 52168-52224 (Nov. 19, 2025), https://www.federalregister.gov/documents/2025/11/19/2025-20278/public-charge-ground-of-inadmissibility.

businesses. APHA is the only organization that combines a 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

RWJF is a leading national philanthropy dedicated to taking bold leaps to transform health in our lifetime. Through funding, convening, advocacy, and evidence-building, RWJF works side-by-side with communities, practitioners, and institutions to get to health equity faster and pave the way together to a future where health is no longer a privilege, but a right.

The individual signatories are distinguished deans, chairs, and scholars at the nation's leading academic institutions and research universities. They are experts in the fields of health law, public health, health care policy and research, and national health reform. They include individuals known for their expertise in health policy regarding U.S. immigrants, mixed-status families, and the communities in which immigrants and their families live. The individual signatories join this comment in their individual capacities and not as representatives of their respective institutions. The complete list of individual signatories is included at the end of this letter.

I. DHS' proposal to rescind the 2022 Final Rule without replacing it with any guidance to immigration officers will lead to inaccurate, inconsistent, and potentially discriminatory decisions.

DHS proposes to rescind its 2022 Final Public Charge Rule.[3] This rule provides clear and concrete guidance to immigration officers and the public that is consistent with longstanding DHS policy about how to implement the "public charge" provisions in the Immigration and Naturalization Act (INA).[4] DHS does not propose a replacement regulation. Instead, DHS would allow immigration officers to consider any public benefit or factor deemed relevant in their sole discretion. DHS states that it may "in the future, formulate appropriate policy and interpretive tools that will guide DHS officers…."[5]

History of Guidance to Immigration Officers Regarding Public Charge

Congress amended the INA in 1996 to add statutory factors that must be considered in a public charge determination – age; health; family status; assets, resources and financial status; and education and skills – and to allow consideration of an affidavit of support.[6] Congress did not add the use of public benefits by immigrants or their families for which they are eligible as a

[3] 8 C.F.R. §§ 212.20-212.23.
[4] 8 U.S.C. § 1182(a)(4).
[5] 90 *Fed. Reg.* at 52169.
[6] 8 U.S.C. § 1182(a)(4).

factor. Notably, Congress, in a separate statute enacted the same year, explicitly extended certain public benefits to specific categories of legal immigrants.[7]

In 1999, the Immigration and Naturalization Service (INS, the predecessor agency to the U.S. Citizenship and Immigration Services in DHS) issued a Field Guidance on how to apply the new statutory provisions to "ensure the accurate and uniform application of law and policy" and to address "public confusion" about which benefits would be considered as part of a public charge determination.[8] In a companion federal register notice proposing to put the Field Guidance into regulations, INS specifically noted that the confusion was "creating significant, negative public health consequences" especially 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."[9]

To provide clarity, the Field Guidance adopted a definition of "public charge" to mean an immigrant who is likely to become "primarily dependent on the government for subsistence, as demonstrated by either (i) the receipt of public cash assistance for income maintenance or (ii) institutionalization for long-term care at public expense."[10] It directed that "officers should not place any weight on the receipt of non-cash benefits (other than institutionalization) or the receipt of cash benefits for purposes other than income maintenance…"[11] It also established a general rule that receipt of benefits by a member of the applicant's family is not attributable to the applicant for purposes of a public charge determination.[12]

The 1999 Field Guidance was in place for twenty years until the Trump Administration proposed and finalized a new rule in 2019. The 2019 Public Charge Final Rule rescinded the 1999 Field Guidance;[13] significantly expanded the public benefits to be considered in a public charge determination to include Medicaid, the Children's Health Insurance Program (CHIP), federal housing assistance, and the Supplemental Nutrition Assistance Program (SNAP); and added a list of negative and positive factors to guide immigration officers' determinations.[14] The 2019 Final Rule was initially enjoined in litigation; it was briefly in place from 2020 to 2021 before it was vacated by a district court and removed from the Code of Federal Regulations by the Biden Administration in March 2021.[15]

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[7] Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C § 1612.
[8] 64 *Fed. Reg.* 28689, 28689 (May 26, 1999). Note the federal register incorrectly states March 26, 1999 although the Field Guidance was signed on May 20, 1999.
[9] 64 *Fed. Reg.* 28676 (May 26, 1999).
[10] *Id.*
[11] *Id.*
[12] *Id.* at 28692.
[13] 84 *Fed. Reg.* 41292 (Aug. 14, 2019).
[14] *Id.*
[15] 86 *Fed. Reg.* 14221 (Mar. 15, 2021).

DHS then issued a new Final Public Charge Rule in 2022, which is currently in place.[16] As DHS acknowledges in its current NPRM, the 2022 Public Charge Rule "closely aligned with the 1999 Interim Field Guidance,"[17] returning to the longstanding interpretation that public charge means likely to become primarily dependent on the government as demonstrated by receipt of public cash assistance for income maintenance or long-term institutionalization at government expense.[18] The 2022 Rule makes clear that other public benefits, including Medicaid, CHIP, SNAP, housing assistance, and any benefits related to immunizations or testing for communicable diseases, will not be considered, nor will any benefits used by family members.[19]

Eliminating Concrete Guidance Will Lead to More Inaccurate, Inconsistent, and Potentially Discriminatory Decisions by Immigration Officers

DHS now proposes to rescind the substance of the 2022 Final Public Charge Rule. DHS does not propose a replacement regulation, claiming that both the Trump Administration's 2019 Final Rule and the Biden Administration's 2022 Rule impermissibly constrain immigration officers.[20] Instead, DHS proposes to allow officers complete discretion to consider "all evidence and information specific to the alien and relevant to the public charge ground of inadmissibility."[21] The NPRM suggests that this should not only include the public benefits added in the 2019 Final Rule, like Medicaid, SNAP, and housing assistance, but *any* means-tested public benefit without limitation.[22] This complete discretion, without concrete guidance or guardrails other than the statutory language in the INA, will lead to inconsistent, inaccurate, and potentially discriminatory decisions.

DHS acknowledges that it is important to "support accuracy, consistency, and reliability" in individual public charge determinations.[23] But leaving decisions to the sole discretion of immigration officers, without concrete guidance about how to consider the use of specific public benefits or how to weigh certain factors, will lead to the opposite result. For example, one immigration officer might find an individual to be a public charge because her U.S. citizen child was entitled to and used Medicaid for a short period several years ago while another might find that is insufficient to deem that individual a public charge.

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[16] 87 *Fed. Reg.* 55472 (Sept. 9, 2022).
[17] 90 *Fed. Reg.* at 52179.
[18] 8 C.F.R § 212.22(a)(3).
[19] *Id.*
[20] 90 *Fed. Reg.* 52180-81.
[21] 90 *Fed. Reg.* at 51283.
[22] The NPRM states that "the alien's ability to meet his or her needs without depending on *any* public resources, plays a critical role in the outcomes of a public charge inadmissibility determination." 90 *Fed. Reg.* at 52190 (emphasis added).
[23] 90 *Fed. Reg.* at 52193.

Moreover, DHS states that its new approach will "restore an inadmissibility determination process that trusts in and relies on DHS officers' good judgment and sound discretion as envisioned by Congress."[24] An analysis of data, however, shows immigration officers often do not make accurate assessments in public charge determinations, even when they have guidance. Removing all concrete guidance will increase the risk of inaccurate decision-making and make officers' decisions essentially unreviewable.

Independent researchers at George Washington University Milken Institute School of Public Health[25] analyzed visa processing determinations by State Department officials from 2015 to 2024, as recorded in the State Department's annual visa statistics reports.[26] The reports list the grounds for refusal under the INA, including "public charge." Researchers relied on the State Department public charge determinations because DHS does not provide similar public information about its determinations.[27]

Between 2015 and 2024, there were 48,844 findings of public charge, most of which occurred from 2018 to 2020 when the expanded criteria under the 2019 Public Charge Rule were being proposed and in place.[28] The researchers found that over 70 percent of the immigration officers' public charge determinations were dismissed because they were subsequently overcome by evidence, approval of a waiver, or other relief as provided by law.[29] The fact that the vast majority of officers' public charge findings are dismissed is contrary to DHS' bare assertion that officers' assessments will be sound, even without concrete guidance to assist them.

Moreover, rescinding the 2022 Final Rule without any replacement guidance will not only increase the chance of inconsistent or inaccurate decisions but also will significantly limit the ability of public charge decisions to be reviewed or overcome by evidence. The George Washington University Researchers found the high rate of dismissals occurred during periods when concrete and specific, albeit changing, federal guidance about public charge determinations was in place, both before and after the changes in the 2019 Public Charge Rule.[30] Guidance, whether through the 1999 Field Guidance or the 2019 Public Charge Rule, not only assisted immigration officers in their determinations but importantly formed the basis on which officers' decisions could be evaluated to be overcome or dismissed. This issue will be exacerbated by the

[24] *Id.*at 51283.
[25] The analysis was led by Leighton Ku, Ph.D., Professor and Director of the Center for Health Policy Research at the George Washington University Milken Institute School of Public Health, who is also an individual signatory to this comment.
[26] Ku L, Krips M, Silverman H. Economic and Mortality Analyses of the DHS Proposed Rule: Public Charge Ground of Inadmissibility. The George Washington University. December 2025. Appendix 1 at 3.
[27] *Id.*
[28] *Id.*
[29] *Id.* at 4.
[30] *Id.* at 3.

NPRM's withdrawal of the 2022 Rule's explicit requirement that officers include in their denial of admission a specific articulation of the reasons for the determination and the factors that were considered.[31]

Finally, leaving public charge decisions to the sole discretion of immigration officers without any additional concrete and specific guidance could lead to biased and discriminatory decisions. For example, DHS is proposing to remove the language in the 2022 Final Public Charge Rule that prohibits immigration officers from determining an individual is a public charge based solely on a finding that the individual has a disability.[32] DHS acknowledges that its immigration officers are bound by Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of disability, but also states that officers should consider disabilities in their assessments.[33] Without concrete guidance, immigration officers will not know how disability can and cannot be considered in a public charge determination, and immigrants with disabilities will be unable to ensure that decisions about them were not made in a discriminatory and illegal manner. Similarly, unfettered discretion by immigration officers could lead to racially biased and discriminatory decision-making, as has been documented in other federal programs.[34]

II. DHS' proposed rule, if finalized, will create significant confusion and fear, leading to a chilling effect that will cause people, including U.S. citizens and legally present immigrants, to forgo or disenroll from critical health care and public health programs for which they are eligible.

