How Could the Public Charge Proposed Rule Affect Community Health Centers?

Geiger Gibson / RCHN Community Health Foundation Research Collaborative

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at the George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at https://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy or at www.rchnfoundation.org.

Executive Summary

By law and mission, community health centers provide care for all community residents. Because Medicaid is the largest source of health center funding, public policy changes that could reduce Medicaid enrollment can be expected to have significant repercussions for health centers, limiting their capacity to care for their community residents. The proposed "public charge" rule released by the Department of Homeland Security is expected to have a significant chilling effect on Medicaid enrollment among eligible legal immigrants as well as their family members. As health centers begin to feel the impact of this chilling effect on patients, we estimate that nationally, Medicaid revenue will decline by $346 million to $624 million. A revenue decline of this magnitude will cause the number of patients served to fall by 295,000 to 538,000. Every state can be expected to sustain losses, with the state-specific impact reflecting the size of the immigrant population and current breadth of Medicaid coverage.

Background

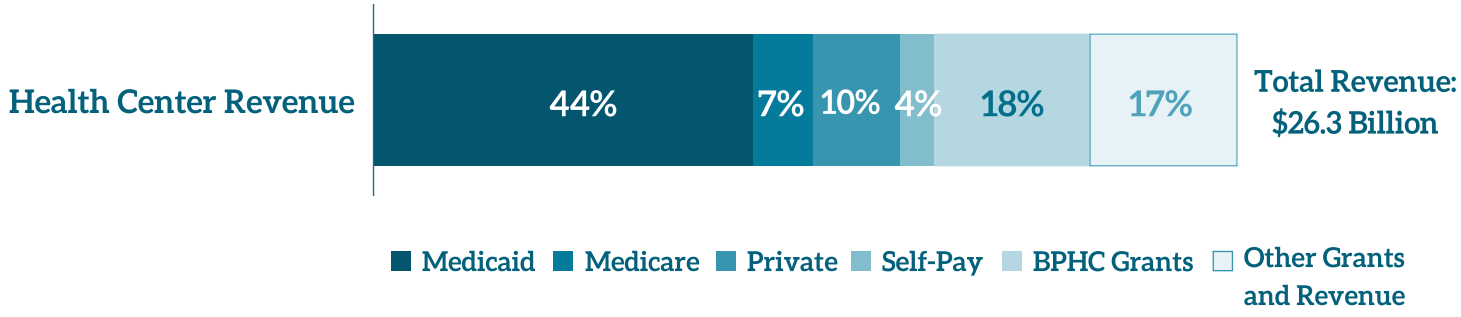
Like public schools, community health centers serve all community residents, with or without health insurance. In carrying out their mission, health centers rely on a variety of funding sources, shown in Figure 1: Medicaid (44 percent); federal health center operating grants (18 percent); other revenue including federal, state, and local grants (17 percent); private health insurance (10 percent); Medicare (7 percent); and direct payments by patients (4 percent). In states that have adopted Medicaid expansions, Medicaid represents a significantly greater percentage of health centers' operating revenue (48 percent compared to 29 percent in non-expansion states).[1] Self-pay patient revenue is relatively low in all states, since health center patients are overwhelmingly low income; 91 percent have family incomes at or below twice poverty,[2] while 69 percent have family incomes at or below the federal poverty level ($25,100 for a family of four in 2018).[3]

[1] Sharac, J., Shin, P., Gunsalus, R., & Rosenbaum, S. (2018). Community health centers continued to expand patient and service capacity in 2017. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 54. https://www.rchnfoundation.org/?p=7172

[2] Bureau of Primary Health Care. (2018). 2017 Health Center Data: National Data. Health Resources and Services Administration. https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=

[3] Office of the Assistant Secretary for Planning and Evaluation. 2018 Poverty Guidelines. U.S. Department of Health and Human Services. https://aspe.hhs.gov/poverty-guidelines

