December 19, 2025

Submitted electronically via regulations.gov

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

RE: Public Charge Ground of Inadmissibility Notice of Proposed Rulemaking (CIS No. 2836-25; DHS Docket No. USCIS 2025-0304)

Dear Secretary Noem:

Health Law Advocates, Inc. (HLA) and Health Care For All (HCFA) submit this comment in opposition to the Department of Homeland Security's (DHS's) November 2025 Notice of Proposed Rulemaking entitled Public Charge Ground of Inadmissibility (the "Public Charge NPRM," the "NPRM," or "Proposed Rule"). This NPRM, if finalized as proposed, would rescind DHS's 2022 Final Public Charge Rule's[1] regulatory framework without a replacement beyond broad statutory language and relevant court decisions for making public charge determinations. Additionally, immigration officers will be allowed to consider any public benefit or factor in determining who is likely to become a "public charge."[2] The rule, if finalized, would give immigration officers virtually unchecked discretion over public charge determinations by allowing consideration of any use of "means-tested" public benefits. For the reasons discussed below, we strongly urge DHS not to finalize the NPRM and to withdraw its proposal.

HLA is a non-profit, public interest law firm headquartered in Boston that represents individuals with low incomes who face barriers to accessing health care and coverage. For the past 30 years, HLA has represented thousands of Massachusetts residents in cases involving access to necessary medical services, including those covered through private insurance and our state Medicaid system, as well as medical debt collections. While Massachusetts has made great progress toward improving access to health care and has achieved the highest rate of insurance coverage in the nation, HLA's work illustrates how gaps remain, especially among our most vulnerable residents. In Massachusetts, immigrants are insured at a significantly lower rates than

[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.

U.S. citizens.[3] HLA works to improve immigrants' access to health care by representing individuals in cases involving insurance appeals, service denials, and eligibility determinations.

HCFA is Massachusetts' leading 501(c)(3) health care consumer advocacy organization. HCFA serves everyone in the Commonwealth, with a particular focus on those at the greatest risk of falling through the cracks of the current health care system including the uninsured, children, the elderly, immigrants, racial and ethnic minorities, and persons with disabilities. We provide direct service through our multilingual HelpLine, partner with community-based organizations on outreach and education campaigns, and advocate for systemic policy change.

HLA and HCFA strongly oppose the Public Charge NPRM because it is an unnecessary and harmful departure from longstanding immigration policy that has been in effect for over a century, particularly considering the recognized chilling effects and public health harms that will result if the NPRM is not withdrawn. The NPRM undermines decades of health policy, will destabilize coverage for many of our most vulnerable citizens and the health systems that serve these populations, and contradicts a substantial body of public health and administrative evidence previously recognized by DHS and the courts. Additionally, if finalized, the Proposed Rule will allow immigration officers virtually unfettered discretion to make public charge determinations without concrete guidance or guardrails other than the broad statutory language in the Immigration and Nationality Act (INA). This will lead to inconsistent, inaccurate, and arbitrary decisions.

This comment addresses the following issues:

1. The Proposed Rule would create a public charge determination framework that will produce incorrect, inconsistent and arbitrary decisions and is unlawful;

2. The Proposed Rule underestimates the "chilling effect" it will have on immigrant communities; and

3. The Proposed Rule will result in substantial costs for our health care system, and our state and local economies.

I. DHS's Proposed Framework Will Produce Incorrect, Inconsistent, and Arbitrary Decisions and Is Unlawful.

In 1996, Congress amended the INA by adding statutory factors that must be considered in a public charge determination (i.e., age; health; family status; assets, resources and financial

[3] The U.S. Census Bureau data tables show that, in Massachusetts, 8.86% of immigrants (49,704) were uninsured compared to 2.1% of U.S. citizens (133,764) in 2023. See: https://data.census.gov/table?t=Citizenship:Health+Insurance&g=040XX00US25&y=2023&d=ACS+5-Year+Estimates+Detailed+Tables (last accessed 12/18/25).

status; and education and skills) and to allow consideration of an affidavit of support.[4] Notably, Congress did not add as a factor use of public benefits by immigrants or their families for which they are eligible. Three years later, in 1999, the Immigration and Naturalization Service (INS) issued 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 ("1999 Field Guidance").[5] In an accompanying Federal Register notice, INS specifically noted 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."[6]