Changes to the public charge rule have a well-documented chilling effect, discouraging the use of public benefits even among legally present immigrants and U.S. citizens. Robust research has documented the widespread confusion and fear that leads many eligible individuals to avoid or disenroll from benefits they need. DHS concedes that the 2019 Final Rule had a significant chilling effect among U.S. citizens and lawful permanent residents, stating that "[t]he 2019 Final Rule described and analyzed expected indirect effects, particularly among populations that were not subject to the 2019 Final Rule such as U.S.-citizen children in mixed-status households, longtime lawful permanent residents, and aliens in a category exempt from public charge considerations."[35]

Indeed, the 2019 Final Rule generated confusion and fear far beyond noncitizen immigrants seeking to adjust their status – causing U.S. citizens and legally-present immigrants to avoid

[31] 90 *Fed. Reg.* at 52190-91.
[32] 90 *Fed. Reg.* at 52188-89.
[33] *Id.* at 52189.
[34] Schram SF, Soss J, Fording RC, Houser L. Deciding to discipline: Race, choice, and punishment at the frontlines of welfare reform. *American Sociological Review*. 2009;74(3):398-422. doi:10.1177/000312240907400304.
[35] 90 *Fed. Reg*. at 52208.

public benefits such as Medicaid, SNAP, or the Supplemental Nutrition Program for Women, Infants, and Children (WIC). The chilling effect from the 2019 Rule caused nearly 20 percent of immigrant households in which all members were permanent residents and 7 percent of households in which all members were citizens to avoid or disenroll from public benefits.[36]

The chilling effect is especially strong in families with children. One in four children in the U.S. (19 million) have an immigrant parent and live in mixed status or all-citizen households. Most of these children are U.S. citizens, with only 3 percent of U.S. children themselves being noncitizens.[37] Following the 2019 Final Rule, 32 percent of low-income immigrant families with children reported avoiding public benefits.[38] While studies have documented a strong chilling effect on children in all-citizen households and mixed status household alike, the effect is nearly twice as strong on children in mixed status households.[39] Between 2016 and 2019, participation in Medicaid and CHIP fell by nearly 10 percent for children in citizen-only households and nearly 20 percent for children in mixed status households.[40] From 2018 to 2019, SNAP enrollment among citizen children in mixed-status households dropped by 23 percent, representing over 718,000 children.[41] Overall, the decline in public program participation was nearly the same for U.S. citizen children in mixed-status households as it was for noncitizens.[42]

[36] Bernstein H, Gonzalez D, Karpman M, Zuckerman S. Amid Confusion Over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019. Urban Institute. Published May 18, 2020. Accessed December 15, 2025. https://www.urban.org/research/publication/amid-confusion-over-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-2019.
[37] Pillai D, Pillai A, Artiga S. Children of Immigrants: Key Facts on Health Coverage and Care. KFF. Published January 15, 2025. Accessed December 15, 2025. https://www.kff.org/racial-equity-and-health-policy/children-of-immigrants-key-facts-on-health-coverage-and-care/.
[38] Haley JM, Kenney GM, Bernstein H, Gonzalez D. One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019. Urban Institute. Published June 18, 2020. Accessed December 15, 2025. https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019.
[39] Capps R, Fix M, Batalova J. Anticipated "Chilling Effects" of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families. Migration Policy Institute. Published December 2020. Accessed August 12, 2025. https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real.
[40] *Id.*
[41] Food Research & Action Center. New Data Reveal Stark Decreases in SNAP Participation Among U.S. Citizen Children Living With a Non-Citizen. FRAC. Published May 2021. Accessed August 12, 2025. https://frac.org/wp-content/uploads/SNAP-Participation-Among-U.S.-Citizen-Children.pdf.
[42] Capps R, Fix M, Batalova J. Anticipated "Chilling Effects" of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families. Migration Policy Institute. Published December 2020. Accessed August 12, 2025. https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real.

Chilling effects were reported across a variety of child benefits, including programs not specified in the 2019 Rule, such as WIC and free or reduced price school lunch.[43] One survey found that over 75 percent of adults in immigrant families with children did not understand that children's program enrollment would not be considered in their parents' public charge determinations.[44] A key lesson from implementation of the 2019 Final Rule is that much of the damage of the public charge rule came not from the actual details of the regulation, but from household-wide avoidance of government benefits and health services out of fear that usage might hurt their families or children.

The chilling effect has similarly impacted the use of public benefits and health services among adults. In 2019, 16 percent of adults in immigrant families reported avoiding applying for non-cash public benefits such as Medicaid, SNAP, or housing subsidies, and this figure rose to 26 percent among low-income immigrant families.[45] Researchers estimated that the chilling effect may have caused as many as 3.2 million people to unenroll from Medicaid and 1.8 million individuals to lose SNAP.[46] Even after the 2019 Rule was rescinded, the chilling effects have lingered; after the revised 2022 Rule was fully in place, 12 percent of adults in all immigrant families and 24 percent of adults in mixed immigration-status families reported avoiding applying for non-cash benefits.[47]

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[43] Haley JM, Kenney GM, Bernstein H, Gonzalez D. One in five adults in immigrant families with children reported chilling effects on public benefit receipt in 2019. Urban Institute. Published June 18, 2020. Accessed December 15, 2025. https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019; Barofsky J, Vargas A, Rodriguez D, Matos E, Barrows A. Putting out the 'unwelcome mat:' the announced public charge rule reduced safety net enrollment among exempt noncitizens. *JBPA*. 2021;4(2). doi:10.30636/jbpa.42.200; Barofsky J, et al. Spreading fear: the announcement of the public charge rule reduced enrollment in child safety-net programs. *Health Aff (Millwood)*. 2020;39(10):1752-1761. doi:10.1377/hlthaff.2020.00763.

[44] Haley JM, Kenney GM, Bernstein H, Gonzalez D. One in five adults in immigrant families with children reported chilling effects on public benefit receipt in 2019. Urban Institute. Published June 18, 2020. Accessed December 15, 2025. https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019.

[45] Bernstein H, Gonzalez D, Karpman M, Zuckerman S. Amid confusion over the public charge rule, immigrant families continued avoiding public benefits in 2019. Urban Institute. Published May 18, 2020. Accessed December 15, 2025. https://www.urban.org/research/publication/amid-confusion-over-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-2019.

[46] Ku L. New evidence demonstrates that the public charge rule will harm immigrant families and others. *Health Aff (Millwood) Forefront.* Published October 9, 2019. Accessed December 15, 2025. doi:10.1377/hblog20191008.70483.

[47] Gonzalez D, Bernstein H, Karpman M, Kenney GM. Mixed-status families and immigrant families with children continued avoiding safety net programs in 2023. *Urban Institute*. Published August 7, 2024. Accessed December 15, 2025. https://www.urban.org/research/publication/mixed-status-families-and-immigrant-families-children-continued-avoiding.

In addition to avoidance of benefits, the 2019 Rule caused many immigrants to avoid health care settings altogether. Health Centers, which are an essential source of care for immigrant families, reported a significant decline in health services utilization among immigrant adults in the aftermath of the 2019 Public Charge Rule.[48]

The 2025 NPRM will cause an even deeper chilling effect than the 2019 Final Rule

Compared to the 2019 Final Rule, the 2025 NPRM is much broader and even less clear. The NPRM permits immigration officers to consider *any and all* public benefits when determining if an individual is likely to become a "public charge." Officers can consider not only the public benefits added in the 2019 Final Rule - including Medicaid, SNAP, and housing assistance - but *any public benefit used by the individual* ***or their family members***. (The rule removes the regulatory definition of "receipt (of public benefits)"[49] that explicitly excludes receipt by family members.) Officers are not provided with limitations or guardrails regarding the public benefits that they can consider in their determinations.

The NPRM is being released in an environment of already heightened fear and confusion by lawfully present immigrants and U.S. citizens in mixed-status families. Since early 2025, the U.S. Immigration and Customs Enforcement (ICE) has detained and deported thousands of lawfully present immigrants and U.S. citizens. More than one in five (22 percent) immigrants say they personally know someone who has been arrested, detained, or deported on immigration-related charges since the change in Administration in January 2025.[50] Moreover, HHS has issued new guidance changing its longstanding interpretation of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) to bar many lawfully present immigrants from accessing federal programs such as Head Start and Community Health Centers.[51]

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[48] KFF. Many Community Health Centers Report that Immigrant Patients Are Declining to Enroll in Medicaid or Renew Their Coverage Amid Concerns About Changes to Public Charge Rules. Published October 15, 2019. Accessed December 15, 2025. https://www.kff.org/medicaid/many-community-health-centers-report-that-immigrant-patients-are-declining-to-enroll-in-medicaid-or-renew-their-coverage-amid-concerns-about-changes-to-public-charge-rules/.

[49] 8 C.F.R. § 212.21(d).

[50] Schumacher S, Valdes I, Montalvo III J, Hamel L, Artiga S, Pillai D, Kirzinger A. KFF/New York Times 2025 survey of immigrants: Worries and Experiences Amid Increased Immigration Enforcement. KFF. Published November 18, 2025. Accessed December 15, 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/.

[51] 90 *Fed. Reg*. at 31236; *see also* HHS Press Room. HHS Bans Illegal Aliens from Accessing its Taxpayer-Funded Programs. HHS. Published July 10, 2025. Accessed December 15, 2025. https://www.hhs.gov/press-room/prwora-hhs-bans-illegal-aliens-accessing-taxpayer-funded-programs.html.

This has created an environment of fear and confusion among U.S. immigrant families about which federal benefits they are eligible for and the impact of using them. Notably, as of 2025, about one-third of lawfully present immigrants report avoiding seeking medical care, traveling, or going to work or other public spaces as a result of increased fears and anxieties.[52] Nearly half (47 percent) of lawfully present immigrants and about three in ten (29 percent) of naturalized citizens report negative health impacts due to immigration-related worries, such as increased stress, anxiety, or sadness, problems sleeping or eating; or worsening health conditions like diabetes or high blood pressure.[53] Even prior to the release of the NPRM, there has been a documented increase in immigrants disenrolling from or avoiding enrolling in public benefits due to immigration-related fears from the Trump Administration's new policies.[54] Among immigrant parents, the share who say they avoided applying for a program in the past year rose from 11 percent to nearly 20 percent.

The broader, vaguer nature of the 2025 NPRM – released into an environment of heightened confusion and fear – **is likely to cause <u>even greater</u> confusion, fear, and chilling effects than the 2019 Final Rule**, causing U.S. citizens, lawful permanent residents, and other lawfully present immigrants to forgo or disenroll from benefits to which they are entitled. DHS acknowledges that "elimination of the definitions and other core elements of the 2022 Final Rule" may cause "individuals both directly and indirectly affected by this proposed rule [to] have a misunderstanding regarding the scope of the rule and how DHS will apply the public charge ground of inadmissibility"[55] and "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."[56]

Indeed, DHS' economic analysis shows that reduced federal spending will result from the chilling effect of U.S. citizens, lawful permanent residents, and other lawfully present immigrants forgoing or disenrolling from benefits for which they are eligible. DHS states that the NPRM would "result in *a reduction in transfer payments from the Federal Government to individuals who may choose to disenroll from or forgo enrollment in a public benefits program* .

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[52] Schumacher S, Valdes I, Montalvo III J, Hamel L, Artiga S, Pillai D, Kirzinger A. KFF/New York Times 2025 survey of immigrants: Worries and Experiences Amid Increased Immigration Enforcement. KFF. Published November 18, 2025. Accessed December 15, 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/.
[53] *Id*.
[54] *Id*; Artiga S, Pillai D, Cervantes S, Pillai A, Rae M. Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment. KFF. Published December 2, 2025. Accessed December 15, 2025. https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/.
[55] 90 *Fed. Reg*. at 52208.
[56] 90 *Fed. Reg*. at 52207.

. . include[ing] aliens as well as U.S. citizens who are members of mixed-status households."[57] DHS estimates that 950,124 members of immigrant households could disenroll or forgo enrollment in Medicaid, CHIP, SNAP, TANF, SSI and federal rental assistance programs, almost all of whom must by definition be U.S. citizens or lawfully present immigrants because these programs generally restrict undocumented immigrants from accessing them.

DHS' analysis is flawed and severely underestimates the extent of the chilling effect

DHS' analysis is inaccurate and flawed because it uses an unsupported assumption that only 10.3 percent of members of immigrant households would disenroll or forgo benefits due to the chilling effect[58] and relies on outdated data about Medicaid and CHIP participation and federal program costs. DHS' own estimate of the very significant chilling effect – over 950,000 people disenrolling or forgoing benefits to which they are entitled – is a mere fraction of that found in independent analyses by KFF and researchers at George Washington University that, unlike DHS, rely on the most current data about program participation rates and costs and immigrant fears.[59]

Specifically, KFF researchers use data from a 2025 nationally representative survey of immigrants conducted by KFF and the New York Times and a similar 2023 KFF/Los Angeles Times survey that queried immigrants about their willingness to use public benefits, like Medicaid, in light of current trends.[60] The KFF and George Washington University analyses also use more current and accurate data about Medicaid and CHIP participation and FY2026 federal program costs from the Congressional Budget Office.[61]

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[57] 90 *Fed. Reg*. at 52170.
[58] 90 *Fed. Reg*. at 52209.
[59] Artiga S, Pillai D, Cervantes S, Pillai A, Rae M. Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment. KFF. Published December 2, 2025. Accessed December 15, 2025. https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/; *see also* Ku L, Krips M, Silverman H. Economic and Mortality Analyses of the DHS Proposed Rule: Public Charge Ground of Inadmissibility. The George Washington University. December 2025. Appendix 1 at 6-7.
[60] Pillai D, Artiga S, Pillai A, et al. KFF/New York Times 2025 Survey of Immigrants: Health and Health Care Experiences During the Second Trump Administration. KFF. Published November18, 2025. Accessed December 15, 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/; Pillai D, Artiga S, Hamel L, et al. Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants. KFF. Published September 17, 2023. Accessed December 15, 2025. https://www.kff.org/racial-equity-and-health-policy/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/.
[61] Congressional Budget Office. Details About Baseline Projections for Selected Programs. Updated 2025. Accessed December 15, 2025. https://www.cbo.gov/data/baseline-projections-selected-programs#9.