Figure 1. Health Center Revenue, By Source, 2017



Note: Percentages may not sum to 100% due to rounding. Source: Bureau of Primary Health Care. (2018). 2017 Health Center Data: National Data. Health Resources and Services Administration. https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=

Changes in public policy can affect the revenue sources on which health centers rely. As these changes occur, they can carry important consequences for health centers' overall patient care capacity. Because Medicaid represents the largest single source of health center revenue, policies that affect Medicaid eligibility or enrollment are particularly significant to health centers' operational and service capacity. When Medicaid enrollment rises, so does health center revenue. They can add staff, open new sites, expand their hours of operation, expand services, and ultimately serve more patients.[4] Conversely, policy reforms that limit Medicaid enrollment can be expected to reduce Medicaid revenue, leading to fewer services, fewer staff, fewer service sites, and fewer patients served. Thus, for example, health centers located in Medicaid non-expansion states tend to be smaller, more modestly staffed, and serve fewer patients.[5]

On October 10th, the United States Department of Homeland Security (DHS) issued a proposed rule that would significantly revise the legal test used under U.S. immigration law for determining when legal immigrants are likely to become "public charges" and therefore ineligible for admission into the country or adjustment of legal status to permanent residency.[6] Among other changes, the rule would, with virtually no exceptions other than emergency care and certain services furnished in schools, treat Medicaid enrollment in the past three years as evidence of public charge. Similarly, use of Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) or public housing benefits would also lead to a public charge determination. Furthermore, simply having a low income or lacking a high school diploma would place a person at risk of being determined a public charge.

Although certain legal immigrants such as refugees or asylees would be exempt from such a determination, many experts have pointed to the chilling effect that such a change could have. Prior research documented the impact of this chilling effect — that is, the extent to which changes in policies affecting legal immigrants deter them and even their U.S.-born citizen children from enrolling in programs for which they are eligible.[7] The proposed rule acknowledges this chilling effect research, although it places only modest weight on the research findings.[8] Previous studies evaluating the effect of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) found that the chilling effect reduced enrollment in affected programs by anywhere from 17 percent to 78 percent, but DHS estimates that the proposed rule will reduce enrollment only by 2.5 percent. Furthermore, DHS claims that this 2.5 percent estimate may be an overestimate and asserts, without evidence, that some immigrants and their families may not be deterred from using Medicaid and other affected public benefits.[9]

Although DHS minimizes evidence of the chilling effect in its own estimates, both the earlier research and extensive anecdotal evidence suggest that the rule could have a widespread chilling effect on Medicaid enrollment. This is especially true since DHS also emphasizes the importance of having private health insurance in avoiding a determination of public charge. Therefore, the Geiger Gibson / RCHN Community Health Foundation Research Collaborative has prepared estimates to illustrate the potential impact of the proposed rule on health center revenue, staffing, and patient service capacity.

[4] Han X, Luo Q, Ku L. Medicaid Expansions and Increases in Grant Funding Increased the Capacity of Community Health Centers, Health Affairs, 2017 Jan.; 36 (1):49-56.

[5] Rosenbaum, S., Tolbert, J., Sharac, J., Shin, P., Gunsalus, R. & Zur, J. (2018). Community Health Centers: Growing Importance in a Changing Health Care System. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/community-health-centers-growing-importance-in-a-changing-health-care-system/

[6] 83 Fed. Reg. 51114 (October 10, 2018)

[7] For example: Fix M, Passel J. Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform. Urban Institute, Mar, 1999. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform. Pederaza F, Zhu L. The Chilling Effect of America's New Immigration Enforcement Regime. Pathways. Spring 2015. Kaestner R, Kaushal N. Immigrant and Native Responses to Welfare Reform. J Population Economics. 2005; 181(1) 69-92.

