AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

December 19, 2025

Submitted via www.regulations.gov

The Honorable Kristi Noem
Secretary of Homeland Security
U.S. Department of Homeland Security
Washington, D.C. 20528

Re: DHS Docket No. USCIS-2025-0304, U.S. Citizenship and Immigration Services

Dear Secretary Noem,

On behalf of the Association of Asian Pacific Community Health Organizations (AAPCHO), I write to express our opposition to the Department of Homeland Security's (DHS) Notice of Proposed Rulemaking (NPRM) regarding the Public Charge Grounds of Inadmissibility (DHS Docket No. USCIS-2025-0304) published in the Federal Register on November 19, 2025.

AAPCHO is a national nonprofit association of community-based provider organizations, primarily federally qualified health centers, dedicated to improving health access and outcomes of Asian Americans (AA), Native Hawaiians, and Pacific Islanders (NH/PI) in the United States, the U.S. territories, and the Freely Associated States. AAPCHO member health centers provide care to nearly three quarters of a million patients annually, many of whom are low-income and culturally and ethnically diverse.

Health centers across the nation serve nearly 34 million patients each year, including about 1.6 million AAs and NH/PIs.[1] [2] They are a medical lifeline for our communities, communicating accurate, scientific information and providing holistic, high quality, coordinated services in ways that are culturally and linguistically appropriate. For the nearly three quarters of a million patients served by AAPCHO member health centers, nearly 90 percent had incomes at or below 200 percent of federal poverty, 60 percent received health care coverage through Medicaid, and 50 percent were best served in a language other than English.

The proposed rule would have a detrimental impact on the communities we serve. Collectively, Asian Americans, Native Hawaiians, and Pacific Islanders are the fastest growing racial or ethnic group in the U.S., accounting for more than 27 million Americans in 2023, and more than doubling in population since 2000.[3] [4] Nearly two thirds of Asian Americans and a quarter of Pacific Islanders in the U.S. are foreign

---

[1] "Community Health Centers Provide Primary Care to Nearly 34 Million Patients." National Association of Community Health Centers. https://www.nachc.org/community-health-centers-provide-primary-care-to-nearly-34-million-patients.
[2] "2023 Uniform Data System Insights: Health Outcomes of Community Health Center Patients." Association of Asian Pacific Community Health Organizations. https://aapcho.org/wp-content/uploads/2025/06/2023-UDS-Report.pdf.
[3] "Asian American, Native Hawaiian, and Pacific Islander Heritage Month: May 2025." 2025. U.S. Census Bureau. https://www.census.gov/newsroom/facts-for-features/2025/asian-american-pacific-islander.html?utm_source=chatgpt.com.
[4] "Key facts about Asian Americans." Pew Research Center. https://www.pewresearch.org/short-reads/2025/05/01/key-facts-about-asians-in-the-us/.

born.[5] As of 2023, 19 million–one in four children in the U.S.--had an immigrant parent; 3.2 million of these children are of Asian descent.[6] This proposed rule is inconsistent with American values of fairness, equal treatment, and freedom from discrimintion—and puts the health and well-being of these children and their families at risk.

AAPCHO is deeply concerned that the proposed rule rescinds the 2022 final rule on public charge as a ground of inadmissibility but does not offer any replacement language in federal rulemaking. Rather, DHS states that it will create new tools and subregulatory guidance to direct USCIS officers in making public charge assessments, but it does not indicate a timeline or certain date when such tools and guidance will be published or whether the public will have an opportunity to provide feedback. The absence of clear, formal regulatory guidance will create severe hardships for patients and families trying to navigate the health care system, spread fear and confusion throughout communities regardless of immigration status, and impose significant financial and operational burdens on both clinical and non-clinical health care providers tasked with delivering care and helping patients afford it.

If finalized, this rule would create a regulatory void. It ignores decades of precedent and Congressional intent defining public charge as an individual *likely to become primarily* dependent on government assistance for subsistence, as demonstrated by either (i) the receipt of public cash assistance for income maintenance or (ii) institutionalization for long-term care at government expense." This longstanding policy and practice was codified in the 1999 field guidance and reaffirmed in the 2022 final rule–both grounded in decades of federal case law.

AAPCHO's specific comments are detailed below.