As compared to DHS' mid-point estimate of 10.3 percent (with a low and high estimate of 3.3 and 17.3 percent), KFF concluded that between 10 percent and 30 percent of members of immigrant households (with a mid-point estimate of 20 percent loss) – totaling between 1.3 and 4 million people – could lose Medicaid or CHIP benefits due to the proposed rule.[62] This includes between 600,000 and 1.8 million U.S. citizen children who are members of immigrant families and who are likely to lose benefits even though they are citizens and remain fully eligible for the program. The George Washington University analysis confirms that the KFF estimates are more reasonable.[63] This range of loss is more consistent with earlier analyses about the chilling effects caused by public charge rules, such as those based on research by the Urban Institute.[64]

These more accurate independent analyses indicate that DHS estimates of the chilling effect are about three-quarters too low. The DHS estimates that 950,000 persons could lose Medicaid, CHIP, SNAP, TANF, SSI, or federal rental benefits per year, leading to $5.3 billion in federal benefits lost per year. In comparison, more rigorous independent estimates find that 3.7 million members of immigrant households (with a range of 1.9 million to 5.6 million) could lose these public benefits due to fear and the public charge chilling effect, which would lead to $21.3 billion in federal benefits lost in 2026 (with a range of $10.5 billion to $32.0 billion). [65]

III. Research demonstrates that DHS' proposed rule will have serious negative impacts on individual and community health.

The significant decrease in the use of critical federal programs caused by the chilling effects of the proposed rule will lead to serious adverse health outcomes, including higher uninsured rates, higher food insecurity, and long-term negative health impacts. [66] All of this will negatively impact adult health, children's health, and community health at large.

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[62] Artiga S, Pillai D, Cervantes S, Pillai A, Rae M. Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment. KFF. Published December 2, 2025. Accessed December 15, 2025. https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/.

[63] Ku L, Krips M, Silverman H. Economic and Mortality Analyses of the DHS Proposed Rule: Public Charge Ground of Inadmissibility. The George Washington University. December 2025. Appendix 1 at 6-7.

[64] See reports summarized in Artiga S, et al. Dec. 2, 2025; *see also* Gonzalez D, Bernstein H. One in Four Adults in Mixed-Status Families Did Not Participate in Safety Net Programs in 2022 Because of Green Card Concerns. Urban Institute. Published August 2023. Accessed December 15, 2025. https://www.urban.org/research/publication/one-four-adults-mixed-status-families-did-not-participate-safety-net-programs.

[65] Ku L, Krips M, Silverman H. Economic and Mortality Analyses of the DHS Proposed Rule: Public Charge Ground of Inadmissibility. The George Washington University. December 2025. Appendix 1 at 6-7.

[66] The Center for Law and Social Policy. CLASP Statement for the Record "Impact of Illegal Immigration of Social Services." Congress.gov. Published January 11, 2024. Accessed December 15, 2025. https://www.congress.gov/118/meeting/house/116727/documents/HHRG-118-JU01-20240111-SD021.pdf

DHS acknowledges the significant negative health impacts from the chilling effect, stating that, "... reduced access to public benefit programs by eligible individuals, including aliens and U.S. citizens in mixed-status households, may lead to downstream effects on public health, community stability, and resilience, to 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."[67]

Despite the requirement for rules to do a full cost-benefit analysis, DHS inaccurately claims that it cannot quantify these health harms and concludes that the benefit of officer discretion outweighs these unquantified health costs. Yet, the health harms of the chilling effect can and have been estimated.

When DHS issued the 2019 Final Rule, researchers estimated that Medicaid disenrollments associated with the chilling effect could lead to as many as 4,000 excess deaths every year.[68] In response to the 2025 NPRM, updated analyses by KFF and George Washington University researchers estimate that the revised public charge rule could cause upwards of 4 million individuals to lose Medicaid and CHIP benefits and lead to as many as 5,300 additional deaths in the United States per year.[69] Over 200 studies have confirmed that Medicaid access is associated with significant declines in mortality rates, improved access to preventive care, primary care, and mental health care, and improved health outcomes, among other positive outcomes.[70] Research

[67] 90 *Fed. Reg*. at 52218.
[68] Ku L. New Evidence Demonstrates That the Public Charge Rule Will Harm Immigrant Families and Others. Health Affairs. Published October 9, 2019. Accessed December 3, 2025. doi:10.1377/hblog20191008.70483
[69] Artiga S, Pillai D, Cervantes S, Pillai A, Rae M. Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment. KFF. Published December 2, 2025. Accessed December 3, 2025. https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/; *see also* Ku L, Krips M, Silverman H. Economic and Mortality Analyses of the DHS Proposed Rule: Public Charge Ground of Inadmissibility. The George Washington University. December 2025. Appendix 1 at 2. (The researchers estimated a low to high range of 1,800 to 5,300 deaths, with a midpoint of 3,500 deaths.)
[70] Antonisse L, Garfield R, Rudowitz R, Artiga S. The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review. KFF. Published March 2018. Accessed December 3, 2025.

has found that after people disenroll from Medicaid/CHIP, most individuals do not transition to and retain other coverage, and that loss of Medicaid coverage results in people forgoing necessary preventive services, medications, and continuous care for chronic illnesses, and can lead to more hospitalizations and emergency room visits.[71]

U.S. citizen children will feel the brunt of this proposed rule, with an estimated 600,000 to 1.8 million U.S. citizen children set to lose public benefits that are essential to their health and wellbeing.[72] Public health benefits for children – including public health insurance benefits, nutrition supports, and housing assistance – promote healthy development and are associated with numerous positive outcomes, such as higher overall health, lower incidences of high blood pressure, lower obesity rates, fewer emergency room visits, better high school graduation rates, college attendance, and higher income prospects as adults.[73] For example, research has shown that childhood receipt of insurance contributes to healthier adults with better employment outcomes.[74]

Disenrollment from programs such as SNAP or Section 8 housing assistance places children of immigrants at risk of food insecurity, malnutrition, poverty, and homelessness, leading to increased health care costs long term, particularly for children with disabilities and other specific

https://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review

[71] Banerjee R, Ziegenfuss JY, Shah ND. Impact of discontinuity in health insurance on resource utilization. *BMC Health Services Research*. 2010;10(1):195. doi:10.1186/1472-6963-10-195; Musumeci M. Taking Action to Reduce Medicaid Churn and Keep People Continuously Enrolled in Coverage. Commonwealth Fund. Published July 3, 2024. Accessed December 3, 2025. doi:10.26099/98MX-AC50; Corallo B, Burns A, Tolbert J, Claxton G. What Happens After People Lose Medicaid Coverage? KFF. Published January 25, 2023. Accessed December 3, 2025. https://www.kff.org/medicaid/what-happens-after-people-lose-medicaid-coverage/

[72] Artiga S, Pillai D, Cervantes S, Pillai A, Rae M. Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment. KFF. Published December 2, 2025. Accessed December 3, 2025. https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/

[73] Percheski C, Bzostek S. Public Health Insurance and Health Care Utilization for Children in Immigrant Families. *Maternal and Child Health Journal*. 2017;21(12):2153-2160. doi:10.1007/s10995-017-2331-y; Chester A, Alker J. Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid. Georgetown University Health Policy Institute Center for Children and Families. Published July 2015. Accessed December 3, 2025. https://ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaid-at-50_final.pdf; Miller S, Wherry LR. The Long-Term Effects of Early Life Medicaid Coverage. Working Paper, Social Science Research Network. Revised August 25, 2016. Accessed December 3, 2025. doi:10.2139/ssrn.2466691; Chester A, Alker J, Wagnerman K. Medicaid & CHIP are Long-Term Investments in Children's Health and Future Success. Georgetown University Center for Children and Families. Published March 3, 2017. Accessed December 3, 2025. https://ccf.georgetown.edu/2017/03/13/medicaid-is-a-smart-investment-in-children/

[74] Goodman-Bacon A. The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes. *American Economic Review*. 2021;111(8):2550-2593. doi:10.1257/aer.20171671

medical needs.[75] Research has shown that these results linger; despite rescinding the expansion of benefits considered in the 2019 Final Rule, there continue to be long-lasting harms to immigrant children and their families, as a result of avoiding assistance for food, housing, and health care.[76]

Immigrant children, including U.S. citizen children in mixed-status households, already face challenges in accessing health care, language barriers, and higher rates of mental health conditions.[77] For these children, the inability to access health care, food, and housing will not only impact their health but also their ability to focus on school or work. The proposed rule poses a serious threat to the health and well-being of low-income children already at risk.

In addition to individual health outcomes, the proposed rule will negatively impact population health. It discourages immigrants from seeking diagnosis, treatment, vaccination and other preventive measures critical to stopping, treating and preventing transmission of communicable diseases. DHS acknowledges that "reduced access to public benefit programs by eligible individuals ... may lead to downstream effects" including a "[h]igher prevalence of communicable diseases, including among U.S. citizens who are not vaccinated."[78] A study found that adult immigrants with U.S. citizen children are less likely to receive free immunization services for both themselves and their children as a result of learning about the public charge rule.[79] This not only impacts their individual health, but potentially puts other community members at risk as well, including immunocompromised individuals or infants who cannot receive certain vaccinations.

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[75] Zallman L, Finnegan KE, Himmelstein DU, Touw S, Woolhandler S. Implications of Changing Public Charge Immigration Rules for Children Who Need Medical Care. *JAMA Pediatr*. 2019;173(9):e191744. doi:10.1001/jamapediatrics.2019.1744; Zallman L, Finnegan KE. Changing Public Charge Immigration Rules: The Potential Impact on Children Who Need Care. California Health Care Foundation. Published October 23, 2018. Accessed December 3, 2025. https://www.chcf.org/resource/changing-public-charge-immigration-rules/

[76] Artiga S, Pillai D, Cervantes S, Pillai A, Rae M. Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment. KFF. Published December 2, 2025. Accessed December 15, 2025. https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/ ; Gonzalez D, Bernstein H, Karpman M, Kenney G. Mixed-Status Families and Immigrant Families with Children Continued Avoiding Safety Net Programs in 2023. Urban Institute. Published August 7, 2024. Accessed December 15, 2025. https://www.urban.org/research/publication/mixed-status-families-and-immigrant-families-children-continued-avoiding.

[77] Derr AS. Mental Health Service Use Among Immigrants in the United States: A Systematic Review. *Psychiatric Services*. 2016;67(3):265-274. doi:10.1176/appi.ps.201500004; Rojas-Flores L, Clements ML, Hwang KJ, London J. Trauma and psychological distress in Latino citizen children following parental detention and deportation. *Psychological trauma: theory, research, practice and policy*. 2017;9(3):352–361. doi:10.1037/tra0000177

[78] 90 Fed. Reg. at 52218.

[79] Wong TK, Cha J, Villarreal-Garcia E. The impact of changes to the public charge rule on undocumented immigrants living in the U.S. U.S. Immigration Policy Center. Published August 13, 2019. Accessed December 3, 2025. https://usipc.ucsd.edu/publications/usipc-public-charge-final.pdf

Community Health Centers are the nation's largest primary health care system for low-income and under-resourced populations and communities, and the backbone of the health care safety net. In 2024, Health Centers provided community-based care to more than 32.4 million people.[80] Health Centers serve all members of their community and disproportionately serve rural communities, those with low incomes, and people of color.[81] Among the diverse populations served in 2024, Health Centers cared for 1 in 8 children, 1 in 5 rural residents, and over 408,000 veterans.[82] Health Centers also served more than 1 in 15 patients aged 65 or older,[83] a figure that has grown as the general population ages, especially in rural areas.[84] Health Centers offer comprehensive primary and preventive health services, including medical, dental, vision, chronic disease management, and behavioral health care for adults living in medically underserved communities who may otherwise have difficulty obtaining needed care.