The 1999 guidance guided public charge determinations for twenty years until the first Trump Administration proposed and finalized a new rule in 2019, which allowed additional public benefits to be considered in a public charge determination, including Medicaid, Supplemental Nutrition Assistance Program (SNAP), and federal housing assistance. The 2019 Public Charge rule was only in effect from 2020-2021; it was otherwise preliminarily enjoined in litigation and then vacated, before being removed from the Code of Federal Regulations in March 2021.[7]

In 2022, DHS issued a new Final Public Charge Rule, which is in effect today.[8] DHS acknowledges in this instant NPRM that the 2022 Public Charge Rule "closely aligned with the 1999 Interim Field Guidance."[9] The current regulations make clear that most public benefits, including Medicaid, the Children's Health Insurance Program (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.[10]

In the instant NPRM, DHS now proposes to rescind the 2022 Final Public Charge Rule without a replacement regulatory framework.[11] Instead, the Proposed Rule would allow officers

[4] 8 U.S.C. § 1182(a)(4).

[5] 64 *Fed. Reg.* 28689, 28689 (May 26, 1999). Note the Federal Register incorrectly states March 26, 1999 although May 26, 1999 was the correct date, which DHS acknowledges in this NPRM.

[6] 64 *Fed. Reg.* 28676 (May 26, 1999).

[7] 86 *Fed. Reg.* 14221 (Mar. 15, 2021).

[8] 87 *Fed. Reg.* 55472 (Sept. 9, 2022).

[9] 90 *Fed. Reg.* at 52179.

[10] *Id.* Under the current rules, only receipt of public cash assistance for income maintenance or long-term institutionalization at government expense can be considered in public charge determinations.

[11] 90 *Fed. Reg.* 52180-81.

complete discretion to consider "all evidence and information specific to the alien and relevant to the public charge ground of inadmissibility."[12] The NPRM suggests that this should not only include the public benefits added in the 2019 Final Rule, like Medicaid and SNAP, but *any* means-tested public benefit without limitation.[13] In the Proposed Rule, DHS states that it "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."[14]

This belief expressed by DHS is unfounded. In fact, in issuing the 1999 Field Guidance to immigration officers, which, as discussed previously, was intended to guide officers on how to apply the new statutory provisions to "ensure the accurate and uniform application of law and policy, INS (DHS's predecessor) specifically recognized that "officers are not expected to know the substantive eligibility rules for different public benefit programs."[15] (Public benefit program rules are no less – and likely more – complicated today than when this guidance was issued in 1999.) Similarly, immigration law is complex and evolving. Immigration officers, who are typically not lawyers, cannot reasonably be expected to know and understand evolving and complex immigration case law.

Accordingly, allowing immigration officers virtually unfettered discretion, without concrete guidance or guardrails other than the broad statutory language in the INA, will lead to inconsistent, inaccurate, and arbitrary decisions. Without concrete guidance, immigration officers are unlikely to understand how to apply the statutory factors and relevant case law when making public charge determination. Inaccurate, inconsistent and arbitrary decisions will certainly result. What's more, immigration officers' nearly unfettered discretion under the Proposed Rule is inconsistent with the holdings of the numerous courts that struck down the even

[12] 90 *Fed. Reg.* at 52183.

[13] 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).

[14] 90 *Fed. Reg.* at 52188.

[15] 90 *Fed. Reg.* at 28692.

narrower 2019 Public Charge Rule as arbitrary and capricious, rejecting DHS's position that the INA "has no natural limitation"[16] and that there is not "any limit to its discretion."[17]

What's more, proposing to allow officers such broad discretion to consider any use of "means-tested" public benefits, including past use of benefits that have been excluded from consideration for almost all of the last 25 years, represents an abrupt reversal that would attach adverse consequences to past lawful, government-encouraged benefit use, raising serious retroactivity and reliance concerns. Unless expressly authorized by Congress, a rule may not "take[] away or impair[] vested rights acquired under existing laws, or create[] a new obligation, impose[] a new duty, or attach[] a new disability, in respect to transactions or considerations already past."[18] DHS's proposal to determine that someone is a public charge because of past use of benefits that were previously excluded from public charge determinations is impermissibly retroactive because Congress has not expressly authorized it.[19]

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. This provision prohibits consideration in public charge determinations of receipt of public benefits by "certain battered aliens." 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…"[20] 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.[21] Relying on this limited provision is particularly dubious when considering that Congress

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[16] By providing complete discretion to DHS officers to determine who is and is not a "public charge," DHS is again taking a position 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).

