Farmworkers: Issues and Challenges in Health Insurance Coverage and Health Care Access

Introduction

An estimated 3 million workers earn their living through migrant and seasonal farm labor, traveling the nation to support an agricultural industry which yielded $28 billion in fruit and vegetable business in 2001 alone.[1] Forty-five years ago, farm labor was the subject of *Harvest of Shame*,[2] a classic documentary which chronicled the devastating conditions under which migrant laborers worked. Much has changed over the past four and a half decades where workplace safety and healthcare access are concerned; at the same time, migrant and seasonal farmworkers (MSFWs) continue to confront unique health and healthcare challenges arising from the hazardous nature of their work, their extreme poverty and mobility, and living and working arrangements which serve to make access to health insurance and health care especially difficult.

As part of the 2002 reauthorization of the health centers program, Congress mandated a study to examine "the problems experienced by migrant and seasonal farmworkers (including their families) under Medicaid and SCHIP." [3] Congress sought an analysis of Medicaid enrollment and portability barriers as well as options for possible solutions, both within the current limits of Medicaid and SCHIP and through use of Section 1115 demonstration authority and public-private partnerships to develop coverage alternatives.

This policy brief begins with a review of the health and healthcare environment in which MSFWs and their families live and work, as well as the challenges faced by the nation's federally funded health centers serving the farmworker population. It then reviews the literature on

[1] National Center for Farmworker Health, *Facts About Farmworkers* (Accessed September 6, 2004) www.ncfh.org.
[2] Walter Goodman, "New Harvest, Old Shame" NY Times (1990) Accessed at http://www.galaninc.com/press/prharvest.phtml (September 6, 2004)
[3] §404, Pub. L. 107-251 (107th Cong., 2d Sess.)

farmworker healthcare coverage and considers policy options for improving health insurance coverage and healthcare access for farmworkers. The information used to develop this analysis comes from a review of the literature as well as two data sources: the 2000 National Agricultural Worker Survey (NAWS), a periodic national survey of farmworkers conducted by the United States Department of Labor; and the Uniform Data System (UDS) maintained on federally funded health centers by the United States Department of Health and Human Services, Health Resources and Services Administration. Although other data sources exist for describing the migrant labor force, only these two data sets provide information on migrant health status and health care access.[4] (In January, 2005, The Department of Labor announced that it was discontinuing NAWS, thereby ending access to specialized economic, living arrangement, and health insurance coverage information about farmworkers).

Several years of NAWS data were examined in this study. The 2000 NAWS data are based on interviews with more than 3500 randomly selected workers who perform various agricultural services. The survey excludes secretaries and mechanics, as well as workers who are non-immigrants working in the U.S. under a temporary visa issued pursuant to the Immigration and Nationality Act.[5] The NAWS analysis is based on a sub-sample of approximately 1400 workers who identified themselves as migrant farmworkers.

The UDS includes tabulated patient data and select encounter information from all federally-funded health centers. The UDS identifies MSFWs, including their dependents. In 2002, 372 out of 843 federally funded health centers (44%) served 708,611 persons identified as migrant and season workers and family members. Among this broader group of grantees receiving both general and

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[4] Although the monthly Current Population Survey provides detailed information on the labor force, it does not specifically target migrant workers. The Department of Agriculture conducts two surveys, the Farm Labor Survey (FLS) every 4 months and Census of Agriculture every five years, for the purpose of tracking wage rates and production.

[5] For more details on the survey methodology, see the Department of Labor's *The National Survey of Agricultural Workers* at http://www.dol.gov/asp/programs/agworker/naws.htm.

migrant health center funding, 15 health centers received MSFW grants exclusively and served a total of 58,350 patients. The UDS analysis provides information on this small grantee subset as well as the broader universe of migrant health centers.

An Overview of Farmworkers and their Families

Defining the population

As with any analysis of population characteristics, an examination of farmworkers and their families begins with a discussion of definitions. Two separate sets of policies – those which are a part of labor law, and those which govern the provision of migrant healthcare – are relevant.