The significant chilling effect of the proposed rule among immigrants and their family members will impact the ability of Health Centers to serve *all* patients. Medicaid is the largest source of Health Center funding; a report from 2018 estimated that as a result of the 2019 Proposed Rule, Medicaid revenue for Health Centers would decline by $346 million.[85] This severe reduction in Medicaid revenue can lead to "fewer services, fewer staff, fewer service sites, and fewer patients served" impacting access to care for immigrants, their family members, and all Health Center patients.[86] Further, a revenue loss of this magnitude could force Health Centers to close altogether, eliminating access to health care for these populations entirely.

The proposed rule will also negatively impact health and hospital systems for all community members. Denying people access to care does not eliminate people's need for services; instead, it shifts the burden to hospital emergency departments and, ultimately, to state systems and

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[80] HRSA. Impact of the Health Center Program. HRSA Health Center Program. Published August 2025. Accessed December 15, 2025. https://bphc.hrsa.gov/about-health-center-program/impact-health-center-program.
[81] Pillai A, Corallo B, Tolbert J. Community Health Center Patients, Financing, and Services. KFF. Published January 6, 2025. Accessed December 15, 2025. https://www.kff.org/medicaid/issue-brief/community-health-center-patients-financing-and-services/
[82] HRSA. Impact of the Health Center Program. HRSA Health Center Program. Published August 2025. Accessed December 15, 2025. https://bphc.hrsa.gov/about-health-center-program/impact-health-center-program
[83] *Id.*
[84] Dutta E, Regenstein M, Jacobs F. Community Health Centers Are Increasingly Important to Medicare Beneficiaries. GW Milken Institute School of Public Health: Geiger Gibson Program in Community Health. Published May 9, 2025. Accessed December 15, 2025. https://geigergibson.publichealth.gwu.edu/community-health-centers-are-increasingly-important-medicare-beneficiaries.
[85] Ku L, Sharac J, Gunsalus R, Shin P, Rosenbaum S. How Could the Public Charge Proposed Rule Affect Community Health Centers? GW Milken Institute School of Public Health: Geiger Gibson Program in Community Health. RCHN Community Health Foundation Research Collaborative. Published November 2018. Accessed December 15, 2025. https://publichealth.gwu.edu/sites/g/files/zaxdzs4586/files/2023-05/public_charge_brief.pdf
[86] *Id.*

taxpayers. Facing decreased access to preventive care, people without insurance often put off seeking medical attention or do not fill prescriptions until health conditions have worsened, requiring more costly interventions and emergency care.[87] Delayed preventive screenings and treatment can lead to late-stage cancer diagnoses, poor maternal and infant health, and delayed identification of clinical and developmental concerns in young children. Consequently, hospitals, especially in rural and underserved areas, will provide more intensive and uncompensated care, threatening their financial viability. In comments provided to the 2022 proposed rule, America's Essential Hospitals explained the impact of the 2019 Final Rule: "Patients forgoing public insurance programs and seeking care at hospitals without insurance strained the tight budgets of essential hospitals. The detrimental effects of the rule reached even further—it harmed the nation's health care system at large, resulting in increased health care costs and worse health outcomes."[88] Individuals who have forgone public benefits may show up sicker at health facilities and emergency rooms, straining health care facilities' costs and capacity to provide quality care for all patients.

IV. DHS' economic impact analysis is seriously flawed and dramatically underestimates the likely harm to individuals, providers, and state and local economies.

DHS' economic impact analysis has several serious shortcomings. Although DHS acknowledges that there could be economic harms due to the revised rule, the NPRM does not provide any analysis of them despite requirements to conduct a full economic analysis.

To address this gap, independent researchers at The George Washington University analyzed the economic impact of the proposed rule.[89] The analysis found that as federal funding for Medicaid, CHIP, SNAP, and SSI benefits are lost, large economic repercussions will ripple out through state and local economies. In addition to the direct harm from loss of important health, nutrition, and other social benefits, the proposed rule could reduce state economies by tens of billions of dollars and cause hundreds of thousands of jobs to be lost. The analysis indicates that as federal funds to states for Medicaid, CHIP, SNAP and SSI are reduced, state economies would shrink by about **$27.4 billion in 2026 (ranging from $13.7 to $41.2 billion) and 212,000 jobs (ranging from 106,000 to 318,000 jobs) would be lost.**[90] An earlier analysis about the 2019 Final Rule,

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[87] Yabroff KR, Zhao J, Halpern MT, et al. Health Insurance Disruptions and Care Access and Affordability in the U.S. *American Journal of Preventive Medicine*. 2021;61(1):3-12. doi:https://doi.org/10.1016/j.amepre.2021.02.014
[88] Siegel B. Comment on Public Charge Ground of Inadmissibility. America's Essential Hospitals. Published April 25, 2022. Accessed December 3, 2025. https://essentialhospitals.org/wp-content/uploads/2022/04/Public-Charge-NPRM-Comment-Letter-4-25-22-for-archive.pdf.
[89] Ku L, Krips M, Silverman H. Economic and Mortality Analyses of the DHS Proposed Rule: Public Charge Ground of Inadmissibility. The George Washington University. December 2025. Appendix 1.
[90] *Id* at 8.

conducted by the Fiscal Policy Institute, reached similar conclusions to those of the George Washington University researchers. They estimated that the 2019 Final Rule – which was even less severe than the current proposed rule – could reduce the gross domestic product by $24 billion and cause the loss of 164,000 jobs nationally.[91]

These losses result from several factors. First, reducing Medicaid and CHIP benefits means that health care providers, including hospitals, clinics, pharmacies, and others, will have less revenue. Denying insurance coverage for primary and preventive care does not eliminate immigrants' need for services. The lack of preventive and primary care means that immigrants' health problems can worsen and eventually require more serious and expensive care at hospitals' emergency departments, which are required to provide at least screening and stabilization services to all patients with emergency needs, regardless of insurance or immigration status, under the Emergency Medical Treatment and Active Labor Act (EMTALA).[92] Thus, the loss of Medicaid and CHIP coverage would result in additional uncompensated care costs for hospitals. In turn, this means that they have less money to pay their staff and suppliers. Because the health care providers and supply chain businesses have less income, they will have to lay off staff or reduce wages.

Some health care facilities, such as community health centers, clinics, pharmacies and even hospitals, could close because of the combined loss of insurance revenue and their higher uncompensated care costs, particularly if they are located in low-income communities with high immigrant populations. An analysis of the 2019 Final Rule estimated that safety net clinics and hospitals could lose $346 to $624 million, which would reduce their ability to stay open and serve vulnerable patients, including U.S. citizens.[93]

The effect of reduced SNAP benefits is similar to that for Medicaid, except the effects will result in reductions in grocery and other consumer purchases. When immigrants are forced to avoid public benefits like SNAP, they must spend less, resulting in losses to local economies.[94] Grocery stores and other retail establishments would lose business, and some might close.

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[91] Fiscal Policy Institute. Only Wealthy Immigrants Need Apply: The Chilling Effects of "Public Charge." Published November 25, 2019. Accessed December 15, 2025. https://fiscalpolicy.org/publiccharge2019
[92] Staman J. Overview of the Emergency Medical Treatment and Active Labor Act (EMTALA) and Emergency Abortion Services. Congressional Research Service. Published March 2023. Accessed December 3, 2025. https://www.congress.gov/crs-product/IF12355
[93] The Center for Law and Social Policy. CLASP Statement for the Record "Impact of Illegal Immigration of Social Services." Congress.gov. Published January 11, 2024. Accessed August 12, 2025. https://www.congress.gov/118/meeting/house/116727/documents/HHRG-118-JU01-20240111-SD021.pdf
[94] *Id.*

As employees lose their jobs or income, they have less to spend on consumer goods like groceries, utilities, and rent, harming those downstream businesses as well. Of the jobs lost, about 73,000 would be health care-related jobs (the direct job losses related to Medicaid and CHIP), about 4,800 jobs lost would be related to grocery and other food-related industries, and the rest would be spread across all sectors of state economies, such as retail, construction, etc.[95] Since the economic and job losses would be broad, most of those losing jobs are U.S. citizens, who comprise the majority of employed persons. In the end, the loss of individual and business income could cause state and local tax revenues to fall by $2 billion, making it harder for state and local governments to provide services like education and health care.[96]

Denying admission or adjustment of status to large numbers of immigrants may also have broader repercussions for the supply of the health care workforce. One study showed that 17 percent of all health care professionals were born outside the U.S.; further, non-U.S.-born professionals worked more hours, were more likely to work at night and in institutional and in-home long-term care settings, and were more likely to reside in medically underserved communities.[97] Immigrants also play a critical role in providing long-term care to older adults and people with disabilities. An estimated one in four direct care workers are immigrants, with even higher proportions in some regions.[98] Denials of admission or of adjustments in status due to the public charge rule, which could lead to the loss of work authorization, could reduce the availability of immigrants who could provide these health care services. This could have repercussions and reduce the availability of care for the general population, including U.S. citizens.

V. If finalized as proposed, the DHS' Public Charge Rule would violate the law.

DHS' proposed rule will lead to arbitrary and capricious decision-making

DHS' proposal to rescind the 2022 Public Charge Rule without any further guidance to cabin immigration officers' discretion, ensure consistent decision-making, and prevent discrimination is arbitrary and capricious in violation of the Administrative Procedure Act.[99] As discussed in detail above, *see* Section I, DHS' plan to "rel[y] on DHS' officers' good judgment and sound

[95] Ku L, Krips M, Silverman H. Economic and Mortality Analyses of the DHS Proposed Rule: Public Charge Ground of Inadmissibility. The George Washington University. December 2025. Appendix 1 at 9.
[96] *Id.*
[97] Commodore-Mensah Y, et al. Prevalence and Characteristics of Non-U.S.-Born and U.S.-Born Health Care Professionals, 2010-2018. *JAMA Network Open* 4. Published April 29, 2021. Accessed December 15, 2025. https://pmc.ncbi.nlm.nih.gov/articles/PMC8085726/.
[98] Paraprofessional Healthcare Institute. Immigration and the Direct Care Workforce. Paraprofessional Healthcare Institute. Published March 31, 2025. Accessed December 15, 2025. https://www.phinational.org/immigration-and-the-direct-care-workforce/.
[99] 5 U.S.C § 706(2)(A).

discretion" by permitting them to consider any benefits, factors, or evidence they deem relevant,[100] will lead to inconsistent, inaccurate, and unpredictable decision-making. The NPRM fails to seriously consider the evidence and impacts of inconsistent decisions caused by granting unfettered discretion to immigration officers, in violation of its rulemaking obligations.[101] Moreover, DHS' expansive view of immigration officers' discretion is inconsistent with the holdings of the numerous courts that struck down the even narrower 2019 Public Charge Rule as arbitrary and capricious, rejecting DHS' position that the INA "has no natural limitation"[102] and that there is not "any limit to its discretion."[103]

DHS does not adequately justify the reversal of its longstanding position that guidance is necessary to ensure that immigration officers' public charge determinations are consistent, predictable, and not arbitrary. For example, in issuing the 1999 Field Guidance to immigration officers, DHS specifically recognized the complexity and frequently changing rules of public benefit programs (which have only become more complex in the last 25 years) and that "officers are not expected to know the substantive eligibility rules for different public benefit programs."[104] Similarly, immigration law is complex and evolving; immigration officers, who are not lawyers, cannot reasonably be expected to know, closely track, and understand immigration caselaw. Yet DHS inexplicably assumes immigration officers are legal experts, stating that guidance is not necessary because "DHS believes that relevant precedent decisions that have guided public charge inadmissibility determinations for decades and as well as recent circuit case law would provide officers with sufficient guidance to conduct subjective individualized determinations based on the specific facts and circumstances of each alien's case."[105]

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[100] 90 *Fed. Reg.* at 52183.
[101] *City & Cty. of S.F. v. United States Citizenship & Immigration Servs.*, 981 F.3d 742, 758-59 (9th Cir. 2020) (finding that an agency rule will be found arbitrary and capricious if the agency, *inter alia*, "entirely failed to consider an important aspect of the problem" or "offer[s] an explanation for its decision that runs counter to the evidence before the agency").
[102] By providing complete discretion to DHS officers to determine who is and is not a "public charge," DHS is again taking the position, which courts repeatedly rejected in challenges to the 2019 rule, that its authority under the INA "has no natural limitation" and that "[t]here is nothing … that would prevent the agency from imposing a zero-tolerance rule under which the receipt of even a single benefit on one occasion would result in denial of entry or adjustment of status. We see no warrant in the Act for this sweeping view." *Cook Cnty. v. Wolf*, 962 F.3d 208, 229 (7th Cir. 2020).
[103] *Id*. at 252 (Barrett, J., dissenting) ("At oral argument, DHS declined to identify any limit to its discretion, implying that it could define public charge to include someone who took any amount of benefits, no matter how small. . . . [This] may well overread" the INA).
[104] 90 *Fed. Reg.* at 28692.
[105] 90 *Fed. Reg.* at 52188.