[17] *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).

[18] *Yanez v. Bondi*, 140 F.4th 35, 48 (2d Cir. 2025) (citing *Landgraf v. USI Film Products*, 511 U.S. 244, 269 (1994)).

[19] *See Vartelas v. Holder*, 566 U.S. 257, 261 (2012).

[20] 90 *Fed. Reg.* at 52178 and n. 105.

[21] *Compare INS v. St. Cyr*, 533 U.S. 289, 317 (2001) (holding 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), *with Valiente v. Swift Transp. Co. of Ariz., Ltd. Liab. Co*., 54 F.4th 581 (9th Cir. 2022) (holding that the FMCSA'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).

has repeatedly decided to expand certain public benefit programs, including Medicaid, to authorize coverage certain non-citizens. As examples, in 1986, Congress chose to mandate emergency Medicaid for non-citizens not lawfully admitted for permanent residence or otherwise permanently residing in the United States, [22] and Congress gave states the option to cover certain children and pregnant women under the section 214 of the Children's Health Insurance Program Reauthorization Act of 2009.[23]

Moreover, in considering the legality of retroactive rulemaking, courts examine the reliance interests of those affected, particularly when individuals have relied on longstanding policies.[24] DHS acknowledges its own use of the 1999 Field Guidance, which was incorporated into the 2022 Public Charge Rule, both of which have prohibited consideration of most benefits that the proposed rule suggests officers may and will consider going forward.[25] 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 required by the Supreme Court.[26] DHS's summary discussion of reliance interests does not suffice when decades of reliance sits atop an agency's prior policies.[27]

Finally, DHS should not replace a rescinded rule with binding standards issued as "interpretive" guidance. 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."[28] This language suggests that DHS is poised to issue revised standards as interpretive rules outside of the notice and comment

[22] 42 U.S.C. §1396b(v)(3) and 8 U.S.C. §1611(b)(1)(A).

[23] Pub. L. 111–3 (2009).

[24] 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)).

[25] 90 *Fed. Reg.* at 52193.

[26] *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).

[27] *Id.* 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.").

[28] 90 *Fed. Reg.* at 52182.

rulemaking process that is required under the Administrative Procedure Act.[29] 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.[30] In contrast, agency action that imposes legally binding obligations or prohibitions on regulated parties, including by effectively amending a prior legislative rule,[31] is a legislative rule that generally must go through the notice and comment rulemaking process.[32] DHS's NPRM makes clear that future DHS guidance will be significantly and substantively different from the 2022 Final Public Charge Rule and the 1999 Field Guidance, rejecting reasonable limits and, instead, allowing consideration of *any* public benefit or factor.[33] Such substantive changes that would 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. Any materially substantive changes that bind officers must proceed through notice-and-comment. DHS should commit in the final rule to use notice-and-comment rulemaking for any such standards.

II. The Public Charge NPRM, if not withdrawn, will cause significant fear and confusion, leading to a chilling effect that will cause U.S. citizens and lawfully present immigrants to forgo critical health care and coverage for which they are eligible.

The Public Charge NPRM acknowledges that there will be a "chilling effect" that discourages immigrants from using public benefits programs for which they are eligible.[34] We agree. Nonetheless, HLA and HCFA believe that DHS severely underestimates the likely extent of the "chilling effect" based on analysis of publicly available data and our own experiences with Massachusetts residents who seek our assistance.

a. Publicly available data demonstrates that DHS significantly underestimates the likely extent of the new public charge proposal's "chilling effect" on access to benefits for immigrants and citizens alike.

In the NPRM, DHS states that "elimination of the definitions and other core elements of the 2022 Final Rule" may cause "individuals both directly and indirectly affected by

[29] 5 U.S.C. § 553.