Department of Labor: The Migrant and Seasonal Agricultural Worker Protection Act[6] (MSAWPA) extends protections to individuals currently employed as farmworkers and reaches two distinct classes of farmworkers: migrant agricultural workers; and seasonal agricultural workers. A migrant agricultural worker is an individual who is

> employed in agricultural employment of a seasonal or other temporary nature, and * * * is required to be absent overnight from his permanent place of residence.[7]

The term "seasonal agricultural worker" means

> an individual who is employed in agricultural employment of a seasonal or other temporary nature and is not required to be absent overnight from his permanent place of residence: (1) When employed on a farm or ranch performing field work[8] related to planting, cultivating, or harvesting operations; or (2) When employed in canning, packing, ginning, seed conditioning or related research, or

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[6] 29 U.S.C. §1801 et., seq.
[7] 29 C.F.R. §500.20. The NAWS survey notes that a 75 mile travel distance is used to measure "required".
[8] The concept of field work as it relates to seasonal and migratory farmwork encompasses planting, cultivating or harvesting operations and "includes all farming operations on a farm or ranch which are normally required to plant, harvest or produce agricultural or horticultural commodities, including the production of a commodity which normally occurs in the fields of a farm or ranch as opposed to those activities which generally occur in a processing plant or packing shed. A worker engaged in the placing of commodities in a container in the field and on-field loading of trucks and similar transports is included."

> processing operations, and transported, or caused to be transported, to or from the place of employment by means of a day-haul operation.[9]

The term "agricultural employment" means agricultural work within the scope of the Fair Labor Standards Act and the Internal Revenue Code. It includes service activities involving

> the handling, planting, drying, packing, packaging, processing, freezing, or grading prior to delivery for storage of any agricultural or horticultural commodity in its unmanufactured state.[10]

Agricultural commodities encompass products "of the soil that are planted and harvested by man."[11]

The definition of migratory and seasonal farmworkers under the MSAWPA does not include individuals who are temporary non-immigrant aliens authorized to work in agricultural employment under the Immigration and Nationality Act. [12] NAWS provides data on both farmworkers employed in their communities as well as those who travel for work as defined under the law.

Health centers program: The definition of "migrant and seasonal farmworker" which is used in the health centers program actually is somewhat broader than that found in U.S. labor law. Under the Public Health Service Act, a migratory agricultural worker means

> An individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode.[13]

A "seasonal agricultural worker means an individual " whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker."[14]

Unlike the more narrowly circumscribed Department of Labor (DOL) definition, the Public Health Service definition recognizes individuals and families for whom migrant labor is their

[9] 29 C.F.R. §500.20
[10] Id.
[11] 29 C.F.R. §780.12
[12] 29 C.F.R. §500.20
[13] 42 U.S.C. 254(g)
[14] Id.

principal, although potentially not their only, form of labor, as well as persons who were farmworkers in the recent past (presumably and sensibly in order to allow for transitional health care within a health center). In addition, the Public Health Service Act does not contain distinctions based on legal or immigrant status.

As with the DOL definition, the term "agriculture" under the health centers program focuses on farming the land, as well as preparation and processing performed either by a farmer or on a farm for the purpose of market and delivery to storage.[15] The Public Health Service Act does not distinguish between immigrant and non-immigrant aliens who perform farm labor duties.[16]

These definitional differences mean that the potential eligible MSFW population at migrant health centers may be larger than the population counted as farmworkers by the DOL. This population would include temporary non-immigrant aliens, as well as citizens and legal residents for whom migrant farm labor is a principal (but non-exclusive) occupation. The eligible population also could include families with a member who worked as a MSFW within the preceding 24 months but does not do so at the present time. Despite these distinctions, NAWS is viewed by experts in migrant health care as providing an accurate portrait of MSFW for purposes of designing health care services.[17]

A Profile of Farmworkers and their Families

Counting farmworkers. Simply calculating the size of the migrant and seasonal farmworker (MSFW) population presents a challenge. Because NAWS is a sample-based study, it does not offer a population census. According to the Bureau of Primary Health Care within HRSA, which administers the health centers program, the most recent national population estimates of migrant

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[15] Id.

[16] Programs of the Public Health Service Act, and specifically health centers, are not considered public benefits whose use is restricted under the Immigration and Nationality Act.