1. The proposed rule will result in fear and confusion about access to benefits for Asian Americans and Pacific Islanders (AAPI)

The proposed rule will have a devastating impact on AAPI families and will drive eligible patients away from health coverage and health centers by triggering a widespread "chilling effect," where families forgo essential services out of fear and confusion–even when they and their children are fully eligible. National research following previous public charge changes found that nearly one in four Asian health center patients stopped participating in a government program to help pay for health care, food, or housing in the past year due to immigration-related fears.[7]

The proposed rule comes at a moment of immense fear and instability for immigrant communities. Children who come to our health centers for well-child visits and immunizations, and parents and older adults who rely on our clinics for insulin or blood pressure medications fear that seeking care could expose them to DHS scrutiny. The magnitude of these consequences threatens to drive entire families away from health centers–even when they are U.S. citizens and legally entitled to care. Health care providers nationally are already reporting appointment cancellations, delayed care, and patients explicitly stating they are afraid to use coverage.[8]

More than 3 out of every 10 individuals obtaining permanent residence in recent years are from Asia or a Pacific Island, and 38 percent of families waiting in long family-based immigration backlogs are from

---

[5] "By the Numbers: Immigration." AAPI Data. https://aapidata.com/featured/by-the-numbers-immigration.
[6] "Children of Immigrants in 2022-2023." Urban Institute. https://www.urban.org/research/publication/children-immigrants-2022-23.
[7] "Asian Immigrant Experiences with Racism, Immigration-Related Fears, and the COVID-19 Pandemic." KFF. https://www.kff.org/covid-19/asian-immigrant-experiences-with-racism-immigration-related-fears-and-the-covid-19-pandemic/
[8] "ICE Tactics and Deportation Fears Limit Access to Health Care for Children of Immigrants: Survey." Physicians for Human Rights (PHR) and Migrant Clinicians Network (MCN). https://phr.org/news/ice-tactics-and-deportation-fears-limit-access-to-health-care-for-children-of-immigrants-survey/

these regions.[9] Under the proposed rule, these future Americans would be subject to vague, undefined standards and judged against a set of criteria subject to broad discretion of immigration officers.

The proposed rule would also cause harm to Pacific Islander communities, particularly citizens of the Freely Associated States—the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau—which are critical to U.S. national security interests in the Pacific. Under the Compacts of Free Association (COFA), these individuals may lawfully enter, live, and work in the United States, and Congress has explicitly affirmed their eligibility for Medicaid and other federal public benefits without waiting periods.[10] [11] At least 94,000 COFA citizens reside in the United States, many of whom rely on community health centers for essential care. Treating lawful Medicaid use as a negative factor in admissibility or reentry would directly contradict congressional intent and treaty obligations, and would further deter Pacific Islander families from accessing needed care.

Additionally, the proposed rule threatens to treat "lack of English proficiency" as a negative factor in a public charge determination. This would reach far beyond the individuals to whom the test would apply–it would effectively penalize millions of individuals with limited English proficiency for the language they speak. Such an approach would disproportionately harm AAPIs, who experience some of the highest rates of LEP of any racial group--1 in 4 Asian Americans and 1 in 10 Pacific Islanders speak English less than "very well."[12] AAPCHO member health centers provide care in up to 70 different languages, offering interpretation, translation, and patient-centered health education and support. These services are proven to improve health outcomes, reduce medical errors, and increase adherence to treatment plans. Research consistently shows that patients with LEP face greater barriers to care, lower access to preventative services, and higher risk of miscommunication with health care providers.

People seeking status would be forced to guess what factors could be used against them. In many instances, many would relinquish short- and long-term health and nutrition support to which they are legally entitled to avoid risking their immigration applications. A nationwide poll of AA and NH/PIs further confirms this confusion: nearly half report that they do not have enough information about recent immigration policy changes to understand how such changes may affect themselves or their families.

As a result, this proposed rule directly threatens to undo the hard-won progress that AAPCHO health centers and providers nationwide have made in enrolling eligible families in coverage and public benefit programs. Our health centers work every day to reduce administrative barriers, correct misinformation, and help patients access care. If the proposed rule is implemented, children, families, and older adults will disenroll from programs such as Medicaid, SNAP, and housing assistance—or decline to enroll altogether. Uninsurance rates will increase significantly. Prior national projections of similar public charge policies estimated that hundreds of thousands of health center patients could lose Medicaid coverage due solely to chilling effects. For AAPCHO member health centers alone, this scale of disenrollment would severely undermine both patient health and the financial stability of the safety net.