[30] *Nat'l Mining Ass'n v. McCarthy*, 758 F.3d 243, 251-252 (D.C. Cir. 2014).

[31] *Sec. Indus. & Fin. Mkts. Ass'n v. United States CFTC*, 67 F. Supp. 3d 373, 417 (D.C. Cir. 2014).

[32] Nat'l Mining Ass'n, 758 F.3d at 251.

[33] 90 *Fed. Reg.* at 52190.

[34] 90 *Fed Reg*. at 52207-52208.

this proposed rule to misunderstand[ ] . . . the scope of the rule and how DHS will apply the public charge ground of inadmissibility"[35] 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."[36] Ultimately, 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**.

Even though DHS offers a staggering estimate that this proposal will cause more than 950,000 people to forego coverage in programs for which they are eligible, this number is inappropriately low based on incorrect assumptions that narrow the agency's calculus. DHS's analysis relies on the unsupported assumption that only 10.3 percent of members in immigrant households would disenroll or forgo benefits due to the "chilling effect" [37] of the rule, and relies on outdated data about Medicaid and CHIP participation, as well as federal program costs.

Independent analyses by the Kaiser Family Foundation ("KFF") provides more realistic estimates that rely on the most current data about program participation rates and costs and immigrant fears.[38] KFF uses 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, such as Medicaid, in light of current trends.[39] KFF concludes that **between 10 percent and 30 percent of members of immigrant households—totaling between 1.3 and 4 million people—could lose Medicaid or CHIP benefits due to the proposed rule**.[40] This includes between 600,000 and 1.8 million U.S.

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[35] *Id.* at 52208.

[36] *Id.* at 52207.

[38] 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/.

[39] 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/.

[40] 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/.

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. 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.[41] **These more accurate independent analyses indicate that DHS estimates of the "chilling effect" are about three-quarters too low.**

Additionally, DHS estimates of the chilling effect focus too narrowly on health insurance coverage when, in reality, it is likely there will be a deeper impact on access to care. In addition to avoidance of benefits, evidence from the 2019 Public Charge Final Rule[42] showed that many immigrants began avoiding health care settings altogether due to fears associated with public charge.[43] Community Health Centers, which are an essential source of care for immigrant families, reported a significant decline health services utilization among immigrant adults in the aftermath of the 2019 Public Charge Rule.[44]

b. <u>People seeking assistance with their health benefits are already being chilled from enrolling due to fears of becoming a "public charge."</u>

Further illustrating the inadequacy of DHS's analysis of the Proposed Rule's chilling effect, HCFA has received numerous inquiries indicating that fear and confusion regarding public charge are already causing individuals to question their enrollment in benefits, or even motivating them to withdraw from benefits for which they are eligible, even before the proposed rule has taken effect. Also, as soon as President Trump won the election in November 2024, HLA began to receive renewed inquiries about this issue from immigrant-serving organizations.

HCFA operates the Health Insurance HelpLine, the only multilingual telephone service that assists Massachusetts residents of all income levels enroll in health insurance. The HelpLine is staffed by counselors trained on eligibility and enrollment for all state health insurance

[41] 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.

[42] 84 *Fed. Reg.* 41292 (Aug. 14, 2019).

[43] Natalie Hernandez, Summary of Research at the Intersection of Public Charge and Health, PROTECTING IMMIGRANT FAMILIES (June 2020); July Lee et al., Opportunities for Supporting Latino Immigrants in Emergency and Ambulatory Care Settings, JOURNAL OF COMMUNITY HEALTH (July 22, 2020).

[44] 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. KFF. Published October 15, 2019. Accessed August 12, 2025. https://www.kff.org/medicaid/press-release/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/

programs. Half of the calls to the HelpLine are conducted in languages other than English.[45] The following are examples of public charge inquiries that HCFA has received during 2025:

- In January 2025, a caller contacted the HCFA HelpLine to ask if he would be considered a public charge due to his enrollment in ConnectorCare, a qualified health plan (QHP) with advance premium tax credits. He was afraid this coverage would impact his family's immigration status.

- In October 2025, a US citizen who applied for a green card for his wife called the HCFA HelpLine to ask whether enrollment in Health Connector programs would count as being a public charge and, if his wife becomes pregnant, whether her enrollment in MassHealth Standard would count against her.