[8] See p. 51266 https://www.gpo.gov/fdsys/pkg/FR-2018-10-10/pdf/2018-21106.pdf

[9] See p. 51269: "On the other hand, the 2.5 percent rate of disenrollment or foregone enrollment estimate may result in an overestimate…Additionally, some prospective adjustment applicants and associated household members may not choose to disenroll or forego public benefits because they may have other factors that counterbalance acceptance of public benefits when looked at in the totality of circumstances." https://www.gpo.gov/fdsys/pkg/FR-2018-10-10/pdf/2018-21106.pdf

How We Did This Analysis

Estimating the effects of the public charge rule on health center revenue, staffing, and patient care capacity is challenging. This is because the impact comes not from policies that are directly aimed at health centers, but from policies that will have an indirect (i.e., spillover) effect. The challenge is especially great for health centers, since, as a critical public health program, health centers do not collect information on the citizenship characteristics of their individual registered patients.

Nonetheless, it is possible to couple the findings from past chilling effect research with information about the residential patterns of immigrant populations to produce broad estimates of the impact of the chilling effect phenomenon on health centers. Importantly, these estimates reflect an impact range rather than a single-point estimate, since the larger body of chilling effect research itself shows an impact range. The estimates provided in this issue brief provide an approximation of the magnitude of the potential effects; we acknowledge some uncertainty about the behavior of patients and health centers in response to the public charge policies.

A longer explanation of how we prepared our national and state-level estimates can be found in the Appendix.

Results

Among the 13.3 million Medicaid beneficiaries served by health centers in 2017, we estimate that approximately 709,000 (5.3 percent) can be expected to be legal immigrants who are not yet citizens and who therefore fall into the group that might disenroll from Medicaid as a result of the public charge rule's chilling effect. We estimate that the chilling effect could affect 2.6 million patients overall, a group that includes not only legal immigrant patients but also their citizen and legal immigrant family members.

Table 1 shows the low and high estimates at the national level (counting only the 50 states and District of Columbia) and at state levels.

Low Estimates: Legal Non-Citizen Immigrants

If 50 percent of legal immigrant health center Medicaid patients disenroll from Medicaid in order to avoid possible public charge implications, then 354,000 nationwide will no longer be covered by Medicaid. Because health centers serve all community residents regardless of insurance status, they will continue to furnish care. At the same time, they will experience a $346 million loss in Medicaid revenue over a one-year period. From our prior research into health center responses to revenue declines,[10] it is reasonable to assume that they will take certain steps to absorb expected losses. These steps include reduced hours, site closures, scaled-back services, and staffing reductions. We estimate that reductions in patient capacity will result in 295,000 fewer patients overall served during the year. Medical staffing reductions – including physicians and nurses– will affect approximately 3,400 full-time equivalent staff. Because health centers are open to all, and do not distinguish among their patients, the reductions will affect the community as a whole.

High Estimates: Members of Immigrant Families

This estimate assumes broader repercussions if additional family members are "chilled out" of Medicaid participation. If we assume that 25 percent of this broader group disenrolls from Medicaid, then 646,000 patients will lose Medicaid coverage. Health center revenue will decline by $624 million over a one-year period. In order to offset this revenue loss, health centers will reduce sites, hours, services and staffing. We estimate that health centers would serve 538,000 fewer patients over the course of the year, while staffing would drop by 6,100 full-time equivalent medical staff. As with the lower estimates, these service and staffing reductions will impact the entire community.

[10] Geiger Gibson/RCHN Community Health Foundation Research Collaborative and the Kaiser Family Foundation. (2018). How Are Health Centers Responding to the Funding Delay? Available at https://www.kff.org/medicaid/fact-sheet/how-are-health-centers-responding-to-the-funding-delay/