[17] For an excellent source of information on farmworkers in a health and healthcare context, see the National Center for Farmworker Health, www.ncfh.org.

and seasonal agricultural workers are found in the 1993 "Atlas of State Profiles which Estimate [the] Number of Migrant and Seasonal Farmworkers and Members of their Families."[18] The Bureau initiated an update of this census in the late 1990s, but the latest estimates are available only for a 10-state subset; [19] as a result, the most recent national census data are about 10 years old. The 1993 Atlas enumeration reports slightly over 3 million MSFWs. This figure is below the 4 million worker census from 1990; however, the estimation methods changed between the two time periods, making accurate trend examination impossible.[20]

Figure 1, drawn from the 1993 enumeration shows, that 68 % of all MSFW were concentrated in 8 states that year: California, Florida, Georgia, Michigan, North Carolina, Oregon, Washington State, and Texas.[21] At the same time Figure 1 also shows that MSFWs are present in nearly all states.

Insert Figure 1

Migrant versus seasonal farmwork: The NAWS data indicate that among MSFWs, 24 % indicate they had at least two farm jobs more than 75 miles apart. The remaining 76 % report they shuttle to two or more crop locations at least 75 miles from their residence.

Farmworker domicile patterns: Approximately 70 % of MSFWs permanently reside in the US. Figure 2, drawn from the 2000 NAWS, shows the states in which MSFWs tend to be domiciled (i.e., reside permanently). As Figure 2 indicates, California is the largest domicile state, representing 30% of all farmworkers. Twenty two percent of respondents report a domicile in a southeastern state,

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[18] National Center for Farmworker Health, Migrant and Seasonal Farmworkers Demographics Fact Sheet http://www.ncfh.org/docs/fs-Migrant%20Demographics.pdf (Accessed September 6, 2004).

[19] State level analyses were completed in 2000 for Arkansas, California, Florida, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, Texas and California. They can be viewed at http://bphc.hrsa.gov/migrant/Enumeration/EnumerationStudy.htm (Accessed September 6, 2004)

[20] National Center for Farmworker Health, Migrant and Seasonal Farmworkers Demographics Fact Sheet http://www.ncfh.org/docs/fs-Migrant%20Demographics.pdf (Accessed September 6, 2004)

[21] Id. Table, p. 3.

17% report a southwestern state domicile, 12% report a Midwestern state domicile, and 12%, an eastern state domicile.[22] These residential patterns underscore that domiciles differ markedly from the states in which workers reside for relatively brief periods of time as they travel for employment reasons.

Insert Figure 2

Farmworker characteristics. Figure 3 shows that MSFWs are overwhelmingly foreign-born and as a group tend to speak and read little or no English. Six percent of NAWS respondents identify themselves as U.S. born, while 67 percent identify themselves as first generation farmworkers.[23]

Insert Figure 3

As Figure 4 illustrates, most MSFWs are male, and 52 % are married. Somewhat fewer than half of all MSFWs have children, while about half live in households with parents and other family members. Among MSFWs with children, 66% migrate with their children and an estimated 250,000 children migrate with their parents each year. [24]

Insert Figure 4

Poverty among MSFW families is very deep. In 2000, U.S. workers earned a median annual income in excess of $42 thousand.[25] Figure 5 shows that the 2000 median income of MSFWs stood at $6,250, even as they reported working 5 to 6 days a week. Further analysis of income data show that 91%

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22 [illegible]

23 First generation migrants report parents did no farm work.

24 National Center for Farmworker Health, *Maternal and Child Health Fact Sheet* (Buda Texas) (Accessed September 6, 2004 at http://.www.ncfh.org)

25 U.S. Census Bureau. http://www.census.gov/hhes/income/income00/inctab1.html (Accessed September 2004)

of MSFWs reported annual income below $15,000 in 2000, while 56% reported earnings lower than $5,000. Income trends drawn from NAWS data and set forth in Figure 6 show the proportion of MSFW with annual family incomes below the federal poverty level increased from 51 % in 1993 to 76 % in 1998, falling back to 59 % in 2000.

