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December 18, 2025

Kristi Noem
Secretary
U.S. Department of Homeland Security
Attention: USCIS–2025–0304
2707 Martin Luther King, Jr. Ave SE
Washington, DC 20528

Re: DHS Docket No. USCIS-2025-0304; Public Charge Ground of Inadmissibility

Dear Secretary Noem,

The AAMC[1] welcomes this opportunity to comment on the proposed rule titled "Public Charge Ground of Inadmissibility" 90 Fed. Reg. 52168 (November 19, 2025), issued by the Department of Homeland Security (DHS), U.S. Citizenship and Immigration Services (USCIS). As we outline in more detail below, we urge DHS to withdraw the proposed public charge definition and keep in place the 2022 public charge final rule, which codified longstanding policy on the public charge ground of inadmissibility.

AAMC-member health systems and teaching hospitals are committed to their four mission areas of clinical care, medical education, biomedical research, and community collaboration. Patients rely on these institutions, knowing that regardless of their economic circumstance or insurance status, they will receive high quality health care. Academic health systems and teaching hospitals provide vital services unavailable at other institutions, including burn centers, trauma centers, transplant centers, psychiatric services, care for substance use disorders, and birthing rooms. AAMC member institutions house 100% of all National Cancer Institutes registered cancer treatment centers, 75% of burn unit beds, 59% of all Level 1 trauma centers, and 64% of all pediatric intensive care unit beds.[2] The impact of the proposals in this rule would be devastating

[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 162 U.S. medical schools accredited by the Liaison Committee on Medical Education; 14 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

[2] AAMC analysis of FY2023 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2024, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2024.

to the health of individuals, including U.S. citizens, already experiencing significant barriers to accessing health care. Ultimately, the rule's provisions would limit the ability of hospitals to offer these comprehensive services in their communities, resulting in worse health outcomes, and threatening public health.

Although AAMC member teaching hospitals make up only 5% of all hospitals, they provide 27% of Medicaid hospitalizations and 33% of hospital charity care.[3] Over the past several years teaching hospitals have been subjected to multiple financial pressures, such as Medicare payment cuts, further straining their ability to remain financially viable while maintaining the breadth of services they provide to their patients. Their financial predicament is bound to further worsen due to continued economic and supply chain uncertainty stemming from tariffs, sweeping changes to Medicaid and the health insurance marketplaces, and other external pressures. If this proposed rule is finalized, academic health systems and teaching hospitals expect to treat more uninsured and sicker patients, thereby increasing their uncompensated care burden and weakening the health care system. These consequences would not be borne solely or even primarily by immigrants or undocumented immigrants—as DHS itself acknowledges, lawfully present individuals, including U.S. citizens, would be disincentivized from enrolling in public benefit programs to which they are otherwise legally entitled. **For the reasons detailed below, we strongly urge DHS to withdraw the proposed rule and maintain the 2022 public charge final rule.**

The proposed rule would unwind decades of precedent and vastly expand the scope of the public charge determination

For decades, immigration officers have assessed whether an individual is likely to become a "public charge" when reviewing their application for admission to the United States, when entering through ports of entry, or for adjustment of status (obtaining lawful permanent residency). The "public charge" term is not explicitly defined in statute and, prior to the first Trump administration, immigration officers had relied on 1999 field guidance issued by the Immigration and Naturalization Service when determining whether an individual is or is likely to become a public charge.[4] The 1999 guidance defines a public charge as an individual applying for admission or adjustment of status who is likely to become "primarily dependent on the government for subsistence," as defined by the receipt of cash benefits or "institutionalization for long-term care at the government's expense," i.e., Medicaid long-term care. The guidance specifically excluded certain public benefits from consideration in public charge determinations, including Medicaid, the Children's Health Insurance Program (CHIP), nutrition programs like the Supplemental Nutrition Assistance Program (SNAP), housing assistance, and other publicly funded benefits, services, and programs. For a brief period from 2019 to 2021, the Trump administration implemented a more stringent public charge definition through a 2019 final rule[5] that was the subject of multiple lawsuits and injunctions. In 2022, DHS reversed the 2019 rule

[3] AAMC analysis of FY2023 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2024, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2024. Data reflect short-term, general, nonfederal hospitals.
[4] Immigration and Naturalization Service. 64 Fed. Reg. 28689. March 26, 1999.
[5] 84 Fed. Reg. 41292. August 14, 2019.

and codified the 1999 field guidance through a final rule.[6] The 2022 final rule added clarifications, such as stating that the receipt of public benefits by an applicant's family members or dependents is not considered in the public charge determination.