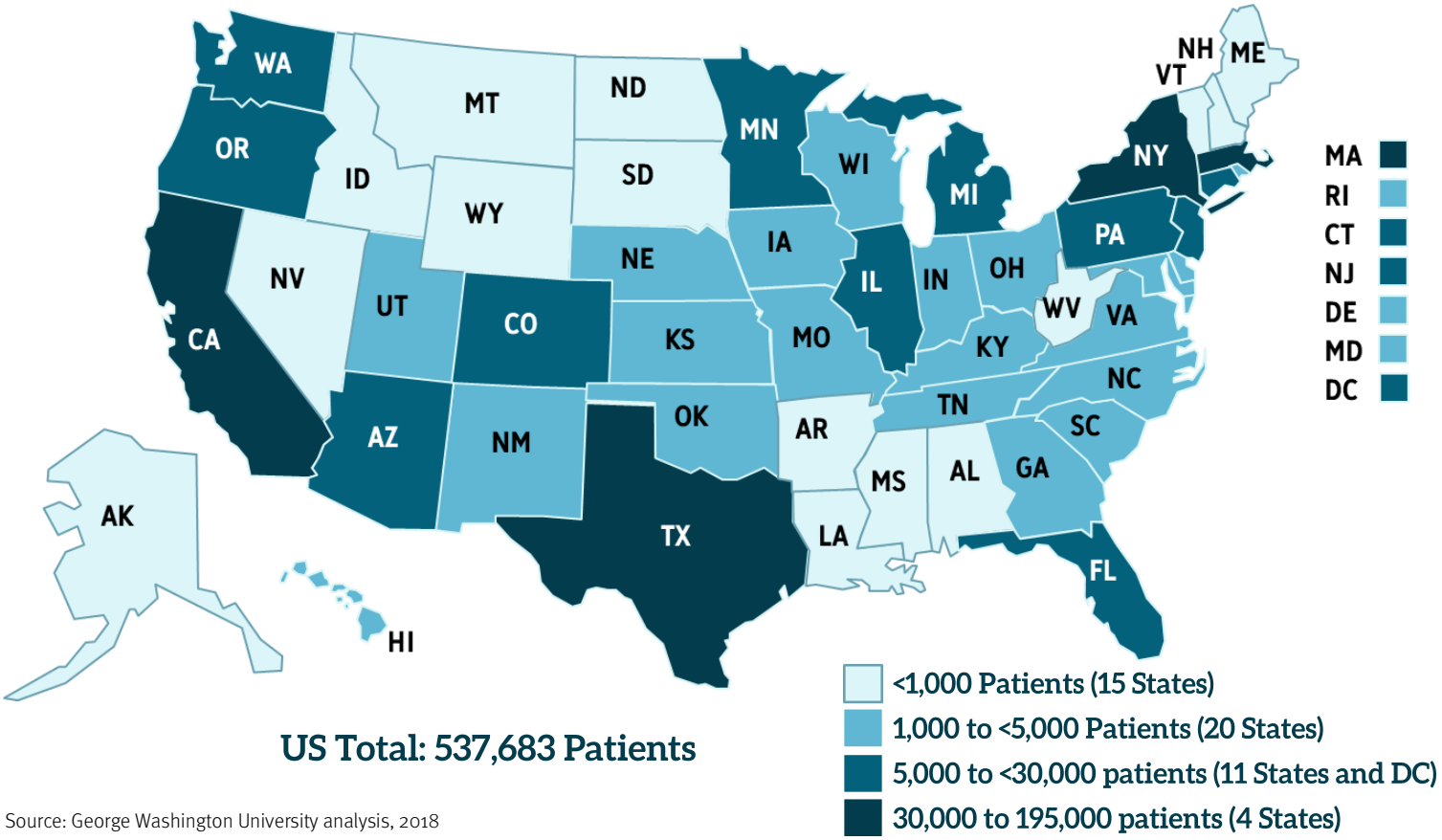
Table 1. Estimates of Impacts of Public Charge Rule on Community Health Centers (Over One Year)

Low estimates for legal non-citizen immigrants directly affected. High estimates for members of immigrant families losing Medicaid due to chilling effect.

