July 24, 2025

The Honorable Robert F. Kennedy Jr.
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Submitted electronically via regulations.gov

RE: Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of "Federal Public Benefit" (90 FR 31232)

Dear Secretary Kennedy,

On behalf of the American Academy of Family Physicians (AAFP), which represents 128,300 family physicians and medical students across the country, we appreciate the opportunity to comment on the department's notice published in the Federal Register on July 14, 2025, regarding the revised interpretation of the term "Federal public benefit" under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.

With this notice, HHS withdraws its 1998 interpretation of PRWORA and retroactively broadens the list of programs classified as "Federal public benefits," limiting access to these services for individuals without lawful immigration status unless a specific legal exception applies.

AAFP values its longstanding partnership with HHS and acknowledges the Department's responsibility to implement federal statutes. At the same time, we write to express serious concerns that the proposed expansion of PRWORA's definition would significantly impede access to essential health care for vulnerable populations and increase downstream financial and administrative burdens across the health care system. **We strongly urge the Department to reconsider this reinterpretation and explore modifications that support the nation's public health infrastructure, uphold fiscal responsibility, and protect access to essential health care services for all who need them.**

PRWORA; Interpretation of "Federal Public Benefit"

HHS's reinterpretation of the term "Federal public benefit" under PRWORA is grounded in its view that the 1998 HHS PRWORA notice improperly narrowed the law's scope. To address

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this, HHS outlines the following key revisions to clarify which services now fall under the updated interpretation of "Federal public benefit":

1. Block grants provided by HHS to states and localities are no longer exempt from PRWORA's reach.
2. HHS programs designed with the aim to target and support communities or groups—rather than individuals, households, or families—are no longer exempt from being considered "Federal public benefits." The regulatory test set forth by the 1998 notice to make this distinction is also defunct.
3. HHS programs that share characteristics with those explicitly listed in PRWORA are effectively subject to the same restrictions, with no exceptions unless specifically mandated by statute.

Having set forth their revised interpretation, HHS expands the list of programs considered "Federal public benefits" under PRWORA from 31 to 44, including Head Start, Health Center Programs under HRSA (FQHCs and CHCs), Title X Family Planning Service Grants, Substance Use Prevention, Treatment, and Recovery Services Block Grants, among others. HHS adds that this list is not exhaustive, and additional programs may be classified as "Federal public benefits" in the future. HHS notes that while they consider immigration status verification as critical to enforcing PRWORA, it is distinct from defining "Federal public benefit". Accordingly, this notice strongly encourages, but does not explicitly require, agencies to verify status. HHS will issue further implementation guidance to each affected program.

AAFP Comments

Family physicians are often the first, and sometimes the only, point of contact for individuals navigating complex health needs across their lifespans. Practicing in all 50 states, they serve more underserved and rural communities than any other specialty, witnessing firsthand the critical role that HHS-funded wraparound public health programs play in improving patient outcomes.[i] The programs newly classified as "Federal public benefits" by this notice are not ancillary, but essential to the comprehensive, continuous, and coordinated care that family physicians strive to deliver. Restricting access to these services will limit the effectiveness of primary care and disrupt care continuity for vulnerable populations, and the AAFP believes that all people should have access to essential health care services, regardless of their immigration status.

When preventive services are out of reach, patients often delay care until conditions worsen, turning to emergency departments for issues that could have been managed earlier, and more affordably, in primary care settings. Health Center Programs, including Community Health Centers (CHCs), are a vital source of care for many vulnerable populations. Under this notice's reinterpretation, limiting access to CHCs would leave many with no choice but to seek emergency care under the Emergency Medical Treatment and Labor Act (EMTALA). These settings are not designed to provide preventive or primary care and are already operating under significant strain. **Redirecting patients to emergency departments escalates uncompensated care costs, overwhelms already strained hospitals, fragments**

care delivery, and ultimately shifts the financial burden onto the shoulders of states and taxpayers. In 2019 alone, two-thirds of the 27 million ED visits by privately insured individuals were avoidable, representing $32 billion in potential annual savings.[ii] Notably, this figure only reflects the privately insured population. The total potential savings across all payer groups, including publicly insured and uninsured individuals, are likely substantially greater.

In addition to the downstream costs of increased emergency care utilization, the implementation of this notice will impose substantial direct costs, further compounded by administrative burdens. The Department's economic impact analysis estimates implementation costs between $184 million and $1.88 billion across programs. For Head Start alone, HHS projects $21 million annually in opportunity costs tied to eligibility documentation, application review, and procedural updates. While we appreciate the Department's acknowledgment of administrative burdens in their analysis, the stakes are especially high for family physicians. Administrative tasks already consume nearly half of their workday, reducing time with patients and contributing directly to burnout, which has climbed to 57%, up from 47% in 2018.[iii] As the Department itself recognizes, this notice would increase that pressure.

And reducing administrative burden is a stated priority of this administration. As Secretary Kennedy noted, *"To Make America Healthy Again, we must free our doctors and caregivers to do what they do best—prevent and treat chronic disease. We cannot allow their time and talent to be wasted on bureaucratic red tape and paperwork."* We strongly agree.

We understand that the President has prioritized protecting benefits for American citizens in need. However, the increase in health care costs and administrative burdens on physicians and other healthcare providers will mean that fewer healthcare resources will be available to all persons in the country: American citizens, lawfully present immigrants, and undocumented persons alike.

As HHS moves forward with implementation guidance, the AAFP urges the Department to carefully weigh the cumulative financial and administrative burdens this notice would impose on physicians and healthcare programs already operating under significant strain. We respectfully recommend revising the proposed approach to preserve access to essential services for all individuals, regardless of immigration status, avoiding additional documentation requirements that risk undermining care delivery. As the Secretary himself states, regulatory frameworks should be designed to support, not obstruct, the ability of clinicians to provide timely, high-quality care.

The AAFP stands ready to work in partnership with HHS to develop thoughtful, evidence-based solutions that reduce care fragmentation, strengthen the primary care infrastructure, and ensure that taxpayer dollars are directed toward maintaining access to health care services for all who need them. We welcome continued collaboration to advance shared goals that protect public health and the integrity of our healthcare system. We appreciate the opportunity to provide comments on this notice. For additional questions, please contact Sahana Chakravartti, Regulatory Specialist, at schakravartti@aafp.org.

Sincerely,

Steve Furr, M.D., FAAFP

Steven Furr, MD, FAAFP
American Academy of Physicians, Board Chair

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[i] Barreto T, Jetty A, Eden AR, Petterson S, Bazemore A, Peterson LE. Distribution of Physician Specialties by Rurality. J Rural Health. 2021 Sep;37(4):714-722. doi: 10.1111/jrh.12548. Epub 2020 Dec 4. PMID: 33274780.

[ii] United Health Group. The High Cost of Avoidable Hospital Emergency Department Visits - UnitedHealth Group. www.unitedhealthgroup.com. Published July 22, 2019. https://www.unitedhealthgroup.com/newsroom/posts/2019-07-22-high-cost-emergency-department-visits.html

[iii] Waldren S, Billings E. A Guide to Relieving Administrative Burden: Essential Innovations for Documentation Burden. *Family Practice Management*. 2023;30(4):17-22. https://www.aafp.org/pubs/fpm/issues/2023/0700/relieving-admin-burden.html