2. The proposed rule endangers the health of the AAPI community

Health centers, which serve millions of low-income families, will be among the first to feel the harmful impacts of the proposed rule. By dismantling a clear and consistent regulatory framework which has

---

[9] "Annual Report of Immigrant Visa Applicants, 2023." U.S. Department of State. https://travel.state.gov/content/dam/visas/Statistics/Immigrant-Statistics/WaitingList/WaitingListItem_2023_vF.pdf

[10] "Status of Citizens of the Freely Associated States of the Federated States of Micronesia and the Republic of the Marshall Islands Fact Sheet." U.S. Citizenship and Immigration Services. https://www.uscis.gov/working-in-the-united-states/status-of-citizens-of-the-freely-associated-states-of-the-federated-states-of-micronesia-and-the

[11] "Coverage Options for COFA Migrants." Centers for Medicare and Medicaid Services. https://www.cms.gov/marketplace/technical-assistance-resources/health-coverage-options-cofa-migrants.pdf

[12] "2024 National Overview of AA and NHPI Communities." White House Initiative on Asian Americans, Native Hawaiians, and Pacific Islanders. https://aapidata.com/data/2024-national-factsheet-whiaanhpi-and-aapi-data/

guided public charge determinations for decades and was codified in regulation in 2022, this proposed rule injects uncertainty into decisions that directly affect whether families seek care and processes upon which health centers rely. This uncertainty will suppress enrollment–as the proposed rule itself reconizes–in Medicaid, CHIP and other basic health, nutrition, and family support programs, affecting both immigrant and U.S. citizens families alike.

Extensive research shows that reductions in health coverage lead to worse health outcomes, particularly for low-income families and individuals with chronic conditions. When patients lack insurance, they delay or avoid preventive and primary care, increasing avoidable hospitalizations and emergency care use. Children who have coverage are more likely to get medical care and have higher survival rates during emergencies than children who are uninsured. Research studies show that Medicaid coverage is effective in reducing infant and teen mortality. These chilling effects were reported across a variety of forms of support, including Medicaid and health insurance purchased through the Marketplaces after the first Trump public charge rule.[13]

Research also demonstrates the high stakes for AAPI communities and the health centers that serve them. In 2019, the Migration Policy Institute estimated that 1.4 million AAPIs who are not U.S. citizens are members of families who have individuals who rely on Medicaid and the Children's Health Insurance Program (CHIP), including 182,000 children.[14] Insurance coverage is directly linked to improved access to preventative care, higher childhood survival rates in emergencies, and long-term cost savings to the health system generally. Medicaid's role in reducing these risks is well established, and we strongly believe utilization of the Medicaid program, or any other program that supports the health, nutrition, housing, and/or education, should never be considered during a public charge determination. This proposal will force many eligible families to avoid enrolling in Medicaid, even as DHS concedes that the proposed rule would "increase poverty of certain families and children, including U.S. citizen children" and lead to "worse health outcomes, including prevalence of obesity and malnutrition, especially for pregnant and breastfeeding women, infants, and children," among other health impacts.[15]

Impacts to mental health are equally critical. People with coverage also report improved mental health and lower rates of clinical depression than those who are uninsured.[16] Discouraging people from seeking mental health services is especially dangerous for health center patients who often face high levels of stress, economic hardship, and limited access to social supports. For the children our health centers serve, untreated mental health needs can have lifelong consequences.

AAPCHO health centers provide care to a disproportionate number of patients with chronic conditions such as diabetes, heart disease, and hypertension. They also play a critical role in the control of infectious diseases, including tuberculosis, hepatitis B, measles, and influenza. Making families fearful that accessing health care or vaccinations could jeopardize their immigration status endangers the public's health due to the increased likelihood of national infectious disease outbreaks caused by undervaccinated communities and undermines health centers' critical role in protecting the public's health.

The proposed rule creates the potential for discrimination against individuals with chronic medical

---

[13] "One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019." Urban Institute. https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019.

[14] "Chilling Effects: The Expected Public Charge Rule and Its Impacts on Legal Immigrant Families' Public Benefits Use." Migration Policy Institute.

[15] Department of Homeland Security, Public Charge Ground of Inadmissibility, November 19, 2025, 90 Federal Register 52168 (2025 NPRM). https://www.federalregister.gov/d/2025-20278/p-523.