Insert Figure 6

Farmworkers' Health Status, Health Insurance Coverage, and Use of Health Care

Not surprisingly perhaps, compared to workers generally, MSFWs and their families are overwhelmingly uninsured. Figures 7 and 8 illustrate the extent to which MSFWs and their families lack coverage. In 2000, 85 % of MSFWs were completely uninsured, compared to 30% of all low income adults nationally (i.e., adults with family incomes at or below 200% of the federal poverty level).[26] Ten percent of MSFWs reported Medicaid coverage, while 5 % reported coverage through a private source of health insurance. Children of MSFW families similarly were pervasively uninsured compared to low income children nationally; nearly 90% were completely uninsured in 2000, compared to 8 % of all low income children that year.[27] Trends over time, as shown in the NAWS data, suggest that despite the advent of major Medicaid reforms for children, Medicaid coverage among children in MSFW families remains very low, although Medicaid represents the dominant form of health insurance for MSFW children.

Insert Figures 7 and 8

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[26] http://www.kaisernetwork.org/health_cast/uploaded_files/4.24.02_MannSlides.pdf, Figure 1 (Accessed September 2004)
[27] http://www.census.gov/hhes/hlthins/liuc02.html (Accessed September 2004)

MSFWs and their families use very little health care compared to other low income persons. The 2000 NAWS data indicate that only 20% of MSFW reported the use of any healthcare services in the preceding 2 years. Research has documented a rate of self reported fair-to-poor health status among farmworker mothers which stands at more than triple the rate for the general population.[28]

Although the NAWS does not inquire about related reasons for use or nonuse of services, it does ask about barriers. Figure 9 shows that respondents identified cost and language as the two most significant barriers to care, a figure borne out by smaller studies of farmworkers in selected states. [29] Researchers have noted that even where services are available, extreme mobility means that families may leave an area before treatment is furnished. [30]

Insert Figure 9

The limited use of health services by MSFW certainly cannot be attributed to a low need for health care. Indeed, by virtue of their extreme poverty, their mobility in search of work, and hazardous living and housing conditions under which they work, MSFWs have an extraordinary need for health care. Farmworkers are at elevated risk for an enormous range of injuries and illnesses. According to a review of data from the Bureau of Labor data, while agriculture-related employment comprised only 2% of overall employment, agricultural and livestock-related production, along with agricultural services, comprised 13%

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[28] National Center for Farmworker Health, *Maternal and Child Health Fact Sheet* (Buda Texas) (Accessed September 6, 2004 at http://www.ncfh.org)
[29] M. Perez, G. Reuben, H. Pinzon, "Northern California Hispanic migrant farm workers health status: a case study," *Migration World Magazine*, 26(1-2), 1998.
[30] Gina R. Lombardi, "Dental/Oral Health Services" *Migrant Health Issues* (National Center for Farmworker Health (Accessed September 6, 2004 at http://www.ncfh.org) 2001.

of all occupational deaths over a 1994-199 time period.[31] Risks arise as a result of work-related conditions, the use of equipment, and exposure to chemicals, with resulting elevated rates of chronic conditions, musculoskeletal injuries, serious disabilities, and fatalities.

Exposure to chemicals can result in contamination which in turn is brought home to the children of MSFWs. [32] More than 40% of all workers reported leaving or changing jobs as a result of chronic pain.[33] Respiratory illnesses such as asthma and bronchitis are relatively common, as are skin problems, exposure to infectious diseases such as tuberculosis and parasites, and diseases related to unsanitary and close living conditions in substandard housing. [34] Higher rates of cancer are suspected, as are elevated rates of eye and vision problems. [35] Pesticide exposure and its consequences represent one of the best documented risks, although experts believe that there are insufficient studies examining the effects of multiple pesticide exposure. [36]

Dental problems among MSFWs and their families rank among the top five health problems for individuals ages 5 through 29; children of farmworkers experience a rate of decay twice that for children in the general population.[37]

Extreme mobility leaves families at particularly great risk for limited and interrupted health care. One study found that only 42% of farmworker women reported early prenatal care (i.e., within the first 3 months of pregnancy) compared to 76% nationally. Data from a special CDC data system which measures pregnancy nutrition among the population found diminished weight gain, a nearly one-in-four incidence of

