GOVERNORS PUBLIC HEALTH ALLIANCE

November 2, 2026

Daniel Sweeney
Deputy General Counsel for Economic, Statistical, and Regulatory Affairs
Office of the General Counsel
1401 Constitution Avenue NW
Washington, D.C. 20230

RE: Docket No. 260903-0005, RIN 0607-AA75 — Decennial Census of the Population of Americans; Proposed Residence Criteria and Proposed Regulations for Demographic Questions, 91 Fed. Reg. 57524 (Sept. 10, 2026)

Dear Mr. Sweeney:

On behalf of the Governors Public Health Alliance (PHA), we appreciate the opportunity to comment on the Census Bureau's proposed rule. PHA is a nonpartisan coalition of 16 Governors, representing approximately 40% of the U.S. population.[1] PHA is committed to protecting and advancing the health and well-being of millions of Americans across our states. As chief executives, PHA's member Governors are responsible for safeguarding the health of all people who reside within their states, regardless of age, income, employment status, or immigration status. They oversee state public health agencies, vaccination policy, Medicaid programs, insurance markets, and emergency response systems, all of which rely on complete, consistent, population-level data. By changing both who is counted and the information collected, the proposed rule threatens the accuracy and reliability of the population data that Governors rely on to serve their communities. We therefore urge the U.S. Department of Commerce and the U.S. Census Bureau (the Bureau) to withdraw the proposed rule.

I. The proposed residence criteria would undermine accurate population counts and the resources that depend on them.

For decades, the Census has counted people where they "live[] and sleep[] most of the time."[2] That principle has made the Census a consistent, nonpartisan measure of the nation's population regardless of changes in political leadership. The proposed rule would abandon that approach in two ways.

First, proposed § 60.2 would redefine "usual residence" as the place a person has "lawfully spent the greatest number of days" during a new January 3-April 1 enumeration period and provides

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[1] PHA membership includes California Governor Gavin Newsom, Colorado Governor Jared Polis, Connecticut Governor Ned Lamont, Delaware Governor Matt Meyer, Guam Governor Lou Leon Guerrero, Hawai'i Governor Josh Green, Illinois Governor JB Pritzker, Maryland Governor Wes Moore, Massachusetts Governor Maura Healey, New Jersey Governor Mikie Sherrill, New York Governor Kathy Hochul, North Carolina Governor Josh Stein, Oregon Governor Tina Kotek, Rhode Island Governor Daniel McKee, Virginia Governor Abigail Spanberger, and Washington Governor Bob Ferguson.

[2] U.S. Census Bureau, *2020 Census Residence Criteria and Residence Situations* (last revised Sept. 1, 2022), https://www.census.gov/programs-surveys/decennial-census/decade/2020/about/residence-rule.html.

that residence "should be consistent with and evidenced by," tax records.[3] Tax records are a poor proxy for where many people live. They miss many older adults and people without taxable earnings, do not reliably show where dependent children live, and often list outdated or nonresidential mailing addresses. To plan emergency, maternal and child health, vaccination and rural health services, officials need to know where people actually live, not where their tax forms are mailed.

Second, § 60.4 would count citizens of foreign countries only if they are also U.S. citizens or lawful permanent residents, excluding everyone else, in a stark departure from past practice.[4] This would exclude not only people present unlawfully, but also refugees and asylees, Temporary Protected Status holders, employment-based and student visa holders, and people with pending applications. Many of these individuals work in agriculture, food production, health care, and other critical sectors, making it important for Governors to plan for their health and service needs. Leaving these residents out of the count would not remove them from our states or change their health needs; it would only remove them from the data states use to plan and pay for services that all residents rely on including hospital Emergency Departments and clinic locations.

An accurate count is the foundation of the nation's public health infrastructure. Population counts supply the denominators used to determine rates of mortality, disease prevalence and spread, and other health indicators. If those denominators are understated for particular communities, the resulting rates are distorted, impairing states' ability to identify needs, evaluate interventions, and direct resources.

In fiscal year 2021, Census-derived data helped guide the distribution of more than $1.6 trillion in U.S. Department of Health and Human Services funding for programs including Medicaid, the Children's Health Insurance Program, Medicare, and Head Start,[5] as well as the distribution of resources during public health emergencies, such as the COVID-19 pandemic.[6]

The Bureau asserts that any effects of changes to the population count would be merely indirect because funding information "would remain available or could be obtained in other ways."[7] The Bureau offers no evidence demonstrating that alternative data sources would provide equivalent accuracy, geographic detail, timeliness, or public trust for public health decision-making. Nor has it sufficiently quantified the effects of the proposed changes on federal funding formulas, public health surveillance, or state planning. Changes of this magnitude should not be finalized without that analysis.