- In November 2025, a person with a pending immigration status who had lost MassHealth coverage due to not returning requested verifications called HCFA's HelpLine to ask whether enrolling in MassHealth would be considered under the public charge test. She decided to not reapply because she was worried about being considered a public charge under the new proposed rule.

Each of the stories above illustrate that immigrant communities are already being chilled by the Proposed Rule and some individuals are electing to forego coverage or services at great personal cost, even before any regulatory changes have gone into effect.

III. DHS Failed to Adequately Assess the Costs and Benefits of the Proposed Rule.

DHS's cost-benefit analysis is inadequate because it provides no analysis to support its conclusions. Instead, DHS provides a long list of conclusory statements about likely direct and indirect costs (e.g., "Worse health outcomes," "Higher prevalence of communicable diseases, including among U.S. citizens who are not vaccinated," and "Increased uncompensated care.) The list concludes with this acknowledgement:

> DHS is generally not able to estimate all of the additional indirect costs that would likely be incurred because of follow-on economic effects of the initial indirect costs identified in the proposed rule due to the wide range of these costs. DHS requests comments on other possible indirect impacts of the rule and appropriate methodologies for quantifying these non-monetized potential impacts.[46]

[45] Based on HLA's and HCFA's experience working directly with immigrant communities, we are especially cognizant of the critical importance of multilingual support in our efforts to engage with the immigrant community. DHS's decision to accept only English language comments is misguided as it will serve only to limit the participation of the very individuals and immigrant groups that this Proposed Rule purports to directly affect. This unfortunate determination will lead to a biased and unbalanced record that systematically excludes the vital stories of millions of immigrants and their citizen families whose lives will be impacted by this rule.

[46] 90 *Fed Reg*. at 52218.

A thorough analysis is necessary because the agency cannot make reasoned policy decisions, including whether any regulatory changes are needed, without first meaningfully assessing the potential costs and benefits. Particularly where restricting immigration will likely contract the economy, and where the effects of the Proposed Rule will be felt across virtually every sector of the economy,[47] the agency should carefully weigh all the attendant costs and benefits of the Proposed Rule. Furthermore, the public is unable to comment on whether DHS appropriately weighed the costs and benefits since the agency has not offered any analysis.

The Proposed Rule acknowledges, without explanation, 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." HLA's work on behalf of low-income individuals suggests there will be costly implications of the Proposed Rule that go far beyond access to benefits.

First, HLA's project helping children with mental illness access treatment and avoid the juvenile justice system supports the conclusion that early access to health care leads to systemwide cost-savings. Second, many of HLA's disabled clients have difficulty accessing in-home services despite having coverage for this care. Because immigrants comprise a significant proportion of the home health workforce in Massachusetts, and because the Proposed Rule will severely limit the supply of immigrants willing to work these jobs, the Rule, if finalized, will make it more difficult and expensive for disabled citizens to obtain needed in-home care.

a. HLA's Mental Health Advocacy Program for Kids Project Confirms that Early Treatment of Mental Illness Helps Individuals and Taxpayers Avoid Significant Long-Term Costs.

Data shows that if individuals do not receive adequate support early enough, particularly with respect to health care, they often become trapped in a cycle of poverty.[48] HLA's work with health care consumers with low incomes supports this view. Specifically, HLA's representation of children with mental and behavioral health conditions reveals that access to treatment often enables children to stay in school and avoid expensive, interruptive hospitalizations, while the alternative includes cascading negative impacts and a lifetime of diminished productivity. HLA's casework has shown that early treatment of childhood mental illness saves significant costs that would otherwise be borne by state and local governments, hospital systems and taxpayers.[49]

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[47] Craig Torres, Fed's Powell Says Reduced Immigration Could Slow U.S. Economy, BLOOMBERG (Nov. 1, 2018), https://www.bloomberg.com/news/articles/2018-11-01/fed-s-powell-says-reduced-immigration-couldslow-u-s-economy.