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[31] Alice Larson, Environmental/Occupational Safety Nd Health, " *Migrant Health Issues Monograph Series* (National Center for Farmworker Health, Buda Texas, 2001) (Accessed September 6, 2004 at http://www. ncfh.org)
[32] Id.
[33] Id.
[34] Id. See also Christopher Holden, "Housing," *Migrant Health Issues* (National Center for Farmworker Health, Buda Texas, 2001) (Accessed September 6, 2004 at http://www.ncfh.org)
[35] Id.
[36] Id.
[37] Gina R. Lombardi, "Dental/Oral Health Services" *Migrant Health Issues* (National Center for Farmworker Health (Accessed September 6, 2004 at http://www.ncfh.org) 2001.

undesirable birth outcomes, elevated low birthweight and preterm rate.[38] Health problems among farmworker children are extensive, with studies showing a high incidence of intestinal parasites, severe asthma, chronic diarrhea, Vitamin A deficiency, chemical poisoning, and continuous ear infections.[39] Despite their greater health risks, depressed access to care means that farmworker children are delayed in their immunization schedules.[40] Migrant children have been found to exhibit "striking" levels of mental illness such as anxiety, depression, and disruptive behaviors. Researchers have attributed these risks to the psychological impact of the extreme poverty, separation, and dislocation experienced by children in farmworker families. [41]

A Profile of Health Centers Serving Farmworkers

In 2002, 125 of the nation's 843 federally funded health centers received funds specifically targeted to meet migrant health needs; these centers served 670 thousand MSFWs and their families. Another 247 health centers, which do not receive a specific migrant subsidy, served additional 39 thousand MSFWs and family members. That year, 44% of all health centers served MSFWs and some 25% of all MSFWs reported in the 1993 Enumeration received health care at a health center. These statistics capture the central importance of health centers to farmworker healthcare access.

Figure 10 shows the relative distribution of health centers receiving migrant grants.

Insert Figure 10

[38] National Center for Farmworker Health, *Maternal and Child Health Fact Sheet* op. cit.
[39] Id.
[40] Id.
[41] Joseph D. Hovey, "Mental Health and Substance Abuse" *Migrant Health Issues* (NCFH, Buda Texas, 2001) Accessed September 6, 2004 at http://www.ncfh.org.

The vast majority of health centers receiving migrant funding (110 out of 125 in 2002) are "mixed grant" centers; that is, they also receive general health center grants. This dual status permits health centers to serve the general population, as well as furnish continuing care to families after they leave farm labor. Approximately 27% of patients served at "mixed grant" centers nationally are MSFWs and their family members; in terms of both insurance distribution of patients and revenue distribution, these "mixed grant" health centers resemble those which do not receive migrant grants. At the same time, mixed grant health centers also offer services which are tailored to MSFW families, in particular, outstationed services in accessible locations and services which are geared to identifying and treating the unique health conditions of migrants (e.g., familiarity with pesticide poisoning or injuries related to agricultural work).

In 15 migrant health centers were funded exclusively as migrant health centers, that is, without mixed grants. These 15 health centers were located in Alabama, Georgia, Iowa, Illinois, Kansas, Kentucky, Massachusetts, Maine, Michigan, Minnesota, Montana, New York, North Carolina, South Carolina, and Wyoming. Although these centers are as likely as their "mixed grant" colleagues to be located in rural areas as other health centers receiving migrant grants and provide similar services, the 15 migrant health centers tend to be far smaller. Approximately two-thirds reported fewer than 5,000 patients and only one exclusively migrant health center reported serving more than 10,000 patients.

Figure 11 shows the age distribution of farmworkers and their family members served at health centers. Because adults are more likely to travel and work, a large proportion of migrant health center patients are working-age adults. However, the proportion of MSFWs served by migrant health centers who are working age adults is only slightly higher than the proportion of patients in health centers that do not receive migrant grants (61% versus 57%).

Insert Figure 11

Health centers with and without migrant health grants report that approximately 35% of their total patients receive Medicaid. The picture is much different at health centers funded solely by migrant health center grants. As Figures 12 and 13 show, health centers receiving migrant-only grants are far more likely than health centers generally to report uninsured patients, and experience vastly reduced levels of Medicaid revenues. In health centers which receive both general and migrant grants, MSFWs comprise 27% of the total registered patient population; this relatively low presence helps explain why "mixed grant" health centers continue to register relatively high proportions of Medicaid patients. Other factors may be the greater likelihood of "mixed grant" health centers to see Medicaid-eligible migrants and the resulting greater level of assistance furnished in Medicaid enrollment.