	Health Center Patients Losing Medicaid		Loss in Health Center Medicaid Revenue		Loss in Total Number of Health Center Patients		Loss in Total Health Center Medical Staff	
	Legal Non-Citizen Immigrants	Legal Non-Citizen Immigrants and Family Members						
	Low	High	Low	High	Low	High	Low	High
US Total	**-354,334**	**-645,502**	**-$345,673,184**	**-$623,753,853**	**-294,642**	**-537,683**	**-3,373**	**-6,075**
Alabama	-502	-1,172	-$225,564	-$526,557	-365	-851	-2	-6
Alaska	-231	-487	-$471,897	-$996,953	-149	-315	-3	-7
Arizona	-11,166	-13,508	-$10,595,610	-$12,817,305	-9,900	-11,976	-116	-141
Arkansas	-573	-1,120	-$394,544	-$771,900	-425	-832	-5	-9
California	-115,357	-219,646	-$126,143,256	-$240,183,200	-102,201	-194,595	-1,139	-2,169
Colorado	-6,555	-13,634	-$5,696,253	-$11,848,222	-5,143	-10,697	-63	-131
Connecticut	-4,984	-12,878	-$4,408,901	-$11,391,917	-4,208	-10,873	-44	-113
Delaware	-1,140	-1,754	-$553,818	-$852,250	-696	-1,071	-6	-9
Dist. of Columbia	-4,245	-6,169	-$9,953,898	-$14,464,689	-4,258	-6,188	-106	-154
Florida	-13,114	-26,703	-$7,813,025	-$15,909,023	-9,334	-19,006	-94	-192
Georgia	-754	-2,434	-$254,034	-$820,574	-310	-1,003	-3	-10
Hawaii	-1,034	-1,692	-$1,008,457	-$1,650,632	-736	-1,205	-10	-16
Idaho	-265	-1,057	-$225,677	-$900,226	-202	-805	-2	-9
Illinois	-9,404	-21,461	-$5,948,171	-$13,574,467	-7,417	-16,927	-64	-147
Indiana	-2,865	-4,618	-$1,817,859	-$2,930,274	-2,312	-3,727	-20	-32
Iowa	-2,513	-3,090	-$1,963,423	-$2,414,045	-2,249	-2,765	-19	-24
Kansas	-864	-1,445	-$471,669	-$789,340	-623	-1,042	-6	-10
Kentucky	-2,983	-3,277	-$1,951,046	-$2,143,024	-2,062	-2,265	-22	-24
Louisiana	-331	-1,198	-$155,599	-$563,779	-164	-595	-2	-6
Maine	-270	-529	-$233,447	-$457,375	-224	-438	-2	-5
Maryland	-2,060	-3,813	-$1,782,988	-$3,300,834	-1,628	-3,013	-20	-37
Massachusetts	-39,382	-53,841	-$32,471,101	-$44,392,363	-23,251	-31,787	-335	-458
Michigan	-5,185	-8,219	-$3,839,013	-$6,084,838	-3,899	-6,180	-40	-64
Minnesota	-3,497	-7,038	-$2,658,967	-$5,351,271	-2,530	-5,093	-25	-49
Mississippi	-30	-643	-$9,842	-$210,900	-15	-312	0	-2
Missouri	-438	-1,630	-$345,504	-$1,286,065	-417	-1,552	-4	-15
Montana	-199	-286	-$137,605	-$197,994	-124	-179	-1	-2
Nebraska	-1,197	-1,631	-$623,129	-$849,313	-742	-1,012	-8	-11
Nevada	-337	-847	-$581,865	-$1,463,941	-390	-981	-8	-20
New Hampshire	-472	-858	-$366,666	-$666,839	-290	-528	-4	-7
New Jersey	-6,888	-17,228	-$2,799,363	-$7,001,699	-3,406	-8,520	-27	-66
New Mexico	-3,834	-6,139	-$3,349,127	-$5,363,475	-2,693	-4,313	-35	-56
New York	-48,224	-88,697	-$55,237,669	-$101,597,422	-41,733	-76,758	-495	-911
North Carolina	-1,997	-6,115	-$1,070,195	-$3,276,186	-1,376	-4,211	-12	-38
North Dakota	-311	-421	-$273,951	-$370,515	-300	-405	-3	-5
Ohio	-2,538	-4,602	-$1,401,176	-$2,540,892	-1,799	-3,262	-16	-29
Oklahoma	-490	-1,696	-$312,067	-$1,079,861	-373	-1,291	-4	-12
Oregon	-5,214	-9,668	-$8,251,838	-$15,300,182	-4,890	-9,066	-80	-148
Pennsylvania	-8,032	-13,008	-$7,616,148	-$12,335,111	-7,967	-12,903	-83	-135
Rhode Island	-3,075	-4,545	-$3,003,273	-$4,439,375	-3,036	-4,488	-33	-49
South Carolina	-319	-1,929	-$209,046	-$1,263,821	-203	-1,227	-2	-15
South Dakota	-719	-884	-$485,598	-$597,119	-614	-755	-6	-7
Tennessee	-803	-2,172	-$347,224	-$938,841	-533	-1,440	-5	-12
Texas	-15,876	-31,333	-$13,410,285	-$26,466,577	-17,137	-33,822	-156	-308
Utah	-1,547	-2,842	-$1,369,508	-$2,516,979	-1,426	-2,622	-16	-29
Vermont	-198	-350	-$166,063	-$293,264	-167	-295	-2	-3
Virginia	-661	-1,692	-$458,375	-$1,173,334	-577	-1,477	-5	-13
Washington	-18,168	-29,907	-$19,832,337	-$32,646,223	-17,036	-28,043	-190	-312
West Virginia	-259	-495	-$172,518	-$330,056	-214	-409	-2	-4
Wisconsin	-3,154	-4,990	-$2,708,512	-$4,285,574	-2,806	-4,439	-28	-44
Wyoming	-81	-108	-$96,085	-$127,240	-91	-121	-1	-1