[48] See Mary Corcoran, Rags to Rags: Poverty and Mobility in the United States, 21 Annual Rev. Sociology 237, (1995); Orley Ashenfelter & David Card (eds.), Intergenerational Mobility in the Labor Market, Amsterdam: North-Holland. Handbook of Labor Economics 3A: 1761-1800 (1999); see also Hilary Hoynes, Diane Whitmore Schanzenbach & Douglas Almond, Long-Run Impacts of Childhood Access to the Safety Net, 106 Am. Econ. Rev. 903, ("effects [of participating in food stamps] for economic self-sufficiency is large and statistically significant for women. . . .").

[49] Mental Health Advocacy Program for Kids Report of Baseline and Follow Up Evaluation Data March 2017-November 2024, Boston University School of Public Health, March 25, 2025, https://healthlawadvocates.org/wp-content/uploads/2025/11/MHAP-Report-25.pdf (last accessed 12/18/25) [hereinafter: "2025 BU Report"].

In 2008, HLA began a program focused on helping children with mental illness overcome barriers to treatment and avoid entanglements with the juvenile justice system. At the time, the Center for Mental Health Services Research at the University of Massachusetts Medical School reported that among court-involved youth who end up in state detention, 60-70 percent needed mental health care but that few received it. To address this need, HLA attorneys began to provide *pro bono* representation for children involved with the juvenile court, helping them obtain access to mental health services and often ending their court involvement. In the intervening years, the Mental Health Advocacy Program for Kids ("MHAP for Kids") has assisted more than 3,280 children access mental health care and other needed services.[50]

In 2015, a research team from the Boston University School of Public Health commenced an in-depth, two-year program evaluation of MHAP for Kids to measure the program's effectiveness.[51] Since then, the BU team has published a series of reports that have reviewed the impact of this program. Prior to working with MHAP for Kids attorneys, the participating children experienced significant mental and behavioral health challenges and problematic barriers to mental health treatment.[52] As a result, the children suffered high rates of emergency mental health care and hospitalizations, detentions, and school truancy. Specifically, among the children participating in the MHAP for Kids program, the BU team found that during the year prior to seeking HLA's services:

- More than 80 percent experienced mental or behavioral health difficulties;[53]
- They experienced more family conflict than 99 percent of families in the general population;[54]
- More than 42 percent went to an emergency room or sought in-home crisis services for treatment of mental or behavioral health problems;[55]
- One-third were hospitalized for psychiatric care;[56]

[50] *Id.* at pg. 4.

[51] The report presented program findings for a two-year period, from February 1, 2015 to March 1, 2017. See, Emily Feinberg & Patricia Elliott, Juvenile Court Mental Health Advocacy Project, Update to Final Report, B.U. SCH. PUB. HEALTH 2 (Nov. 3, 2017), https://www.healthlawadvocates.org/get-legalhelp/resources/document/BUSPH-J-MHAP-Evaluation-Final-Report-11.3.17.pdf (last accessed 12/18/25) [hereinafter "2017 BU Report"].

[52] 2025 BU Report, pgs. 7-11.

[53] *Id.* at 7.

[54] *Id.* at 8.

[55] *Id.* at 10.

[56] *Id.*

- 18 percent were removed from their families and detained in a residential facility;[57]

- Nearly 30 percent were either suspended or sent home from school due to behavior.[58]

After MHAP for Kids' intervention, the youth experienced dramatic improvements. Specifically, the BU team observed:

- Decreased use of emergency mental health services – while 43 percent of children had recently utilized emergency mental health services before entering the program, less than 19 percent utilized these services after receiving HLA's services;[59]

- Use of mobile crisis services decreased from 42 percent before working with MHAP for Kids to 24 percent afterwards;[60]

- Need for partial hospitalization/day programs to treat behavioral health conditions decreased from 26 percent of children to just 11 percent; [61]

- Children who required overnight hospitalization to treat an acute mental health crisis decreased by more than half from 33 percent to 15 percent;[62]

- Children requiring residential treatment decreased from 18 percent to only 8 percent.[63]

- Youth experienced fewer behavioral health difficulties and emotional symptoms, their conduct improved at school, they had lower rates of hyperactivity and inattention, they faced fewer problems with peers, and their pro-social behavior improved.[64] Additionally, parental depression and conflict at home decreased markedly, and family income stability increased.[65]

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[57] *Id.*

[58] *Id.* at 9.