[16] "Exploring the Rise in Mental Health Care Use by Demographics and Insurance Status." KFF. https://www.kff.org/mental-health/exploring-the-rise-in-mental-health-care-use-by-demographics-and-insurance-status.

conditions. Under potential future guidance, individuals with manageable illnesses such as arthritis, heart disease, and or diabetes could be denied a green card, particularly if they are uninsured or underinsured. Fear of triggering a public charge determination will deter eligible families from enrolling in programs that provide affordable access to medication, disease management, and preventative care. The rule also deepens the stigma associated with seeking health care, particularly for low-income and immigrant patients who already experience shame and social pressure when accessing medical and behavioral health services.[17] This fear and stigma will push them further away from the trusted health centers and safety-net providers they rely on. This combination of untreated illness, stigma-drive avoidance of care, and immigration penalties could lead to family separation solely because a medical condition went unaddressed, outcomes of which are avoidable.

4. Health centers will be dramatically and negatively impacted by this proposed rule, undermining their ability to serve their patients and increasing overall healthcare costs

Community health centers are the backbone of our nation's primary care safety net. Our network serves more than 34 million patients, including more than 1.6 million AAPIs, and employs more than 326,000 employees across 17,000 clinic sites.[18] The health center model and mission ensure access to affordable health care so that all individuals can contribute to their communities and reach their full potential. Patients visit their health centers an average of five times per year, relying on them for well-child care and immunization, chronic disease management, infectious disease treatment, behavioral health services, and support for complex social needs. Health centers provide this care by ensuring that every person can obtain quality and affordable care regardless of their ability to pay–as Congress intended.

Health centers and other safety‐net health care providers have seen firsthand how changes to the public charge policy can destabilize the system and impact patient care. Following the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, health centers saw steep declines in enrollment and patient visits because a climate of fear and confusion was created among immigrants that using safety-net programs could jeopardize their immigration status. Health centers and patient advocates have worked hard to thaw the chilling effects of that time so that individuals can get the care they need and entire communities can benefit from a healthier population. However this proposal, combined with other recent policy changes including H.R. 1 and the Administration's reinterpretation of "federal public benefit" threatens this progress and risks recreating disruptions on an even larger scale.

The proposed rule also imposes new and substantial administrative burdens on health centers. Responding to heightened patient fears, increased inquiries about immigration consequences, staff retraining, and managing coverage losses and disenrollment ("churn") will require significant time and resources. Health centers are already operating on margins between 1-2%, and these additional administrative demands will divert staff capacity away from direct patient care and strain already limited budgets.[19]

Even more troubling, the proposed rule places clinicians and care teams in a profoundly untenable ethical position. Providers will be forced to counsel patients about treatment options knowing that accessing essential–and at times life-saving–health care services could have immigration consequences. Already health care providers are beginning to field questions from patients and are having to explain the immigration risks of using health care services. This diverts time and resources away from actual patient care, undermines the trust that is foundational to the health center model, conflicts with providers' Hippocratic ethical obligation to "do no harm," and contradicts Congressional intent that health centers serve everyone in their service area.

---

[17] "Refugee and migrant mental health." World Health Organization. https://www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-mental-health.

[18] "America's Health Centers: By the Numbers." National Association of Community Health Centers. https://www.nachc.org/resource/americas-health-centers-by-the-numbers/

[19] "Community Health Centers: Separating Myths from Facts." Advocates for Community Health. https://advocatesforcommunityhealth.org/community-health-centers-separating-myths-from-facts

As safety-net health care providers, AAPCHO members primarily serve Medicaid and uninsured patients, providing comprehensive medical, mental health, dental, laboratory, pharmacy, and non-clinical enabling services such as health insurance enrollment assistance, health education, and interpretation and translation services. Medicaid is the primary source of funding that supports health centers' ability to offer these services. When patients disenroll from Medicaid out of fear, health center revenue declines and uncompensated care rises, making it harder for health centers to maintain services and staffing levels.