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[3] Decennial Census of the Population of Americans; Proposed Residence Criteria and Proposed Regulations for Demographic Questions, 91 Fed. Reg. 57524, 57529 (proposed Sept. 10, 2026) (to be codified at 15 C.F.R. § 60.2), https://www.federalregister.gov/documents/2026/09/10/2026-18481/decennial-census-of-the-population-of-americans-proposed-residence-criteria-and-proposed-regulations.

[4] 91 Fed. Reg. at 57529 (to be codified at 15 C.F.R. § 60.4).

[5] U.S. Census Bureau, *Uses of Decennial Census Programs Data in Federal Funds Distribution: Fiscal Year 2021* (Working Paper, June 2023), https://www2.census.gov/library/working-papers/2023/decennial/census-data-federal-funds-fy-2021.pdf.

[6] Grant A. Driessen, Cong. Rsch. Serv., R46298, *General State and Local Fiscal Assistance and COVID-19: Background and Available Data* (updated Feb. 8, 2021), https://www.everycrsreport.com/reports/R46298.html.

[7] 91 Fed. Reg. at 57528.

II. The proposed exclusion of certain demographic questions would deprive states of data essential for evaluating and responding to public health needs.

Proposed § 70.2(a) would bar questions about race, ethnicity, or sexual orientation from the short-form questionnaire and any questionnaire used for enumeration.[8] Census race and ethnicity data allow public health officials to identify disparities in disease, mortality, and access to care. This allows them to design programs, target prevention, and support applications for philanthropic funding. Although the Census does not currently collect data on sexual orientation, whether it should be included is a question best answered through research, not foreclosed by regulation.

The proposal notes that the Bureau may still ask demographic questions on the American Community Survey (ACS) and other surveys,[9] but a sample survey cannot replicate the geographic coverage, consistency, or small-area detail of a full count. Only the decennial census produces race and ethnicity data at the census-block level; the ACS does not publish below the block-group level, and its small-area estimates carry wide margins of error that limit their usefulness. The ACS also depends on the decennial census. Its sample is drawn from the census address file, and its responses are weighted to match the Bureau's annual population estimates by age, sex, race, and Hispanic origin, which start from the last census. Removing race and ethnicity questions from the census, and narrowing who is counted, would therefore weaken the ACS and every statistic built on it, including disability data and data used to manage the Rural Health Transformation Program and understand community health needs.

Nor can administrative records fill this gap. Healthcare administrative data sources rarely contain accurate race and ethnicity data.[10] Collection of race and ethnicity information in Medicaid cannot be required under program rules[11] and electronic medical records often contain inaccurate data on race and ethnicity.[12] The decennial census remains the only complete, consistent source of these data.

Conclusion

Governors are responsible for ensuring that their states are accurately represented in the nation's population count, and that federal data reflect the communities they serve. We therefore urge the Department of Commerce and the Census Bureau to withdraw the proposed rule in its entirety and to uphold the longstanding principle that the decennial Census counts every person where

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[8] 91 Fed. Reg. at 57530 (to be codified at 15 C.F.R. § 70.2(a)).
[9] 91 Fed. Reg. at 57530 (to be codified at 15 C.F.R. § 70.4).
[10] Kevin T. Nead, Candice L. Hinkston & Mackenzie R. Wehner, *Cautions When Using Race and Ethnicity in Administrative Claims Data Sets*, 3 JAMA Health F. e221812 (2022), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2793906.
[11] Heather Saunders & Priya Chidambaram, *Medicaid Administrative Data: Challenges with Race, Ethnicity, and Other Demographic Variables*, KFF (Apr. 28, 2022), https://www.kff.org/medicaid/medicaid-administrative-data-challenges-with-race-ethnicity-and-other-demographic-variables/.
[12] Josh A. Johnson et al., *The Accuracy of Race & Ethnicity Data in US Based Healthcare Databases: A Systematic Review*, 226 Am. J. Surgery 463 (2023), https://www.sciencedirect.com/science/article/abs/pii/S0002961023001976.

they live, so that Governors, public health officials, and local leaders can responsibly plan for and serve the communities entrusted to them.

Respectfully submitted,



Angela Botticella
Managing Director
Governors Public Health Alliance