In the new rule, DHS proposes to rescind the 2022 final rule but does not specify a new framework to replace the existing definition of public charge, instead stating further guidance will be forthcoming through "policy and interpretive tools."[7] DHS does indicate that it will deviate from the longstanding definition in key respects:

- Lowering the standard for public charge determinations from the likelihood of an individual becoming "primarily dependent" on the government for assistance to "dependent on public resources to meet their needs."[8]
- Affording immigration officers substantial discretion, allowing them to go beyond considering mandatory minimum statutory factors and instead consider "all evidence and information" specific to the individual.[9]
- Expanding the categories of public benefits evaluated in the public charge determination to include "any means-tested public benefit," which suggests the inclusion of any federal or state benefit program.[10]

Each of these changes would drastically expand the applicability of the public charge determination. Lowering the "primarily dependent" threshold would mean that even minimal reliance on the government for assistance that does not arise to a predetermined threshold could result in an individual being deemed a public charge. Allowing immigration officers to consider all evidence and information specific to the individual gives the immigration officer carte blanche to consider factors without being subject to any constraints or parameters. This could lead to the consideration of a family member's (including a U.S. citizen family member's) receipt of public benefits in the public charge determination, which is currently prohibited by the 2022 final rule. And, arguably most concerning, expanding the type of benefits included in the public charge determination to include any federal or state benefit program could result in the addition of health, housing, and nutritional benefits. This could include Medicaid, CHIP, Medicare Part D low-income subsidies (provided to low-income Medicare beneficiaries to cover the cost of prescription drugs), SNAP, and state-only benefits. These changes would result in a chilling effect that would deter citizens and lawfully present noncitizens from seeking benefits.

As noted, DHS' proposal to rescind the 2022 rule would have far-reaching consequences for the public, while providing minimal meaningful opportunity for the public to shape the outcome and analyze the rule's effects. DHS has provided an expedited 30-day comment period instead of the customary minimum 60-day comment period. The agency says it will provide further direction on the public charge definition through guidance and not through formal rulemaking, thus

[6] 87 Fed. Reg. 55472. September 9, 2022.
[7] 90 Fed. Reg. 52169. November 19, 2025.
[8] 90 Fed. Reg. 52169, 52184.
[9] 90 Fed. Reg. 52169, 52183.
[10] 90 Fed. Reg. 52169, 52187.

depriving the public of the opportunity to provide input on any new definition that is put forth in future guidance.

The public charge rule would pose a setback to public health and undermine the goals of the administration, particularly the Make America Healthy Again initiative

We believe that the repercussions of the public charge rule would counteract the goals of the Trump administration, particularly the efforts of HHS to Make America Healthy Again through addressing the root causes of chronic disease, making our children healthy again, and addressing healthy nutrition.[11]

If DHS finalizes the rule and people forgo seeking benefits such as Medicaid, nutritional benefits, and housing benefits, these individuals will choose not to seek preventive care and care for chronic illnesses for fear of being labeled as public charges even though they are lawfully entitled to such care. Forgoing nutritional benefits will result in worse overall health. Therefore, when these patients come to a hospital for treatment, they will be sicker and costlier to treat. Individuals may also delay or avoid needed follow-up care and will again wait until their circumstances are dire, creating a cycle that is bad for their health, will be bad for the health of their communities, and will further endanger the financial health of the providers who treat them. In DHS' own words, the rule "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."[12] DHS also notes other impacts of the rule, including higher prevalence of communicable disease, including among unvaccinated US citizens, increased poverty, housing instability, and lower educational attainments. These adverse outcomes benefit neither noncitizens nor U.S. citizens and are a detriment to the nation as a whole.

The Trump administration and HHS have prioritized the Make America Healthy Again agenda,[13] which is focused on addressing the rise of chronic illnesses, including through improved nutrition. One of the key early focus areas of the MAHA initiative has been childhood chronic disease. As noted in more detail below, the rule would cause potentially up to 1.8 million children to lose benefits.[14] With that change, there would likely be a delay in preventive care and instead, care would be sought as a last resort which is bound to increase the incidence of and worsen the management of chronic disease. We cannot afford to have this happen, especially in children. Therefore, the effects of the public charge rule will run counter to the goals of other federal agencies, including HHS.

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[11] Department of Health and Human Services. Make America Healthy Again. https://www.hhs.gov/maha/index.html
[12] 90 Fed. Reg. 52169, 52218.
[13] White House Fact Sheet. President Donald J. Trump Establishes the Make America Healthy Again Commission. February 13, 2025.
[14] KFF. Artiga, Samantha, et al. Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment. Dec 2, 2025.

The public charge rule would deter millions of lawfully residing Americans, including U.S. citizens, from seeking or maintaining benefits for which they are eligible.

