Data Note

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How the COVID-19 Pandemic Has Intensified the Impact of the Public Charge Rule on Community Health Centers, their Patients, and their Communities

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Background

Community health centers operate in the poorest urban and rural communities that experience elevated health risks as well as a serious shortage of primary health care. Immigrants are **disproportionately likely to be poor**, and therefore experience a greater need for publicly supported health services. Community health centers serve large numbers of immigrants, not only because of their location but also because of the extent to which health centers have adapted their care and services to meet immigrants' unique language, cultural, and health needs.

The Trump administration's **public charge rule** represents a serious threat for immigrants who seek permanent U.S. residency status. Under its terms, immigrants who use public benefits for which they are eligible (including most forms of Medicaid) can be considered dependent on government assistance and therefore ineligible for permanent legal residency. Moreover, in measuring eligibility for permanent residency, the rule establishes both a health and wealth test. Extensive **news coverage** as well as **systematic research** have documented the rule's significant chilling effect, not only on those immigrants directly subject to its terms but also their families, including their citizen children.

The rule's impact on immigrants' use of Medicaid is of major concern, because its sanctions apply to many forms of Medicaid coverage. Furthermore, because of the rule's health test, an equally significant concern has been whether immigrants would avoid health care itself. In March 2020, the U.S. Citizenship and Immigration Services (USCIS) issued a limited **COVID-19-related public benefit exception**. However, in its **July 2020 ruling blocking the rule from taking effect during the pandemic**, a federal court explicitly found that the COVID exception was poorly designed and unable to mitigate the rule's impact. Since this ruling, there has been no evidence that the exception has in any way lessened the rule's chilling effect.

The Estimated Impact of the Public Charge Rule on Community Health Centers, pre-Pandemic

Our **previous estimate of the impact of the public charge rule on community health centers and their patients** found that between 165,000 and 495,000 Medicaid patients could be expected to lose coverage and that in turn, these losses would translate into a decline in the capacity to serve between 136,000 and 407,000 patients nationally. California's community health centers alone could expect to lose patient capacity for 142,000 patients and New York's community health centers could experience a drop of more than 77,000 patients. The loss of patient care capacity would be the consequence of revenue declines ranging from $164 million to $493 million as a result of the Medicaid coverage drop. Beyond these estimates, community health centers across the country reported **a decline in Medicaid enrollment among their patients**, as immigrants feared the consequences of using Medicaid under the rule.

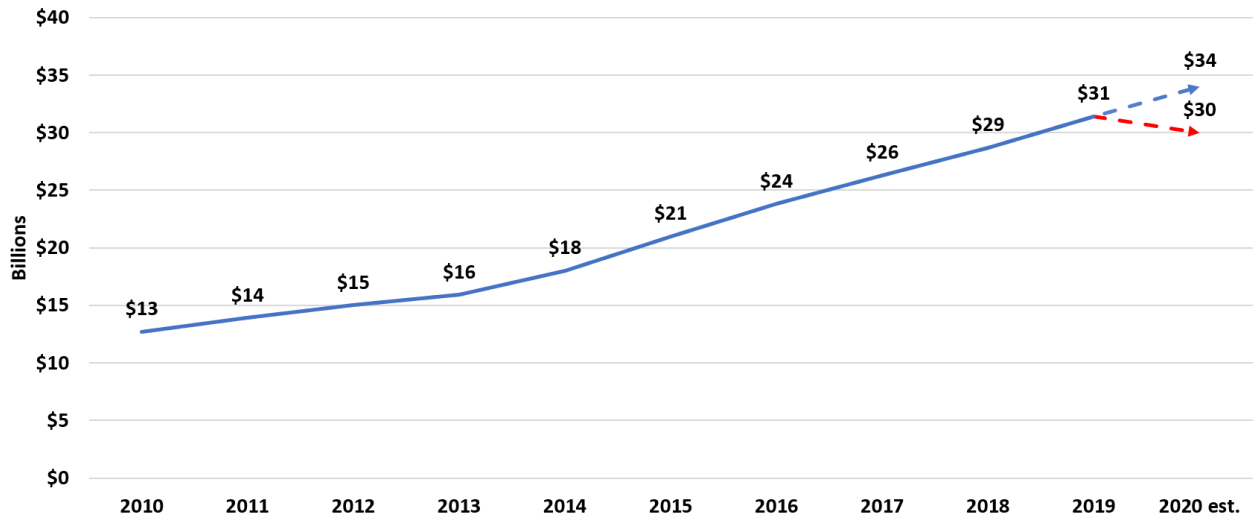
Since that time, community health centers have experienced a major revenue decline as a result of the COVID-19 pandemic. This decline is in addition to the continuing revenue losses from the public charge rule, which was allowed to take effect nationwide in February 2020 under a **United States Supreme Court ruling** that stayed multiple injunctions against implementation of the rule while the government appealed.