Source: George Washington University, 2018. Numbers may not sum due to rounding.

Figure 2. Estimated Health Center Patients Lost Due to the Public Charge Rule (High Estimate)



Source: George Washington University analysis, 2018

Figure 2 illustrates the geographic distribution of the reduction in health center patients, based on the high estimates. In four states (California, Massachusetts, New York, and Texas) between 30,000 and 195,000 patients could lose care. In another 11 states (Arizona, Colorado, Connecticut, Florida, Illinois, Michigan, Minnesota, New Jersey, Oregon, Pennsylvania, and Washington) and the District of Columbia, between 5,000 and 30,000 patients could lose access to services.

Discussion

Broad social policy changes can be expected to have significant consequences for service providers serving all community residents and open to all. As a key public health response to the problem of medical underservice, community health centers furnish care at more than 11,000 sites in low-income urban and rural communities across the nation.[11] These communities are characterized by elevated poverty and health risks and a shortage of primary care. Health centers care for everyone in the community without regard to citizenship status or other personal characteristics not related to health care need.

Because the communities in which health centers operate also tend to have sizable immigrant populations, policies that either directly or indirectly implicate their Medicaid enrollment are likely to produce significant spillover effects. While the public charge rule does not treat health centers as a type of public benefit that counts toward a determination of public charge status, this analysis underscores that its indirect effect could be considerable if large numbers of patients affected by the rule begin to disenroll. This spillover effect can be expected to translate into declining revenue and ultimately, decreased staffing and service capacity.

[11] Sharac, J., Shin, P., Gunsalus, R., & Rosenbaum, S. (2018). Community health centers continued to expand patient and service capacity in 2017. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 54. Available at https://www.rchnfoundation.org/?p=7172

Appendix: Methods

This brief presents state and national estimates of the effect of the proposed public charge rule on federally-funded community health centers, their patients, and staff in the fifty states and the District of Columbia (DC). We present low and high estimates of potential effects of the proposed rule on Medicaid enrollment among health center patients.

- The **low estimates** examine the effects of the rule on patients who are themselves legal immigrants (who have not yet become naturalized citizens) who could be directly affected by the public charge rule. It assumes that a large proportion of these legal immigrants disenroll from Medicaid because of fears that a history of Medicaid use could jeopardize their legal immigration status.
- The **high estimates** also include other members of immigrant families, such as their U.S.-born citizen children. This scenario assumes that some of these family members may be "chilled out" of Medicaid participation because of concerns over the impact of using Medicaid on their immigrant family members, as occurred when earlier changes were made to immigrant policies.