Insert Figures 12 and 13

Reflecting their patient distribution, health centers receiving only migrant grants are more dependent on federal funding to care for largely an uninsured MSFW population. Figure 13 shows that in 2002, health centers operating exclusively as migrant health centers report Medicaid reported that only 2 percent of their operating revenues came from migrant health center revenues. In contrast, other health centers reported Medicaid accounted for more than one-third of their operating revenues. Unlike health centers generally, for whom Medicaid is the largest source of financing, migrant only health centers exist virtually exclusively on grants; their modest size offers a further suggestion of the role played by Medicaid in permitting health centers to grow and expand their services.

Options for Improving Coverage of Farmworkers and their Families

Barriers and Challenges

Reforming Medicaid to improve its performance for MSFWs and their families has been a program focus for some 30 years; the literature on farmworkers and Medicaid[42] points to a set of problems which are related, specific, longstanding, and well-recognized. Although there are few systematic studies of farmworker Medicaid eligibility and enrollment barriers, information gathered by researchers, as well as repeated and widespread anecdotal evidence supplied over nearly four decades by a legion of health care providers and analysts, point to a series of problems which combine to cause exclusion. Some of these problems are present among many low income populations excluded from Medicaid, but what is striking is how migratory farmwork serves to elevate and intensify their effect, while adding others attributable to barriers created by legal status and frequent changes in state residence. In short, classic Medicaid eligibility and enrollment barriers appear to combine with particular force in the case of MSFWs.

The principal Medicaid barriers identified in the literature are shown on Table 1 and can be summarized as follows:

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[42] See, e.g., Mary Kennesson, *Improving Health Service Access for Medicaid-Eligible Migrant Farmworkers* (Center for Health Care Strategies, Princeton N.J., 2000); National Health Policy Forum, *Policy Options for Serving Migrant Children and Families Under Medicaid and SCHIP* (The George Washington University, Washington D.C., 2000); Sara Rosenbaum, *Options for Expanding Publicly Financed Health Coverage of Migrant Farmworkers and their Families,* (National Association of Community Health Centers, Washington D.C. 2000); Elizabeth Kapeller, *Farmworker Access to Safety Net Insurance Programs: Harvesting Solutions to a Thirty-Seven Year Old Issue,* (National Center for Farmworker Health, Buda TX, 2003); E. Gallardo and V. Huang, *Expanding Acces ot Health Care Services: A Policy Brief* (California Primary Care Association, Sacramento, CA 2002); National Immigration Law Center, *Guide to Immigrant Eligibility for Federal Programs, 4th ed.* (Los Angeles, CA, 2002); Judith Moore, *Policy Options for Serving Migrant Children and Families Under Medicaid and SCHIP* (National Health Policy Forum, Washington D.C. 2000). In addition, the Congressionally mandated National Advisory Council on Migrant Health, the Migrant Clinicians Network (a special network of health center clinicians who specialize in farmworker healthcare), and others have recommended changes. In addition, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services (CMS) commissioned a study in the early 1990s to examine the feasibility of Medicaid reforms. The results were published in 1993. George E. Wright, Nancy Fasciano and Hilary Frazer (Mathematica Health Policy), Ian Hill and Beth Zimmerman (Health Systems Research), and Nancy Pindus (Urban Institute), *Feasibility Study to Develop a Medicaid reciprocity Program for Migrant and Seasonal Farmworkers* (Cont. No. 500-92-0037, Task 2). The National Association of Community Health Centers has been extensively involved in this issue over the years and from time to time has compiled information on the problem and options for reform. See, e.g., *Migrant and Seasonal Farmworker Access to Health Care Services and Insurance Coverage: Summary Report on Issues, Resources and Potential Solutions* (NACHC Washington D.C., 2003).