The proposed rule, if finalized, is illegal retroactive rulemaking and does not sufficiently take into account reliance interests

DHS proposes that immigration officers consider past receipt of any public benefits, including benefits that have been excluded from consideration in public charge determinations for almost all of the last 25 years since the issuance of the 1999 Field Guidance and certainly since issuance of the 2022 Final Public Charge Rule, including Medicaid, CHIP, SNAP, and housing assistance. Similarly, DHS also proposes to rescind longstanding policies that exclude consideration of benefits by household members (including U.S. citizen dependent children) or benefits used when an individual was in an exempted status, such as a refugee, allowing past receipt of those benefits to be considered.[106] Allowing immigration officers to consider past receipt of previously excluded benefits in future determinations is unlawful retroactive rulemaking that would punish pre--effective date -conduct.[107]

A rule has an impermissible retroactive effect if it "takes away or impairs vested rights acquired under existing laws, or creates a new obligation, imposes a new duty, or attaches a new disability, in respect to transactions or considerations already past."[108] Retroactive rulemaking is only permitted when authorized by Congress in express terms.[109] Judgment about whether a particular statute acts retroactively should be informed and guided by familiar considerations of fair notice, reasonable reliance, and settled expectations."[110]

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[106] *See* discussion of repeal of the definitions in 8 C.F.R. § 212.21, including "Likely to become a public charge" at § 212.21(a); "Receipt (of public benefits)" at 212.21(d); and "Household" at § 212.21(f) at 90 *Fed. Reg.* at 52185-90.
[107] Receipt of past benefits, particularly short after an immigrant arrives, is also not effective in predicting whether or not an individual will become self-sufficient. *See* Ku L, Krips M, Silverman H. Economic and Mortality Analyses of the DHS Proposed Rule: Public Charge Ground of Inadmissibility. The George Washington University. December 2025. Appendix 1 at 4.
[108] *Yanez v. Bondi*, 140 F.4th 35, 48 (2d Cir. 2025) (citing *Landgraf v. USI Film Products*, 511 U.S. 244, 269 (1994)).
[109] "[C]ongressional enactments and administrative rules will not be construed to have retroactive effect unless their language requires [such a] result." *Landgraf v. USI Film Products*, 511 U.S. 244, 264 (1994).
[110] *INS v. St. Cyr*, 533 U.S. 289, 321 (2001) (internal quotations omitted). *In Retail, Wholesale & Dep't Store Union v. NLRB*, the court set forth a non-exhaustive list of five factors to assist courts in determining whether to grant an exception to the general rule permitting "retroactive" application of a rule enunciated in an agency adjudication:

> (1) whether the particular case is one of first impression, (2) whether the new rule represents an abrupt departure from well established practice or merely attempts to fill a void in an unsettled area of law, (3) the extent to which the party against whom the new rule is applied relied on the former rule, (4) the degree of the burden which a retroactive order imposes on a party, and (5) the statutory interest in applying a new rule despite the reliance of a party on the old standard. 466 F.2d 380, 390 (D.C. Cir. 1972).

The assessment of the second factor—whether a new rule presents an abrupt departure from well-established practice—informs the reasonableness of a plaintiff's reliance. *Clark-Cowlitz Joint Operating Agency v. FERC*, 826 F.2d 1074, 1082-83 (D.C. Cir. 1987)). This is a factual inquiry evaluated in the context of the new rule.

DHS' proposal to "attach[ ] a new disability" – in this case, a determination that someone is a public charge – because of past use of benefits that were previously excluded situations is impermissibly retroactive because Congress has not expressly authorized it.[111] In a single paragraph, DHS attempts to justify its expansive retroactive application by citing a provision Congress added to the INA, as part of the Victims of Trafficking and Violence Protection Act of 2000, a prohibition from considering receipt of public benefits by "certain battered aliens" in public charge determinations. In its NPRM, DHS states that "Congress' prohibition of consideration of prior receipt of benefits of a specific class of aliens suggests that Congress understood and accepted consideration of an alien's past receipt of public benefits in other circumstances…"[112] This language is not an express command by Congress to consider pre-effective date conduct in public charge determinations for everyone else and is not legally sufficient to be considered an express grant of retroactive rulemaking power by Congress to DHS.[113]

Moreover, in considering the legality of retroactive rulemaking, courts examine the reliance interests of those impacted, particularly when individuals have relied on longstanding policies.[114] DHS acknowledges its own longstanding use of the 1999 Field Guidance, which was incorporated into the 2022 Public Charge Rule, both of which prohibit consideration of most benefits that the proposed rule suggests officers may and will consider going forward.[115] Yet DHS fails to meaningfully consider the profound reliance interests built up over the nearly three decades of consistent federal interpretation, raising additional procedural defects with this rulemaking. Merely soliciting comments about reliance after announcing wholesale rescission of the operative framework is not the "reasoned explanation" with "awareness" of reliance interests

[111] *See Vartelas v. Holder*, 566 U.S. 257, 261 (2012).
[112] 90 *Fed. Reg.* at 52178 and n. 105.
[113] *INS v. St. Cyr*, 533 U.S. 289, 317 (2001) (holding that the agency could not apply the repeal of IIRIRA § 212(c) retroactively to noncitizens who pleaded guilty before the 1996 laws because Congress gave no clear state ment authorizing retroactivity); *Valiente v. Swift Transp. Co. of Ariz., Ltd. Liab. Co*., 54 F.4th 581 (9th Cir. 2022) (holding that the FMSCA's retroactive application of a 2018 preemption determination under 49 U.S.C. § 31141 was permissible because Congress clearly authorized the agency to halt enforcement of preempted state laws).
[114] The length and consistency of which an agency has followed one view of the law, "the more likely it is that private parties have reasonably relied to their detriment on that view." *Yun Shi Li v. Garland*, No. 21-cv-10601, 2022 U.S. Dist. LEXIS 210749, at *35-36 (S.D.N.Y. Nov. 21, 2022) (quoting *Clark-Cowlitz Joint Operating Agency v. FERC*, 826 F.2d 1074, 1082-83 (D.C. Cir. 1987)).
[115] 90 *Fed. Reg.* at 52193.

required by the Supreme Court.[116] DHS' summary discussion of reliance interests does not suffice when decades of reliance sits atop an agency's prior policy.[117]

States, localities, nonprofit organizations, and millions of individuals have structured their programs, budgets, and lives around the longstanding understanding of "public charge." This abrupt reversal threatens to upend the delivery of essential services, disrupt state and local budgets, and harm the most vulnerable residents, including U.S. citizens and lawful residents, as discussed in detail earlier in this comment. DHS' discussion of reliance interests in the preamble is cursory and vague, with no analysis or weighing of these significant reliance interests in a meaningful way, or consideration of alternatives to accommodate them. Simply requesting "comments from the public on what aspects of the 2022 Final Rule might have engendered reliance interests, and how DHS should best address such reliance interests given its stated objective for the rulemaking"[118] is insufficient to address this serious infirmity in its rulemaking.

DHS is attempting to circumvent the notice and comment rulemaking process for new guidance

Finally, DHS states that in addition to rescinding the 2022 Final Public Charge Rule, it plans "in the future" to issue "appropriate policy and interpretive tools that will guide DHS officers for public charge inadmissibility determinations."[119] The "policy and interpretive" language previews that DHS is poised to issue revised standards as interpretive rules outside of the notice and comment rulemaking process required under the Administrative Procedure Act.[120] Agency action that merely interprets a prior statute or regulation, and does not itself purport to impose *new* obligations or prohibitions or requirements on regulated parties, may be properly characterized as an interpretive rule that does not require public participation.[121] In contrast, agency actions that impose legally binding obligations or prohibitions on regulated parties, including by effectively amending a prior legislative rule,[122] is a legislative rule that generally must go through the notice and comment rulemaking process.[123] DHS' NPRM makes clear that future DHS guidance will be significantly and substantively different from the 2022 Final Public

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[116] *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211 (2016); This framework is further emphasized in *Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, where the court found that "because DHS was 'not writing on a blank slate,' it was required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns." 591 U.S. 1, 33 (2020).
[117] *Encino Motorcars,* 579 U.S. 211 at 223-224 (finding that "the Department's conclusory statements d[id] not suffice to explain its decision" and "lack[ed a] reasoned explication for a regulation that [was] inconsistent with the Department's longstanding earlier position result[ing] in a rule that cannot carry the force of law.").
[118] *Id*.
[119] *Id.* at 52182.
[120] 5 U.S.C. § 553.
[121] *Nat'l Mining Ass'n v. McCarthy*, 758 F.3d 243, 251-252 (D.C. Cir. 2014).
[122] *Sec. Indus. & Fin. Mkts. Ass'n v. United States CFTC*, 67 F. Supp. 3d 373, 417 (D.C. Cir. 2014).
[123] Nat'l Mining Ass'n, 758 F.3d at 251.

Charge Rule and the 1999 Field Guidance, rejecting those guidances' limits on the public benefits to be considered and relevant factors and instead allowing consideration of *any* public benefit or factor.[124] Substantive changes like this, which will fundamentally alter what is considered as part of a public charge determination and will be binding on officers adjudicating those determinations, must be made through notice and comment rulemaking. Simply put, DHS cannot legally circumvent the requirement for public transparency and input.

Conclusion

For all the foregoing reasons, APHA, RWJF, and the individual public health deans and scholars listed below urge DHS to withdraw the NPRM and leave in place the 2022 Final Public Charge Rule. If finalized, DHS' proposed rule will lead to significant individual health, public health, and economic harms, will be arbitrary and capricious, and violate the law.

We also respectfully request that the full text of our comments, as well as the full text of each of the individual studies, reports, and other supporting materials that we have cited and made available through active links in our comments, be considered part of the formal administrative record on this NPRM for purposes of the Administrative Procedure Act. Please let us know if DHS is unable for any reason to include our linked materials, so we will have the chance to otherwise submit copies of the supporting documents into the administrative record.

Thank you for your consideration of our comments. If you need any additional information, please contact Alison Barkoff at Alison.Barkoff@gwu.edu.

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[124] 90 *Fed. Reg.* at 52190.

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Appendix 1

Economic and Mortality Analyses of the DHS Proposed Rule: Public Charge Ground of Inadmissibility

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An important element of the regulatory process is the development and public dissemination of regulatory impact analyses, as required by Executive Orders 12866 and 13563. The Department of Homeland Security (DHS) included an economic impact analysis in its Notice of Proposed Rulemaking (NPRM): "Public Charge Ground of Inadmissibility," dated Nov. 19, 2025.[1]

We examined DHS' published analysis and found it seriously flawed. While DHS' analysis found evidence of serious harm from the proposed rule, the agency did not provide adequate analysis of these harms and proposed no policies to mitigate them. Particularly important, the NPRM acknowledges that the evidence shows that many of those who lose federal assistance benefits may be U.S. citizens and other lawfully present immigrants, including household members who may avoid seeking services due to the "chilling effect" of the rule, which appears to be contrary to the intent of the statute which is focused on those seeking admission or adjustments in immigration status. DHS also acknowledges that the rule may have other damaging consequences, including (see page 52818 of the NPRM): worse health outcomes, increased communicable disease, more uncompensated health care, increased poverty, housing instability, diminished productivity and educational attainment, as well as other economic losses, such as lower healthcare revenues, economic losses by grocery stores and food producers and landlords and even the possibility of 4,000 more deaths.