Health centers do not collect data on the citizenship status of individual patients. Data from the 2014 Health Center Patient Survey, a national sample survey, indicate that 84 percent of health center patients were born in the U.S.[12] The UDS provides information about the total number of patients in each center who are best served in a language other than English, which is correlated with being a member of an immigrant family.

Our estimates are based upon the following assumptions and data sources, with variables based on state-level data:

1. We began with 2017 data from the Uniform Data System (UDS) about the number of health center patients best served in a language other than English because of its high correlation with immigrant status. Analyses of the 2014 Health Center Patient Survey found that 96 percent of adult health center patients who spoke to a doctor or other staff in Spanish, Chinese or another non-English language are foreign-born, while 11 percent of adults who communicated with their provider in English are not foreign-born. A smaller share of children who received care in another language are immigrants, because most children in immigrant-headed households are U.S.-born citizens. Overall, 61 percent of the combined adult or child patients who spoke to a doctor or other staff in another language were foreign-born.
2. State-specific adjustment factors were developed based on: (a) state-specific Migration Policy Institute data[13] to estimate the proportion who are legal noncitizen immigrants and (b) state-specific data about the number of limited-English-proficiency noncitizens with incomes below 200 percent of poverty who were enrolled in Medicaid coverage, based on 2016 ACS data.[14]
3. We estimated the number of health center lawfully present patients with Medicaid coverage at the individual and family level by multiplying the number of health center patients best served in a language other than English by these adjustment factors to estimate the number of lawfully present immigrants receiving Medicaid in health centers. To estimate the number of family members who could be subject the chilling effect, we used a parallel method including the factors above, excluding only the adjustment for whether the individual was a legal, non-citizen immigrant.

[12] Bureau of Primary Health Care. Health Center Patient Survey. https://bphc.hrsa.gov/datareporting/research/hcpsurvey/index.html

[13] Migration Policy Institute (MPI). https://www.migrationpolicy.org/programs/us-immigration-policy-program-data-hub/unauthorized-immigrant-population-profiles. Missing values for Montana and North Dakota were imputed from Idaho and Vermont was imputed from Maine.

[14] US Census Bureau. American Community Survey (ACS). https://www.census.gov/programs-surveys/acs/

Prior research guided the potential ranges of Medicaid disenrollment among affected immigrants or their family members. The Migration Policy Institute reviewed chilling effects for public benefits from prior immigration policy changes and estimated that between 20 percent and 60 percent of affected immigrants would disenroll;[15] we applied a 50 percent rate of disenrollment for legal noncitizen immigrants. The Kaiser Family Foundation[16] estimated that Medicaid chilling effects for citizen children could range between 15 and 35 percent; we used an estimate of 25 percent disenrollment for members of immigrant families. We conservatively assume stronger effects among those who are themselves legal noncitizen immigrants and somewhat milder effects among other members of immigrant families.

We next estimated the lost Medicaid revenue resulting from disenrollment by multiplying the estimated number of people in each state who are expected to drop Medicaid coverage by that state's average per-patient Medicaid revenue, using the 2017 UDS. In order to compute the reduction in the total number of patients served and medical staff employed, we divided the revenue loss by each state's average total cost per patient from the 2017 UDS. We computed potential medical staffing reductions based upon each state's average accrued cost of full-time equivalent [FTE] medical providers. This approach was used with both the high and low estimates of Medicaid enrollment loss.

[15] Batalova, J., Fix, M., & Greenberg, M. (2018). Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefits Use. Migration Policy Institute. https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families

[16] Artiga, S. Potential Effects of Public Charge Changes on Health Coverage for Citizen Children. Kaiser Family Foundation. May 2018. Available at https://www.kff.org/disparities-policy/issue-brief/potential-effects-of-public-charge-changes-on-health-coverage-for-citizen-children/