[59] *Id.* at 13.

[60] *Id.*

[61] *Id.* at 20.

[62] *Id.* at 20.

[63] *Id.* at 13.

[64] *Id.* at 12.

[65] *Id.*

These data show that statistically significant improvements in the well-being of these children were driven by increased access to up-front treatments for their mental health conditions. In other words, better access to mental health interventions for these young people decreased more expensive treatments down the line, saving money for the health care system overall. The Commonwealth has recognized these gains and successfully replicated them by investing public money in the MHAP for Kids program, expanding its reach across the state.[66]

The reduction in the rate of utilization of costly services by children who participate in the MHAP for Kids program is compelling evidence of the economic benefits of access to mental health treatment. Not only are children able to avoid the high per diem costs of emergency mental health hospitalization and juvenile detention, they also benefit from increases in high school graduation rates and workforce participation. Where the estimated lifetime burden to taxpayers for every 16-year-old youth who drops out of high school is approximately $275,000[67] in decreased earnings, lost taxes, additional health care, criminal justice and corrections, and other social service expenses, providing needed supports that interrupt the vicious cycle of poverty yields economic benefits for the entire community.

While the economic benefits of early access to mental health care should not be ignored, the most significant benefits are the profoundly positive impacts that mental health treatment has on the individual lives of our youth. Children who would otherwise have been removed for significant periods of time from their homes, schools and social networks because of repeated emergency psychiatric hospitalizations or detentions, were able to receive treatment that enabled them to continue in their daily lives. These children avoided the fate of thousands of less fortunate Massachusetts youth who lack adequate access to mental health treatment who, as a result, experience life interruptions from which it is difficult if not impossible to recover.

Indeed, the Proposed Rule is likely to chill access to health care, including mental health care, for children – even citizen children – leading to a lifetime of costs for the taxpayer. In fact, the "chilling effect" is especially strong in families with children. For example, 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.[68] Studies have documented a strong "chilling effect" on children in all-citizen households and "mixed status" household alike, but the effect is nearly twice as strong on children in "mixed status" households.[69] An economic analysis of the nuanced harms

[66] *Id.* at 4.

[67] 2017 BU Report at 21.

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

[69] 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.

that will result from the Proposed Rule and the extensive data available regarding these harms is necessary to show that DHS has engaged in reasoned policymaking with this rulemaking.

b. The Proposed Rule Will Lead To Crippling Consequences for the Massachusetts In-Home Health Care Work Force.

The Proposed Rule will also harm the ability of Massachusetts residents who depend on long term in-home services and supports to remain in their homes. HLA has encountered a disturbing trend where, even with insurance coverage for in-home services, many of HLA's disabled clients are unable to access care because of a shortage of nurses and home health aides. In Boston, immigrants comprise 53 percent of the home health work force.[70] In Massachusetts, 67 percent of home health workers receive public benefits, including 51 percent who are on Medicaid and 41 percent who receive food and nutritional assistance.[71] Twenty-four percent of home health workers earn less than 138 percent of the federal poverty level ("FPL") and 39 percent of workers earn under 200 percent FPL.[72]

The vast majority of immigrant home health workers will be subject to the Proposed Rule and, as a result, could be considered public charges because of their low income and benefit use. In Massachusetts, approximately 46 percent of home health workers are foreign-born[73] and many will be potentially chilled by the Proposed Rule and could decline to participate in the public benefit programs that enable them to maintain these jobs.[74] Thus, the Proposed Rule is likely to drive down the number of available immigrant workers precisely as the need for their services is increasing. A 2020 study by the Blue Cross Blue Shield of Massachusetts Foundation reports that "[b]y 2026 a 24 percent increase in LTSS job openings is expected in Massachusetts…[and] the number of Massachusetts working-age adults (ages 20–60) is expected to stay about the same, making it unlikely that Massachusetts residents alone will be able to fill the need for LTSS

[70] Paul Osterman, William Kimball & Christine Riordan, Boston's Immigrants, an Essential Component of a Strong Economy, JVS CTR. FOR ECON. OPPORTUNITY (May 10, 2017), https://www.jvs-boston.org/wpcontent/uploads/2017/11/Osterman-Report-Final.pdf.