A Deteriorating Financial Picture for Community Health Centers Because of COVID-19

The COVID-19 pandemic has led to a large revenue loss for community health centers. Our ongoing review of COVID-19 and community health centers finds that health centers have experienced an estimated revenue loss totaling $4.006 billion over eight months from April to December 4th, 2020 – 13 percent of total health center revenue reported in 2019. These losses come as the nation experiences the worst phase of the pandemic, with over 200,000 confirmed cases each day and deaths now exceeding 300,000. Community health center patients are in worse health and thus at elevated risk for COVID-19 in its severest forms as well as COVID-19-related deaths. Nearly half – 47 percent of all health center patients – are expected to qualify for phase one priority immunization because they are adults of advanced age or with certain medical conditions.

Figure 1 below depicts projected and actual community health center revenue over time. It shows the major revenue decline that occurred in 2020 following the pandemic onset; this decline came after a decade of steady financial growth and expansion. This revenue drop has led to severe operational strains at community health centers even as COVID-19 has surged in poor communities and the demand for COVID-19 testing has soared. As of early December 2020, weekly visits to health centers remain 17 percent below pre-pandemic levels, six percent of staff members are unable to work, and 5 percent of the nearly 13,000 service sites operated by community health centers are closed.

Figure 1. Projected and Actual Community Health Center Revenue, 2010-2020 (in billions)



Notes: 2020 estimates based on historical revenue data, estimated patient revenue losses based on reported declines in weekly visits, and do not account for COVID-19 supplemental grants and COVID-19 relief funds. Sources: 2010-2019 Uniform Data System data, HRSA; Weekly Health Center COVID-19 Survey, HRSA.

Replacement funding, including $2 billion in supplemental COVID-19 grants as well as additional COVID-19 relief funding to help offset the effect of the pandemic, has proven inadequate. As data on revenue, staffing reductions and site closures underscore, funds made available to health care providers under the 2020 CARES Act have been insufficient to ensure that community health centers are able to sustain pre-pandemic operational levels. Indeed, large health centers (with over 500 employees), which tend to operate in highly urbanized areas that in turn are likely to have large immigrant populations, were prevented from qualifying for the CARES Act Paycheck Protection Program (PPP). Furthermore, the average PPP loan of $2 million represented only about one month of operating costs at the typical community health center. Other sources of CARES Act funding, such as the Provider

Relief Fund, have provided only limited funding, especially for community-based non-hospital safety net providers; indeed, Fund relief **has been inadequate even for high-need hospitals** serving large numbers of uninsured patients.

Discussion

Even pre-pandemic, community health centers, like other safety net providers, operated with narrow financial margins, and the need for care often exceeded service capacity. In 2019, we found that the sanctions imposed by the public charge rule on use of public benefits could be expected to have a significant, negative effect on revenue and overall patient care capacity.

Since we produced our analysis, the financial outlook for community health centers has worsened and their capacity to provide care has declined. The cause of this worsening is a once-in-a-century pandemic that demands a major increase in care capacity, especially for the worst-hit populations, who tend to reside in impoverished communities and to include large numbers of immigrants. Federal funding aimed at stabilizing health care during the pandemic has fallen well short of need, and even the pending extension of relief funding is not expected to restore essential health care providers such as community health centers to pre-pandemic operational strength. For these reasons, the public charge rule, which was already having **measurable effects on health center Medicaid enrollment** and operations, becomes a matter of even greater concern not only because of the direct threat it poses to community health but because of its spillover financial and operational effects on community health providers struggling to care for their communities.