Key findings of our analysis, described in more depth below, are:

1. Giving greater discretion to immigration officials in making public charge determinations will not necessarily lead to better assessments. Federal data reported over ten years by visa officials indicate that the officials' public charge inadmissibility findings were "overcome" or dismissed 70 percent of the time.
2. Public charge rules are inherently based on immigrants' early experiences in the U.S., when they are still adjusting as newcomers. However, immigrants make significant progress as they gain experience living in here; they become better off economically and their use of public benefits declines. Keeping them from being able to enter or to remain here legally short-circuits their ability to become more productive members who improve their own financial and social circumstances and contribute to the U.S. economy.
3. DHS produced an economic analysis of the impact of the public charge rule. Although it indicated that numerous members of immigrant households, including citizens, would lose

public benefits—including Medicaid, the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI) and federal rental assistance due to the "chilling effect" and fear, the DHS analysis is seriously flawed and understates the harm of the rule. Our independent analyses, based on stronger and more recent data, indicate that about 3.7 million members of immigrant households could lose public benefits, with a combined value of about $21.3 billion in federal benefits lost in 2026. The DHS analyses underestimate the likely harm by about three-quarters. (Both the DHS analysis and ours provide a range of low to high estimates, the numbers shown above are our midpoint estimates. But even our low estimates indicate a substantially greater impact than DHS' preferred midpoint estimates.)

4. The DHS economic impact analysis indicated that there was evidence of more extensive economic and health harm to the nation, such as harm to health care providers, but did not provide any analyses of these harms. We conducted an economic and employment analysis, using the IMPLAN economic modeling system; we found that the loss of federal funding will create further repercussions as the losses ripple out through state and local economies. Our midpoint estimates are that state economies could lose about $27.4 billion in 2026 due to the new public charge proposal, roughly one-third more than the direct loss of federal funds. About 212,000 jobs would be lost that year because of the economic effects of the proposal. the economic and employment losses will extend well beyond immigrant households and would create harm to U.S. citizens and other lawfully present immigrants on a much broader basis. There will be particularly large effects in the health care sector, due to the loss of Medicaid and CHIP coverage, and will cause hospitals, clinics, pharmacies and other providers to lose staff and, in some cases, to shut down.
5. The revised estimates indicate that about 2.7 million members of immigrant households (with estimates ranging from 1.3 to 4.0 million), many of them citizens or other lawfully present immigrants, would lose Medicaid or CHIP health insurance coverage. Prior research indicates that Medicaid coverage is associated with reductions in mortality. The large loss of Medicaid and CHIP coverage could increase the number of premature deaths by about 3,500 per year (with estimates ranging from 1,800 to 5,300) due to the changes in public charge guidance.

Eliminating Public Charge Guidance Will Not Lead to Better Assessments by Immigration Officials

The implicit goal of public charge exclusions is that denying admission or adjustments in immigration status by immigrants who have used public benefits in the past – even if they were legally eligible for the benefits – reduces the number of people who will not become productive and self-supporting members of the United States. An underlying principle of the NPRM is that eliminating regulatory and sub-regulatory public charge guidance will empower immigration officials to use their discretion to make determinations of public charge and, as a result, they will make better assessments.

But do immigration officials make sound determinations? Do they have adequate judgment to assess the facts and to accurately predict who will become a public charge in the future? We examined this by looking at ten years' worth of visa processing determinations by State Department officials from 2015 to 2024, as recorded in the State Department's annual visa statistics reports (see the table below).[2] The reports list the reported grounds for refusal in each year under the Immigration and Nationality Act; there are dozens of categories such as drug abusers, communicable disease, etc. For the category "public charge" the data show that between 2015 and 2024 there were 48,844 findings of public charge. The number of public charge findings was higher in the 2018 to 2020 period when the first Trump Administration broadened public charge guidance, before the guidance was withdrawn following a federal court

Public Charge Findings - According to Dept of State, Report of the Visa Office: FY 2015-24
https://travel.state.gov/content/travel/en/legal/visa-law0/visa-statistics.html

Note: The Visa report tables list many reasons for ineligibility findings, this is just the public charge ineligibility findings.

From Tables XX (2016-2019) and XIX (2020 to 2024): **Public Charge Determinations**

	For Immigrants:		
	Ineligibility	Ineligibility	
Fiscal Year	Finding (1)	Overcome (2)	
2015	897	1,011	
2016	1,026	912	
2017	3,230	2,016	
2018 #	13,450	7,932	
2019 #	20,941	9,622	
2020	6,541	6,175	
2021	621	3,104	
2022	678	2,063	
2023	452	766	
2024	1,008	846	**Cumulative Share Overcome**
TOTAL	**48,844**	**34,447**	**70.5%**

Footnotes in the Visa Reports describe the headings of "Ineligibility Finding" and "Ineligiblity Overcome":
1 The table above reflects the number of unique applications found ineligible for issuance based on a given ineligibility ground during the listed fiscal year. The total of ineligibility findings does not necessarily reflect the number of applications refused because an application may be found ineligible under more than one ground of ineligibility during a fiscal year.

2 The ineligibilities overcome may not necessarily represent the same ineligibilities recorded in the total of ineligibility findings. A visa may be refused in one fiscal year and the refusal overcome in a subsequent fiscal year. Each action will be separately recorded as part of the appropriate statistical report for the year in which it occurred. A refusal can be overcome by evidence that the ineligibility does not apply, by approval of a waiver, or by other relief as provided by law.

decision.[3] (These are data reflecting State Department determinations; we do not believe that DHS provides public information about its public charge determinations.)

Most of the time, the public charge findings are subsequently dismissed. Data show that 34,447 of the 48,844 public charge findings (70.5 percent) were subsequently "overcome," meaning that they were later dismissed. The reports note that the cases overcome may occur in a later year after the initial finding and refusal of entry. It explains "A refusal can be overcome by evidence that the ineligibility does not apply, by approval of a waiver, or by other relief as provided by law." That such a large proportion of public charge findings are dismissed suggests that immigration officers' assessments are often imperfect, contrary to DHS' belief that assessments without guidance will be sound.

Moreover, the high rate of dismissals occurred during periods of varying federal guidance about public charge determinations, both before and after the modifications of the prior Trump Administration. Unlike the proposed situation, in which DHS believes that there should be neither regulatory nor sub-regulatory guidance, there were some guidelines to help immigration officers make public charge determinations, as well as bases on which they could be evaluated to be overcome or dismissed. While DHS asserts that eliminating guidance about public charge determinations will help immigration staff make better assessments, the lack of any regulatory or sub-regulatory guidance means that there is no basis to determine whether they are better or worse in making these important determinations.

Judging Immigrant's Ability to Be Self-Supporting and Productive Based on Public Benefit Use Soon After They Arrive Fails to Recognize the Progress Immigrants Make as They Remain for a Longer Period

More fundamentally, we need to ask whether immigration officials are able to make reasonable assessments of the future economic and social trajectory of new immigrants and of their ability to become successful and productive members of the United States. The underlying premise of public charge process is that immigration officials can reasonably predict the future economic and social trajectory of immigrants based on their past or current use of public benefits.

Research and experience indicate the hazard of predicting future economic status based on immigrants' initial years in the U.S. as immigrants are often initially disadvantaged when they arrive in the United States; they have limited American job experience and have not developed the social and business networks that enable people to find better work. However, their status improves rapidly. Research consistently shows that when immigrants first enter the U.S., they tend to have lower incomes than similar U.S.-born adults. But their earnings grow rapidly as they remain in the U.S. and gain experience, skills and opportunities, enabling them to integrate into the economic mainstream.[4] The prototypical immigrant success story is one of a person who comes to the U.S. with little in his or her pocket, but, through hard work and persistence, eventually becomes a success. For example, analyses of Census data reveal that immigrants

without a high school education, such as those targeted by the public charge rule, initially have lower average incomes than similar U.S.-born citizens (with the same gender, age, and education), but the immigrants' average incomes catch up and then surpass their U.S.-born peers within six or seven years.[5] Immigrants often begin with disadvantages but have great economic mobility.

Contrary to stereotypes, analyses by the conservative/libertarian Cato Institute found that immigrants were about 21 percent less likely to use public benefits than native-born citizens.[6] Further, longitudinal data tracking of people's experience over four years demonstrate that not only are immigrants less likely to use public benefits than native-born citizens at the beginning, but immigrants' use of benefits like Medicaid, SNAP, TANF and SSI declines steadily as they remain in the U.S. for more time, consistent with their growing ability to become financially independent and self-supporting.[7]

It is not surprising that immigrants most need assistance when they first arrive in the nation, but they make progress in attaining self-sufficiency over time. Historically, the U.S. has recognized this, and often provided assistance such as refugee resettlement programs to help immigrants make successful transitions to American life. Refusing to admit immigrants or to adjust their immigration status because of prior use of public benefits is short-sighted and effectively sanctions those who will become self-supporting, productive members of the nation and who will make subsequent economic and social contributions.

Public charge policies that make it harder for immigrants to remain in the U.S. jeopardize their ability to improve their economic status. There is even stronger evidence of the economic and educational success of "second generation" immigrants, the U.S.-born children of immigrants.[8] [9] Public charge policies that reduce the ability of immigrants or their children to remain in the United States could short-circuit their subsequent economic well-being.

The DHS Economic Impact Analysis Is Seriously Flawed and Dramatically Understates the Likely Harm for Members of Immigrant Households

The NPRM includes an economic impact analysis, as required under by Executive Orders 12866 and 13563, which indicates that a large number of members of immigrant families, who include U.S. citizens and other lawfully present immigrants, may disenroll from or be deterred from enrolling in federal benefit programs for which they are eligible. This is largely presented in the context that the federal government (and states) would save money by not having to pay for benefits in these programs.

DHS estimated that 950,124 members of immigrant households could disenroll or forego enrollment in Medicaid, CHIP, SNAP, TANF program, SSI and federal rental assistance programs such as Section 8 housing vouchers. This was its primary or midpoint estimate based on an assumption that 10.3 percent of members of immigrant households would lose benefits (disenroll or forego) due to the "chilling effect" of fear and confusion related to the public charge

rules[10] (See Table VI.11 on page 52216 of the NPRM.) It also uses low and high estimates of losses based on a 3.3 percent and 17.3 percent loss rates, and used older data about program costs to estimate federal savings of $5.29 billion per year (the midpoint estimate).

The DHS analyses are flawed and seriously underestimate the likely scope and scale of the harms resulting from the public charge rule. An independent analysis by researchers at KFF (formerly the Kaiser Family Foundation, a nonpartisan, nonprofit research organization) provides different, more reasonable and up-to-date estimates of the "chilling effects" of the proposed rule.[11] Their estimates used data from a 2025 nationally representative survey of immigrants conducted by KFF and the New York Times and a similar 2023 KFF/Los Angeles Times survey that queried immigrants about their willingness to use public benefits, like Medicaid, in light of current trends.[12] The KFF analysis also uses more current and accurate data about participation in Medicaid and CHIP than that used by DHS used.

KFF concluded that between 10 percent and 30 percent of members of noncitizen immigrant household, totaling between 1.3 and 4.0 million persons, could lose Medicaid or CHIP benefits due to new NPRM and relaxed public charge rules. This includes between 600,000 and 1.8 million U.S. citizen children who are members of immigrant families and who are likely to lose benefits even though they are citizens and remain fully eligible for the program. It is noteworthy that the revised DHS public charge rule does not clearly indicate that the use of program benefits by citizens or other lawfully present members of immigrant households should not be used as the basis for a public charge finding against an immigrant, unlike prior guidance including the 2022 regulation that DHS now seeks to rescind. This range of loss is more consistent with earlier analyses about the chilling effects caused by public charge rules, such as those based on research by the Urban Institute.[13] The KFF researchers also used improved and more recent estimates of the number of immigrant household members who participate in Medicaid or CHIP; by comparison the data used by DHS were out-of-date and less accurate.