The public charge determination is limited to individuals applying for admission, adjustment of status, and entry to the U.S. on a visa (adjudications of applicants for visas are under the jurisdiction of the Department of State). Due to eligibility restrictions established by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), most categories of noncitizens are ineligible for most of the additional benefit programs that would be included with this proposed rule, such as Medicaid and SNAP.[15] For example, eligibility for federally-funded Medicaid is limited to lawfully residing individuals, which currently includes those with a green card (lawful permanent resident status) and certain humanitarian categories of immigrants, such as refugees and asylees. However, lawful permanent residents must wait five years before being eligible for Medicaid. The types of individuals who would be subject to the public charge rule (those applying for lawful permanent resident status) are therefore generally ineligible for Medicaid or other public benefits that could be added by the rule. Therefore, if the purpose of the rule is to disincentivize undocumented immigrants or other immigrants from accessing these public benefits, it is unnecessary in that PRWORA already prohibits these individuals from accessing public benefits. Individuals who are eligible for benefits such as federally-funded Medicaid generally already have their lawful permanent resident status and have passed a five-year waiting period and therefore would not be subject to the public charge determination. In other words, the populations DHS seeks to restrict from seeking public benefits are not eligible for those public benefits anyway.

While doing little to change the reality that most noncitizens and non-green card holders can't access these federally-funded public benefits, the rule would deter individuals who are eligible for public benefits, including U.S. citizens, from receiving these benefits. Although U.S. citizens are not subject to the public charge determination, many citizens with noncitizen family members in their household might disenroll or forgo enrollment out of the fear that their receipt of benefits could affect a family member's immigration status. This runs counter to the stated goal of the proposed rule, which DHS notes is driven by the administration's stated priority of "uphold[ing] the rule of law, defend[ing] against the waste of hard-earned taxpayer resources, and *protect[ing] benefits for American citizens in need, including individuals with disabilities and veterans*.''[16] DHS acknowledges in the rule that the changes "could result in decreased participation in public benefit programs by individuals who are not subject to the public charge ground of inadmissibility."[17] DHS estimates that 4 million people on Medicaid and CHIP live in households with at least one family member that is not a U.S. citizen or lawful permanent resident. Assuming a disenrollment rate of 10 percent based on historical data on previous disenrollment trends when the 2019 public charge rule was promulgated, DHS estimates that over 400,000 people would disenroll or forgo enrollment in Medicaid and CHIP. While this is alarming, as it would include lawful permanent residents and citizens entitled to Medicaid and

[15] Personal Responsibility and Work Opportunity Act of 1996, P. Law 104-193 (1996).
[16] 90 Fed. Reg. 52169, 52180 (citing Executive Order 14218, Ending Taxpayer Subsidization of Open Borders (emphasis added)).
[17] 90 Fed. Reg. 52169, 52207.

CHIP coverage, we believe it significantly understates the chilling effect of the proposed rule. A recent KFF analysis estimated potential Medicaid and CHIP disenrollment from 1.3 to 4 million, including from 600,000 to 1.8 million U.S. citizen children.[18] Deterring citizens from seeking benefits that will improve their overall health counteracts DHS' stated goal of reducing enrollment of "aliens dependent on public benefits programs" and "protecting benefits for American citizens in need."[19] These trends are borne out by past behavioral responses to immigration policy changes. In the years leading up to the 2019 final rule, even before the rule was implemented, studies documented sharp declines in Medicaid and SNAP enrollment among noncitizens and citizens due to the fear of imminent changes to immigration policy, with an 8 percent drop in Medicaid enrollment for US-born citizens and a 5 percent drop in Medicaid enrollment for naturalized citizens.[20]Another study showed that in 2021, more than one in five adults avoided applying for public benefit programs because of immigration-related fears.[21] And, this time around, the chilling effect of the rule is likely to be amplified due to other changes directed at immigrants, such as aggressive enforcement actions in places of employment and health care settings.

Disenrollment and forgone enrollment would drive up uninsured rates, increase uncompensated care costs, and further strain the budgets of health systems on the frontline of health care innovations and care in their communities.

Decreases in enrollment would translate to higher uninsured rates, decreased Medicaid and CHIP revenues for hospitals, and increased hospital uncompensated care costs. The patients losing health insurance coverage would avoid seeking preventive care, end up getting sicker and would ultimately seek care at the hospital emergency room, driving up costs to the entire health care system. While millions of beneficiaries would lose access to these benefits, the costs of caring for these patients would not disappear. The responsibility for paying for their care would fall on health care providers and state and local governments. AAMC member health systems and teaching hospitals would be compelled to provide these services while receiving no reimbursement, increasing their uncompensated care costs. State and local governments would be forced to search for ways to subsidize their care.