[71] Workforce Data Center, PHI, https://phinational.org/policy-research/workforce-datacenter/#states=25&var=Public+Assistance&tab=State+Data (accessed Dec. 16, 2025).

[72] Workforce Data Center, PHI, https://phinational.org/policy-research/workforce-datacenter/#var=Poverty&states=25 (accessed Dec. 16, 2025).

[73] Sarah Bettencourt, "Mass. immigrants who had legal status lose work in home and health care," WGBH News, August 19, 2025, https://www.wgbh.org/news/local/2025-08-13/mass-immigrants-who-had-legal-status-lose-work-in-home-and-health-care (last accessed 12/18/25), citing Neeta Fogg, Paul Harrington, and Nancy Snyder, Center for Labor Markets and Policy Drexel University, "GRAY WARNINGS: Challenges in the Direct Care Workforce," Prepared for The Commonwealth of Massachusetts Office of the State Auditor, June 2018, https://www.mass.gov/files/documents/2018/10/02/Workforce_report_2018_REVISED.pdf (last accessed 12/18/25).

[74] Kelly Anthoula Love, Rachel Gershon, Margaret Sullivan, The Final Public Charge Admissibility Rule: Implications for Massachusetts, Blue Cross Blue Shield of Massachusetts Foundation, Sept. 29, 2020, https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2020-10/Public_Charge_Report_final.pdf (last accessed 12/28/2025).

workers."[75] The report then plainly recounts that "[o]ne of the few solutions put forward has been to rely on immigrant labor."[76]

Unfilled in-home service hours have a traumatic effect on disabled individuals and their families. Skilled nurses, personal care attendants, and home health aides serve critical functions by maintaining durable medical equipment, completing activities of daily living for their patients, monitoring for new symptoms or reactions, and assisting with medications and other minor in-home procedures (such as checking blood glucose) among other supportive services. Parents or other family members often leave behind outside jobs to assume the role of primary caregiver if a disabled individual is unable to secure in-home services.

The following summaries of the experiences of HLA clients illustrate the difficulties that families face when they are unable to access in-home services.

- A.S. is a 9-year-old boy from Worcester who has significant mental and physical health issues that require in-home nursing care. Since 2013, A.S. has been covered for in-home nursing services through Massachusetts Medicaid's Community Case Management program (CCM). CCM authorized 65 hours per week of medically necessary skilled nursing care for A.S., however, his family has filled only 48 of these approved weekly hours. Because the family has not been able to find sufficient in-home care, A.S.'s mother was not able to work full-time for an entire year.

- K.F. is a 29-year-old who suffers from several complex medical, developmental and psychiatric conditions. K.F. is unable to care for herself or complete her activities of daily living without assistance. She is prescribed multiple medications that are adjusted frequently and pose risks for serious side effects. HLA represented K.F. in her appeal of Massachusetts Medicaid's decision to terminate her in-home services. During the appeal, K.F. was approved for 40 hours per week of home health aide services, but she never received them. When HLA contacted the home health agency about the home health aide services, the agency said that it was unable to meet the staffing demands because it simply did not have any home health aides available. K.F.'s mother needed to work full-time and could not leave her job to care for her daughter. Because the family could not access in-home services, K.F.'s mother was left with no alternative but to bring her severely disabled daughter to work with her every day.

Notably, the Proposed Rule does not address these or other workforce shortage issues at all.

Conclusion

HLA and HCFA vigorously oppose the Proposed Rule. As organizations dedicated to improving access to health care for our state's most vulnerable residents, we are certain that the

[75] *Id.* at 10.

[76] *Id.*

rule, if finalized, will cause devastating harm to individuals, families, and communities and needlessly disrupt our health care system and state and local economies. As a result, we urge the Secretary to abandon this Notice of Proposed Rulemaking and leave the existing rule in place.

Please do not hesitate to contact us regarding any of the matters discussed above.

Very truly yours,

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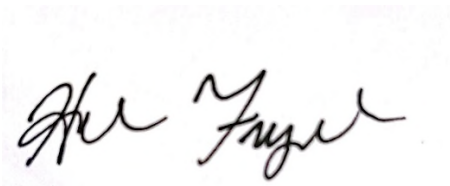

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