We compared the DHS analyses with the more reasonable KFF estimates and generated a revised range of estimates of participation in Medicaid, CHIP, SNAP, TANF, SSI and federal rental assistance and the reduction in federal costs for these programs if the new public charge rules go into effect. Like both DHS and KFF, we acknowledge that there is some uncertainty of the impacts because of both the lack of clarity in the new public charge NPRM and the changing level of fear in immigrant communities during the Trump Administration. The table below compares low, midpoint and high estimates of the number of members of immigrant households who could lose federal benefits and the cost of federal benefits lost.

The DHS estimates indicate that between 304,000 and 1.59 million people could lose Medicaid, CHIP, SNAP, TANF, SSI or federal rental benefits per year and annual reduction in federal funds for assistance will range from $1.7 billion to $8.9 billion per year; DHS cites 950,000 persons and $5.3 billion as the midpoint estimates. Our improved independent estimates indicate that 3.70 million members of immigrant households (with a range of 1.85 to 5.56 million) could lose these public benefits due to fear and the public charge "chilling effect,"

which would lead to $21.3 billion (with estimates ranging from $10.5 billion to $32.0 billion) in federal benefits lost in 2026.

Comparison of DHS and Revised Estimates of the Impact of Changes in Public Charge Guidelines Based on the DHS Proposed Regulation of Nov. 19, 2025

DHS ESTIMATES OF IMPACT (BASED ON TABLES VI.11 and VI.12 OF the NPRM)

	Estimate of Those Losing Benefits			Annual Federal Funds Lost		
	Low 3.3% Loss	Midpoint 10.3% Loss	High 17.3% Loss	Low 3.3% Loss	Midpoint 10.3% Loss	High 17.3% Loss
				($ mil.)	($ mil.)	($ mil.)
Medicaid/CHIP (persons)	135,444	422,748	705,948	$1,104	$3,432	$5,760
SNAP (persons)	143,106	446,664	745,886	$328	$1,018	$1,709
TANF (persons)	5,282	16,486	27,530	$9	$28	$46
SSI (persons)	20,577	64,226	107,251	$155	$482	$809
Federal Rental (households)	11,308	35,294	58,938	$106	$330	$554
TOTAL*	**304,409**	**950,124**	**1,586,615**	**$1,701**	**$5,290**	**$8,878**

REVISED ESTIMATES OF IMPACT, BASED ON ANALYSES BY GEORGE WASHINGTON UNIVERSITY

	Count of Those Losing Benefits			Federal Funds Lost in 2026		
	Low 10% Loss	Midpoint 20% Loss	High 30% Loss	Low 10% Loss	Midpoint 20% Loss	High 30% Loss
				($ mil.)	($ mil.)	($ mil.)
Medicaid/CHIP (persons)	1,340,000	2,680,000	4,020,000	$8,923	$17,845	$26,768
SNAP (persons)	433,654	867,309	1,300,963	$976	$1,953	$2,929
TANF (persons)	16,006	32,012	48,017	$27	$67	$107
SSI (persons)	62,355	124,711	187,066	$559	$1,397	$2,236
Federal Rental (households)	34,266	68,532	102,798	$320	$800	$1,281
TOTAL*	**1,852,016**	**3,704,031**	**5,556,047**	**$10,485**	**$21,263**	**$32,040**

* Total Count of Those Losing Benefits is persons. It does not include households losing Federal Rental Assistance. Total Federal Funds Lost is millions of dollars lost in 2026, all sources combined.

There are three primary reasons for the differences between the DHS estimates and GW's revised estimates, which are based on more recent and more accurate information. First, DHS assumed a midpoint estimate of 10.3 percent of members of immigrant households losing benefits (bracketed by a 3.3 percent low and a 17.3 percent high rate), while we have used a midpoint estimate of 20 percent loss, bracketed between 10 percent and 30 percent loss, based on KFF's analysis of recent survey data. Second, DHS used very out-of-date and inaccurate data about Medicaid and CHIP participation. Application of more accurate and up-to-date data from KFF, yielded higher estimates of the number of Medicaid and CHIP beneficiaries losing benefits. Finally, DHS used dated information about federal program costs in its estimates, typically based on averages between 2019 and 2024, which fail to properly account for inflation and changes in program costs. We relied on estimates of federal Medicaid, CHIP, SNAP and SSI costs per participant for Fiscal Year 2026, as estimated by the Congressional Budget Office, the nonpartisan body that provides estimates for Congress that are used for official budget estimates.[14]

DHS has seriously underestimated the number of low-income people who might lose federal benefits and the level of federal funding that they will lose. In comparison to more rigorous independent estimates using stronger data, the DHS midpoint estimates of the number of people losing benefits (DHS 950,000 vs. revised 3.7 million) and of the cost of federal benefits lost (DHS $5.3 billion vs. revised $21.3 billion) appear to be about three-quartets too low.

The Revised Public Charge Proposal Would Cause Tens of Billions of Dollars in Damage to the Economy and Cause Hundreds of Thousands of Jobs to Be Lost

DHS' economic impact analysis has another serious shortcoming. Although it acknowledges that there could be additional economic or health harms due to the revised rule because so many people will lose health, nutrition, housing or economic benefits, DHS did not try to estimate the economic impact. We provide estimates of the economic and employment harm that will occur across states as a result of the loss of federal funding for Medicaid, CHIP, SNAP and SSI benefits, estimated for 2026. As explained in note 15, these estimates do not include TANF or federal rental assistance losses in the federal funding losses.[15] We used a widely-respected economic modeling system called IMPLAN,[16] which we have used in similar policy research studies,[17] to estimate economic and employment effects of the loss of federal funding. The results are summarized in the table below.

Estimates of Economic, Employment and State/Local Tax Revenue Losses in 2026, Due to Revised Public Charge Guidelines: Low, Midpoint and High Estimates

	Federal Funding Loss	State GDP Loss	Job Loss			State/Local Tax Loss
	($ mil.)	($ mil.)	Direct	Indirect	Total	($ mil.)
Low Estimate (10% Loss)						
Medicaid/CHIP	-$8,923	-$12,669	-36,600	-60,700	-97,300	-$897
SNAP	-$976	-$380	-2,400	-1,300	-3,700	-$47
SSI	-$559	-$674	-2,300	-2,600	-4,900	-$66
TOTAL*	**-$10,458**	**-$13,722**	**-41,400**	**-64,600**	**-106,000**	**-$1,010**
Midpoint Estimate (20% Loss)						
Medicaid/CHIP	-$15,949	-$1,346	-73,300	-121,400	-194,600	-$1,795
SNAP	-$1,953	-$759	-4,800	-2,600	-7,500	-$94
SSI	-$1,118	-$1,347	-4,700	-5,200	-9,900	-$131
TOTAL*	**-$20,916**	**-$27,444**	**-82,800**	**-129,200**	**-212,000**	**-$2,020**
High Estimate (30% Loss)						
Medicaid/CHIP	-$26,768	-$37,409	-109,900	-182,000	-292,000	-$2,692
SNAP	-$2,929	-$1,139	-7,200	-4,000	-11,200	-$141
SSI	-$1,677	-$2,021	-7,000	-7,800	-14,800	-$197
TOTAL*	**-$31,374**	**-$41,165**	**-124,100**	**-193,800**	**-318,000**	**-$3,030**

***** Total federal funding losses do not include TANF or federal rental assistance losses. See text.

Sourc: George Washington University analyses, using IMPLAN

The analysis indicates that the estimated loss of federal funds for Medicaid, CHIP, SNAP and SSI ($20.9 billion in the midpoint estimate) would shrink state economies, as measured by

their gross domestic products or GDPs, by about $27.4 billion in 2026, or 31 percent more than the reduction in federal funding. In addition, this could lead to the loss of 212,000 jobs. Of the jobs lost, about 73,000 would be health care-related jobs (the direct job losses related to Medicaid and CHIP), about 4,800 jobs lost would be related to grocery and other food-related industries and the rest would be spread across all sectors of state economies, such as retail, construction, etc. Finally, state and local governments would lose about $2.0 billion in state and local tax revenues because of the loss of individual and business incomes. Our low and high range estimates are also shown in the table above.

The analyses indicate that the broader economic impact of the proposed public charge policies could lower state economies by between $13.7 and $41.2 billion in 2026 and cause between 106,000 and 318,000 jobs to be lost. An earlier analysis, conducted by the Fiscal Policy Institute about the public charge regulation promulgated during the first Trump Administration in 2019 (which was subsequently withdrawn), reached similar conclusions to those of the George Washington University researchers. They estimated that the 2019 public charge rule could reduce the gross domestic product by $24 billion and cause the loss of 164,000 jobs nationally.[18] As noted above, DHS did not try to estimate these economic impacts, although they indicated that there could be broader harm to the national economy.

Some health care facilities, such as community health centers, clinics, pharmacies and perhaps even hospitals, could close because of the combined loss of insurance revenue and their higher uncompensated care costs, particularly if they are located in low-income communities with high immigrant populations, although we do not try to estimate the number of health facility closures. An analysis of the public charge policy proposed by the first Trump Administration in 2019 estimated that safety net clinics and hospitals could lose $346 to $624 million, which would reduce their ability to stay open and serve vulnerable patients, including U.S. citizens.[19]

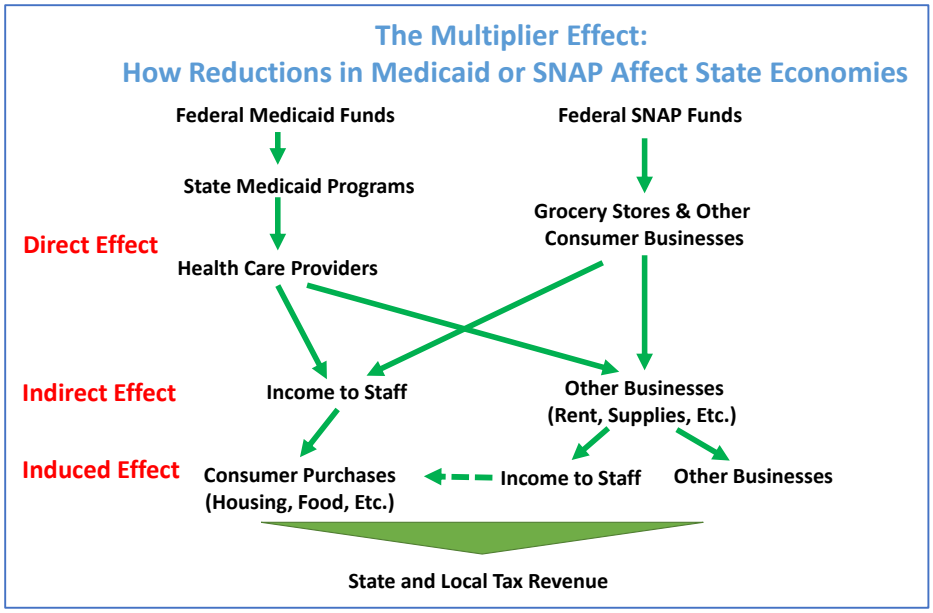
The loss of Medicaid and CHIP coverage due to revised public charge rules can deter healthcare access, which can exacerbate health and economic problems. Denying insurance coverage for primary and preventive care does not eliminate immigrants' need for services. The lack of preventive and primary care means that immigrants' health problems can worsen and eventually require more serious and expensive care required at hospitals' emergency departments, which are required to provide at least screening and stabilization services to all patients with emergency needs, regardless of insurance or immigration status, under the Emergency Medical Treatment and Active Labor Act (EMTALA).[20] Thus, the loss of Medicaid and CHIP coverage would result in additional uncompensated care costs for hospitals.

Denying admission or adjustment of status to large numbers of immigrants may also have broader repercussions for the supply of the health care workforce. One study showed that 17.3 percent of all health care professionals were born outside the U.S.; further, non-U.S.-born professionals worked more hours, were more likely to work at night and in institutional and in-home long-term care settings, and were more likely to reside in medically underserved communities.[21] Immigrants also play a critical role in providing long-term care to older adults

and people with disabilities. An estimated one in four direct care workers are immigrants, with even higher proportions some regions.[22] Denials of admission or of adjustments in status due to the public charge rule, which could lead to the loss of work authorization, could reduce the availability of immigrants who could provide health care services. This could have repercussions and reduce the availability of care for the general population, including U.S. citizens.

