American Hospital Association™
Advancing Health in America

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December 19, 2025

Joseph B. Edlow
Director
U.S. Citizenship and Immigration Services
Regulatory Coordination Division
5900 Capital Gateway Drive
Camp Springs, MD 20746

Re: Notice of Proposed Rulemaking – Public Charge Ground of Inadmissibility

Dear Director Edlow:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Department of Homeland Security's (DHS) proposed rule regarding the Public Charge Ground of Inadmissibility. Public charge determinations assess how likely it is that an individual seeking immigration to the United States will become dependent on government assistance for support and subsistence. These policy changes redefine what information DHS officers can consider during public charge determinations and expand DHS discretion in assessing whether individuals may become dependent on government assistance, potentially affecting their access to federal health care programs.

The AHA is concerned that the proposed rule will cause a "chilling effect" that could disrupt coverage for *lawfully present* populations who are eligible for Medicaid and CHIP and may include children, pregnant women, individuals with chronic conditions, and families with mixed immigration status. Furthermore, the proposed rule's ripple effects could impact the health of all Americans, including citizens, should those living among them delay preventive care due to lack of coverage. **The AHA urges DHS to exclude Medicaid and the Children's Health Insurance Program (CHIP) from its public charge determinations.**

The proposed rule would repeal the 2022 Public Charge regulatory framework and eliminate specific definitions, allowing DHS officers greater flexibility in deciding whether an individual is likely to become a "public charge." Under this proposal, officers could consider a wider range of public benefits, including Medicaid, CHIP, the Supplemental

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Nutrition Assistance Program (SNAP), supplemental or special-purpose benefit, and any other information they determine to be relevant to the public charge determination. The rule also removes from regulation the list of exemptions and waivers for the public charge ground of admissibility. According to DHS, should the rule be finalized, the agency will develop policy and interpretive tools to support DHS officers in decision making in public charge determinations, in lieu of the regulatory framework.

While the One Big Beautiful Bill Act (OBBBA) clarified that certain categories of legal immigrants remain eligible for Medicaid and CHIP, this proposed rule threatens to undermine that statutory intent. Refugees, asylees, humanitarian entrants, lawful permanent residents, certain Cuban/Haitian nationals, and individuals residing under a Compact of Free Association (COFA) with Palau, Micronesia, and the Marshall Islands continue to qualify for coverage under federal law. However, the public charge policy may create fear and confusion among these groups, leading them to avoid enrollment out of concern that participation could negatively impact their own or their family members' immigration status.

DHS acknowledges that disenrollment from programs like Medicaid and CHIP can lead to a reduction in revenues for hospitals participating in Medicaid. However, it did not consider the extent of the impact of coverage loss on the broader communities hospitals serve. Federal law requires hospitals to provide emergency care to all individuals, regardless of immigration status, availability of health insurance or a patient's ability to pay. Specifically, even if individuals do not have health insurance, hospitals will treat them when they show up in the emergency department often sicker than if they had received appropriate preventive care. Increased wait times for care and reduced bed and provider capacity, alongside an increase in uncompensated care, jeopardizes access to these vital but limited resources for everyone in the community. Many hospitals are already experiencing negative hospital margins, and this regulation would exacerbate those challenges. Previous changes to the public charge rule resulted in disenrollment from health care programs, including 8% of children living in citizen-only households who disenrolled from Medicaid and CHIP.[1]

Lastly, if DHS does proceed with these changes, to ensure clarity, consistency and transparency, the AHA recommends that DHS formulate and propose policy and regulatory guidelines before rescinding the existing framework and regulations. The AHA appreciates the department's commitment to developing interpretive guidelines to better guide DHS officers in making individualized, fact-specific decisions related to admissibility. However, when DHS proposed changes to the public charge regulations in 2019, it continued to follow the 1999 interim field guidance and the public charge guidance until those changes were finalized. While DHS' stated desire to develop flexible and adaptive policies and regulations using new data is

[1] https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/

understandable, repealing the current regulations before such policies and regulations are developed and finalized will undoubtedly lead to uncertainty and confusion, with negative downstream effects impacting access to health care for entire communities.

Hospitals and health systems are committed to the patients and communities they serve. As such, the AHA opposes this rule and urges DHS to continue to exclude Medicaid and CHIP from its public charge determinations and to propose transparent frameworks and guidelines for stakeholder consideration. Additionally, we urge the agency to provide accessible information regarding its immigration policies, so eligible individuals do not forego Medicaid or CHIP coverage out of fear that participation could negatively impact their or their family member's immigration status.

We appreciate your consideration of our comments. If you have any questions, please contact Benjamin Finder, vice president for coverage policy at bfinder@aha.org, or Akin Demehin, vice president of policy, at ademehin@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis & Development