A previous analysis of the Trump administration's 2018 public charge proposed rule found that hospitals were at risk of losing $17 billion in one year in hospital Medicaid and CHIP payments associated with beneficiaries potentially affected by the public charge rule.[22] The estimated number of potentially affected Medicaid and CHIP beneficiaries in recent analyses is similar and

[18] KFF. Artiga, Samantha, et al. Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment. Dec 2, 2025.
[19] 90 Fed. Reg. 52169, 52184.
[20] Migration Policy Institute. Anticipated "Chilling Effects" of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families. December 2020.
[21] Urban Institute. Immigrant Families Faced Multiple Barriers to Safety Net Programs in 2021. November 10, 2022.
[22] Medicaid Payments at Risk for Hospitals Under Public charge. https://www.manatt.com/insights/white-papers/2018/medicaid-payments-at-risk-for-hospitals-under-publ. November 15, 2018.

given the scope of the changes included in the proposed rule, the lost Medicaid and CHIP revenues would be even more pronounced if this rule were to be finalized.[23]

Medicaid is a vital source of coverage and care for over 70 million Americans, including, infants, children, the frail elderly, people with disabilities, and working adults. AAMC-member health systems and teaching hospitals play an outsized role in caring for this population—although our members comprise just 5 percent of hospitals nationwide, they account for 29 percent of Medicaid inpatient days.[24] For this reason, any policy that would reduce federal Medicaid funding would disproportionately impact our member institutions, impeding their ability to serve the nation's most vulnerable patients.

The harm to AAMC member health systems and teaching hospitals and their patients resulting from the public charge changes would only be compounded by coverage losses and payment cuts associated with the One Big Beautiful Bill Act.[25] That act made sweeping changes to Medicaid and health insurance marketplace eligibility, provider payments, and Medicaid financing mechanisms, which the Congressional Budget Office estimates will lead to nearly $1 trillion in Medicaid cuts and 10 million people becoming uninsured.[26] We are concerned that, taken together, these policy changes would result in substantial irreversible harm to academic health systems and teaching hospitals and their patients.

The public charge rule, which does not provide a new definition or any standards, would lead to variability and inconsistency

The rescission of the 2022 rule, coupled with the vast expansion of the public charge definition proposed by DHS, provides for an open-ended definition of public charge that will be difficult to administer and lead to inconsistent adjudications of immigration applications. Immigration officers have become accustomed to assessing lawful permanent resident applications against the decades-old public charge standard, and a reversal of this definition, without a detailed framework in its place, would result in inconsistency and confusion in its application. The rescission of the rule would in effect result in each immigration officer imposing their own definition of the public charge definition, not held to any standard or following any guidelines. This would be administratively burdensome and an inefficient use of public resources, as immigration officer determinations would likely be subject to widespread further review due to inconsistencies.

In addition to the uncertainty for immigration officers, benefit-granting agencies and their personnel would be left in the untenable position of fielding questions from constituents about their ability to apply for benefits without jeopardizing their immigration status or that of a family member. After the Trump administration revised the public charge definition in 2019 to include

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[23] KFF. Artiga, Samantha, et al. Potential "Chilling Effects" of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment. Dec 2, 2025.
[24] AAMC analysis of AHA Annual Survey Database FY2023 and NIH Extramural Research Award data. Data reflect short-term, general, nonfederal hospitals.
[25] One Big Beautiful Bill Act. P. Law 119-21 (2025).
[26] Center for Children and Families. New CBO Health Coverage Estimates of Budget Reconciliation Law**.** August 14, 2025; Congressional Budget Office. Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline. July 21, 2025.

more public benefits, state and local agencies, as well community-based organizations, were flooded with inquiries from their community members about whether they could apply for benefits without risking their immigration status. This put these organizations in the precarious position of having to play the role of immigration attorney. The lack of clarity that would result from the rescission of the 2022 rule would place these agencies in a similarly difficult situation, particularly because the rule does not delineate the specific benefit categories that would be included. Agencies and organizations would have to train their staff on the updated regulations, develop public-facing materials for communities, and conduct outreach to their communities to explain which populations are and are not affected. **For the reasons cited above, we recommend that DHS withdraw the proposed rule and maintain the 2022 public charge final rule.**

Thank you for the opportunity to comment on this proposed rule. We would be happy to work with DHS on any of the issues discussed or other topics that involve the academic medicine community. If you have questions regarding our comments, please feel free to contact my colleagues – Shahid Zaman (szaman@aamc.org) and Andrea Price-Carter (apricecarter@aamc.org).

Sincerely,

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Cc: David J. Skorton, M.D., AAMC President and Chief Executive Officer