When immigrants are forced to avoid public benefits like SNAP, they must spend less, resulting in losses to local economies.[23] Grocery stores and other retail establishments would lose business, and some might close. Since the economic and job losses would be broad, most of those losing jobs are U.S. citizens, who comprise the majority of employed persons. Some of those losing jobs would be immigrants but not necessarily recent immigrants or those seeking to adjust status. The losses to businesses and economic and employment harm would be felt by citizens and immigrants who are NOT targets of the public charge rule; these are broader harms inflicted upon the general public, "ordinary Americans".

It is worth explaining how these losses occur, as estimated by IMPLAN. For example, reducing Medicaid and CHIP benefits means that health care providers, including hospitals, clinics, pharmacies and others, will have less revenue; this is sometimes called the "direct effect". (See the illustration below.) In turn, this means that they have less money to pay their staff and to purchase goods or services from others, such as rent for their space, equipment or IT services; this is the "indirect effect." The businesses that supply them will also lose revenue, creating problems paying their staff and purchasing goods or services as well. Because the health care providers and supply chain businesses have less income, they will have to lay off staff or reduce wages. As employees lose their jobs (or income), they have less to spend on consumer goods like groceries, utilities and rent, harming those downstream businesses as well; this is the "induced effect." In the end, the loss of individual and business incomes ultimately also causes state and local tax revenues to fall, making it harder for state and local governments to provide



services like education and health care. The effect of reduced SNAP benefits is similar to that for Medicaid, except the effects are mediated through reductions in grocery and other consumer purchases.

Our models rely on changes in federal funding, rather than total funding associated with the public charge policies. The changes in federal funding can be considered exogenous "shocks" to state economies that arise because of the change in federal policy. There may be adjustments made at state levels: some states might use state resources to protect immigrant households, while others might take related state savings (e.g., state matching funds for Medicaid or CHIP) and use these savings for other budget purposes. But since almost all states have balanced budget requirements, there will be trade-offs in other parts of the state budgets that will also have economic repercussions. Focusing on changes dictated by federal policy is superior in isolating causal factors that affect state economies and employment and is a more conservative approach to estimation.

In addition to the direct harm that is caused to members of immigrant households who lose important health, nutrition, and other social benefits, there are broader losses to health care providers, food establishments, and to employment of citizens as well as immigrants. The aggregate harm to state and local economies is about 31 percent more than the direct loss in federal benefit payments because of the multiplier effect and repercussions of the funding losses.

Reductions in the Number of People with Medicaid Coverage Could Cause Thousands of Additional Deaths

There is a substantial body of research that demonstrates the health benefits of Medicaid coverage.[24] [25] Nutrition assistance from SNAP also has demonstrated health benefits that can both promote better health outcomes as well as lower health care costs.[26] [27]

One of the signs of the importance of Medicaid and CHIP benefits is research that has demonstrated how the expansion of Medicaid eligibility under the Affordable Care Act was associated with reducing premature mortality rates, i.e., death, by improving access to health care. Sarah Miller (University of Michigan) and her collaborators at the U.S. Census Bureau and New York University found that Medicaid participation was associated with a 0.132 percentage point reduction in the annual mortality rate.[28] Based on our midpoint estimate of 2.7 million people losing Medicaid and CHIP benefits, this suggests that there could be about 3,500 more deaths in the United States per year due to the new public charge proposal. Using our low and high estimates of reductions in the number of participants, this indicates a range of about 1,800 to 5,300 additional deaths per year as a consequence of millions of members of immigrant households losing Medicaid or CHIP coverage due to DHS' public charge proposal.

End Notes

[1] Department of Homeland Security. Notice of Proposed Rulemaking: Public Charge Ground of Inadmissibility. 90 *Federal Register* 52168-224, Nov. 19, 2025.

[2] U.S. State Department. Visa Statistics. Reports of the Office of Visas, Fiscal Years 2015-24. Particularly, see Tables XX and XIX. Immigrant and Nonimmigrant Visa Ineligibilities (by Grounds for Refusal Under the Immigration and Nationality Act). https://travel.state.gov/content/travel/en/legal/visa-law0/visa-statistics.html

[3] State Department. Update on Public Charge, March 26, 2021. https://travel.state.gov/content/travel/en/us-visas/visa-information-resources/visas-news-archive/update-on-public-charge.html.

[4] See, for example, Chiswick B. The effect of Americanization on the earnings of foreign-born men. *Journal of Political Economy* October 1978: 897–922; Duleep H, Dowhan D. Research on immigrant earnings. *Social Security Bulletin*. 2008; 68(1): 31-50; Kaushal N, et al. Immigrant employment and earnings growth in Canada and the USA: evidence from longitudinal data. *Journal of Population Economics*. 2016; 29(4): 1249–1277; Borjas G, Friedberg R. Recent trends in the earnings of new immigrants to the United States. National Bureau of Economic Research Working Paper 15406. Oct.2009.

[5] Ku L, Brantley E. Immigrants' Progress: Changes in Public Charge Policies Can Promote The Economic Mobility of Immigrants and Their Contribution to the U.S. Economy (April 18, 2022). Available at SSRN: http://dx.doi.org/10.2139/ssrn.4086782. Ku L, Pillai D. The Economic Mobility of Immigrants: Public Charge Rules Could Foreclose Future Opportunities. Nov. 15, 2018. Social Science Research Network. http://ssrn.com/abstract=3285546

[6] Nowrasteh A, Famularo J. Immigrants Used Less Welfare than Native-Born Americans in 2022. Cato Institute. Feb. 18, 2025. https://www.cato.org/blog/immigrants-used-less-welfare-native-born-americans-2022 . Nowrasteh A, Orr R. Immigration and the Welfare State: Immigrant and Native Use Rates and Benefit Levels for Means-Tested Welfare and Entitlement Programs. Cato Institute Immigration Policy and Research Brief No. 6. May 10, 2018. https://www.cato.org/publications/immigration-research-policy-brief/immigration-welfare-state-immigrant-native-use-rates.

[7] Ku and Brantley, *op cit.*

[8] Pew Research Center. Second-Generation Americans: A Portrait of the Adult Children of Immigrants. Feb. 2013. https://www.pewresearch.org/wp-content/uploads/sites/3/2013/02/FINAL_immigrant_generations_report_2-7-13.pdf; Doung M, et al. Generational Differences in Academic Achievement Among Immigrant Youths: A Meta-Analytic Review. Review of Education Research. 2016; 86(1): 3-41.

[9] Brief of Social Science Scholars as Amici Curiae in Support of Plaintiffs-Appellees and Affirmance. Related to an Appeal from a Decision of the United States District Court for the Western District of Washington in U.S. Court of Appeals for the Ninth Circuit. State of Washington, et al, v Donald J. Trump, et al.

[10] Table VI.11 of the proposed regulation, page 52216.

[11] Artiga S, Pillai D, Cervantes S, Pillai A, Rae M. Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment. KFF. Dec. 2, 2025. https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/

[12] Pillai D, Artiga S, Pillai A, et al. KFF/New York Times 2025 Survey of Immigrants: Health and Health Care Experiences During the Second Trump Administration. KFF. Nov. 18, 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/. Pillai D, Artiga S, Hamel L, et al. Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants. KFF. Sept. 17, 2023. https://www.kff.org/racial-equity-and-health-policy/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/

[13] See reports summarized in Artiga S, et al. Dec. 2, 2025. Also see Gonzalez D, Bernstein H. One in Four Adults in Mixed-Status Families Did Not Participate in Safety Net Programs in 2022 Because of Green Card Concerns. Urban Institute. Aug. 2023. https://www.urban.org/research/publication/one-four-adults-mixed-status-families-did-not-participate-safety-net-programs

[14] Congressional Budget Office. Details About Baseline Projections for Selected Programs. https://www.cbo.gov/data/baseline-projections-selected-programs#9

[15] We do not include federal funding estimates for losses in TANF or federal rental assistance programs, such as Section 8 housing vouchers. They are funded as grant programs given to states or housing agencies; if fewer immigrant family members use TANF or rental assistance, the states or housing agencies can use the funds to serve other people This is unlike Medicaid, SNAP or SSI which are eligibility-based entitlement programs where fewer participants lower federal outlays. CHIP is also a grant-based program but is typically operated along with Medicaid, so it effectively functions like an entitlement for this analysis.

[16] For more information about IMPLAN, see https://implan.com.

[17] For example, Ku L, Kwon K, Nketiah L, Gorak T, Krips M, Cordes J. How Medicaid and SNAP Cutbacks in the "One Big Beautiful Bill" Would Trigger Big and Bigger Job Losses Across States. Commonwealth Fund. June 23, 2025. https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/how-medicaid-snap-cutbacks-one-big-beautiful-bill-trigger-job-losses-states. Ku L, Gorak T, Orgera K, Kwon K, Krips M, Cordes J. Expiring ACA Premium Tax Credits Could Lead to Nearly 340,000 Jobs Lost Across the U.S. in 2026 Commonwealth Fund. Oct. 16, 2025. https://www.commonwealthfund.org/publications/issue-briefs/2025/oct/expiring-premium-tax-credits-lead-340000-jobs-lost-2026.

[18] Fiscal Policy Institute. Only Wealthy Immigrants Need Apply: The Chilling Effects of "Public Charge." Nov. 25, 2019. https://fiscalpolicy.org/publiccharge2019

[19] The Center for Law and Social Policy. CLASP Statement for the Record "Impact of Illegal Immigration of Social Services." Congress.gov. Published January 11, 2024. Accessed August 12, 2025. https://www.congress.gov/118/meeting/house/116727/documents/HHRG-118-JU01-20240111-SD021.pdf

[20] Staman J. Overview of the Emergency Medical Treatment and Active Labor Act (EMTALA) and Emergency Abortion Services. Congressional Research Service. Mar. 2023. https://www.congress.gov/crs-product/IF12355

[21] Commodore-Mensah Y, et al. Prevalence and Characteristics of Non-U.S.-Born and U.S.-Born Health Care Professionals, 2010-2018. *JAMA Network Open* 4 (April 29, 2021). https://pmc.ncbi.nlm.nih.gov/articles/PMC8085726/

[22] Immigration and the Direct Care Workforce. Paraprofessional Healthcare Institute. March 31, 2025. https://www.phinational.org/immigration-and-the-direct-care-workforce/

[23] Center for Law and Social Policy. CLASP Statement for the Record "Impact of Illegal Immigration of Social Services." Congress.gov. January 11, 2024.

https://www.congress.gov/118/meeting/house/116727/documents/HHRG-118-JU01-20240111-SD021.pdf

[24] Chu R, Peters C, Buchmueller T. Medicaid: The Health and Economic Benefits of Expanding Eligibility. Office of the Assistant Secretary for Planning and Evaluation, US Dept. of Health and Human Services. Sept. 2024. https://aspe.hhs.gov/sites/default/files/documents/effbde36dd9852a49d10e66e4a4ee333/medicaid-health-economic-benefits.pdf

[25] Robert Wood Johnson Foundation. Medicaid's Impact on Health Care Access, Outcomes and State Economies. Feb. 2019. https://www.rwjf.org/en/insights/our-research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html

[26] Carlson S, Llobrera J. SNAP Is Linked With Improved Health Outcomes and Lower Health Care Costs. Center on Budget and Policy Priorities. Dec. 14, 2022. https://www.cbpp.org/research/food-assistance/snap-is-linked-with-improved-health-outcomes-and-lower-health-care-costs

[27] Berkowitz S, et al. Supplemental Nutrition Assistance Program Participation and Health Care Use in Older Adults: A Cohort Study. *Archives of Internal Medicine*. Oct. 2022. Vol 174, No. 12.

[28] Miller S, Johson N, Wherry L. Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data. *Quarterly Journal of Economics*. Aug. 2021; 136(3): 1783-1829.