These financial pressures directly threaten the health center workforce, including not only doctors and nurses, but also front desk staff who register patients, enrollment specialists to help families navigate coverage, medical assistants who take vitals, health educators who support diabetes and hepatitis B management, and bilingual staff and interpreters who ensure meaningful access for patients with LEP. As more patients forgo coverage, these staff will continue to provide care regardless of insurance status, driving up uncompensated costs and placing additional strain on local communities to make up for funding gaps. Over time, the combined financial losses, operation strain, and erosion of patient trust will force AAPCHO members and other health centers to reduce services, shorten hours, or cut services.

This will weaken the nation's public health system and drive up costs. Health centers generate substantial savings for the health care system by providing accessible, high-quality primary and preventive care. Under the proposed rule, however, these savings will be lost as immigrant patients—along with their U.S.-citizen family members—delay or forgo routine care due to fear and confusion. When patients avoid primary care, manageable conditions worsen until they require emergency department visits, hospitalizations, or costly specialty care.

Studies have shown the savings health centers provide. According to the National Association of Community Health Centers, health centers save Medicaid $1,400 per adult, $800 per child, and $3,500 per dually eligible patient each year by preventing complications, managing chronic illness, and reducing avoidable hospital use.[20] The Congressional Budget Office similarly found that health centers generate long-term reductions in Medicare and Medicaid spending, producing a net federal savings of $3.4 billion.[21]

5. Reduces immigrants' pathways to self-sufficiency and meaningful contribution to society.

AAPCHO members serve patients who work in industries and small businesses that often do not offer affordable health insurance, if they offer coverage at all. For these families, Medicaid fills a critical gap, ensuring that workers and their children can stay healthy enough to attend school, maintain employment, and contribute to their communities. Medicaid prevents medical debt and bankruptcy, protects families when illness or accidents occur, and allows patients to manage chronic conditions before they become disabling. For the patients our members serve, Medicaid is a work support, not a handout. And to be clear, people who are undocumented and with certain legal status are not eligible for Medicaid–but family members, like U.S. citizen children, are legally eligible and rightly rely on these benefits.

Federal data from the Bureau of Labor Statistics underscore this reality. In 2024, immigrants comprised 19.2 percent of the U.S. civilian labor force, and Asian Americans accounted for 24.5 percent of that immigrant workforce.[22] Yet many newly arrived immigrants work in low-wage service sector jobs that lack employer-sponsored coverage and pay significantly less than jobs held by U.S.-born workers

---

[20] "Community Health Centers and Medicaid: Working Together to Make Americans Healthy." National Association of Community Health Centers. https://www.nachc.org/wp-content/uploads/2025/01/chcs-and-medicaid_working-together-to-make-america-healthy-may-2025

[21] "Cost Estimate: Bipartisan Primary Care and Health Workforce Act." Congressional Budget Office. https://www.cbo.gov/publication/59945

[22] "Foreign-Born Workers: Labor Force Characterstics–2024." U.S. Bureau of Labor Statistics. https://www.bls.gov/news.release/pdf/forbrn.pdf

($1,001/week in 2024 versus $1,190 for U.S.-born workers).[23] For these families, Medicaid is often the only viable source of coverage.

The proposed rule will cause millions of eligible individuals to forgo Medicaid out of fear, despite its essential role in helping families remain healthy and financially stable. Without employer-sponsored insurance—and with premiums that are unaffordable for many low-income workers—these individuals will have no realistic alternative for health coverage. As more people become uninsured, they will delay preventive care, avoid necessary treatment, and face worsening health conditions that threaten their ability to work and achieve self-sufficiency. For health centers, this means a growing number of uninsured patients with more complex health needs—exactly the opposite of what helps families thrive.

We Urge DHS to Withdraw the Proposed Rule on "Public Charge"

AAPCHO and our member health centers witness every day the challenges that deter families from seeking the care they need, including among many Asian American, Native Hawaiian, and Pacific Islander patients. The proposed rule will exacerbate the fear and confusion rooted within immigrant patients and their U.S. citizen family members. This proposed rule dismantles a clear regulatory framework and replaces it with uncertainty.. The proposed rule will drive eligible families out of essential programs, worsen health outcomes, destabilize safety-net providers, and erode decades of progress toward improving the nation's health. The harm will disproportionately affect health centers and the communities our members serve.

We strongly urge DHS to withdraw the proposed rule in full and keep in place the 2022 public charge final rule. Thank you for considering these comments.

Sincerely,

Adam P. Carbullido
Director of Policy and Advocacy
Association of Asian Pacific Community Health Organizations

[23] Ibid.