- Problems which are common to many low income populations who need Medicaid, but which get reported with particular frequency by persons who work with, or health professionals who treat, farmworkers. One problem is the lack of categorical eligibility for certain classes of low income persons, in particular, childless working-age adults without disabilities. A second problem is financial eligibility barriers. States have considerable discretion in how the define and count income and resources. Barriers arise in states that use monthly budgeting rules and maintain restrictive asset tests are financial eligibility rules which tend to penalize itinerant and fluctuating work income (relatively high in relation to Medicaid eligibility rules one month, and then extremely low in the next month) and that fail to recognize work implements (e.g., tools, a truck) as a permissible asset. A third major barrier is legal status requirements which prohibit all but emergency Medicaid coverage of otherwise eligible but short term legal U.S. residents; this barrier is the result of 1996 welfare reform legislation that eliminated eligibility for otherwise-eligible short-term legal residents.[43] A final barrier arises from application and enrollment barriers arising from inaccessible site locations, long application forms, extensive verification requirements, and limited to no language assistance.
- Barriers related to the lack of state residency. Medicaid is a state-based program; as a result, state residency requirements, coupled with the problems described above, can lead to nearly insurmountable Medicaid access problems. State residency problems arise in one of two ways. Medicaid recognizes state residency among persons who live in a state for work-related purposes. Medicaid also requires states to provide for out-of-state coverage for their residents, to permit travel. The work-related test may be honored only in the breach; furthermore, state policies on coverage for out-of-state travel may reflect policies that

[43] §401, Personal Responsibility and Work Opportunity Act of 1996 (P. L. 104-193)

address only persons whose travel is related to out-of-state institutional placement, the use of services located in nearby regional facilities (e.g., a regional children's hospital), or persons who travel for brief periods of time and face emergency health care needs. Federal regulations appear to permit states to recognize as permissible out of state care services customarily used in another state.[44] These rules would permit a state, for example, to treat as a permissible out-of-state service routine, covered, and medically appropriate health care used by eligible families as they travel for work. Without such policies, farmworker families are caught between two diametrically opposed problems. On the one hand, farmworkers who seek to apply for Medicaid as they change their state of residence for work related reasons may encounter numerous barriers including the absence of a rapid enrollment system, inaccessible points of entry, extensive verification requirements, and inadequate application support. On the other, farmworkers who attempt to travel with a valid Medicaid card from issued by the state in which they permanently reside may find that coverage is denied for all but dire emergencies. Compounding this restriction is the fact that few if any out-of-state providers other than programs such as migrant health centers that are accustomed to traveling patients will honor the card.

Migrant health concerns have been a feature of public policy for more than 4 decades, beginning with the 1962 passage of the Migrant Health Act[45] and continuing with the legislative establishment of the Health Centers Program in 1975, which contained specific authority for grants to serve MSFWs.[46] In 1979 the Carter Administration promulgated regulations which revise the definition of state residence for Medicaid and cash welfare assistance purposes to require states to recognize as residents workers and their families who were present in a state for employment related

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45 P. L. 85-61 (85th Cong., 2d Sess.)

46 P.L.

reasons (either with a job or seeking one). No interpretive guidelines applying out-of-state coverage and payment rules to travel related to coverage for farmworkers ever have been issued.

No systematic evaluation of the impact of the 1979 rule ever has been conducted, but its limited effect appears to be evident in the statistics on Medicaid enrollment and revenues from the UDS, as well as the results of our NAWS analysis. Anecdotal evidence from the literature and from persons familiar with farmworker issues suggests widespread failure on the part of local welfare agency staff to consistently recognize this expanded definition of residency. Furthermore, community health providers frequently report that even where employment-related residence is recognized, the application process poses such serious problems that the residency change alone has little impact.

Moreover, there is evidence that residency-related problems are *intrastate* as well as interstate, with documented barriers in states such as California,[47] where migration is significantly in-state, and where county government agencies appeared to require reapplication and submission of new proof of eligibility with each move. Following the 2000 issuance of a State Medicaid Directors letter clarifying that such procedures violate Medicaid statewideness requirements,[48] along with sustained advocacy, California officials issued a directive to county officials clarifying their obligations to allow county-to-county movement by Medicaid-enrolled farmworkers. [49]

Over the years a few states have attempted to improve Medicaid program performance for farmworkers. Wisconsin is particularly notable for having developed a reciprocal rapid enrollment system, which automatically extends coverage to any family with an valid out of state enrollment card, using a shortened application process; enrollment lasts until the date on which the out-of-state

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[47] California Primary Care Association, *Policy Options Related to the Medicaid Portability for Migrant Farmworkrs Project* (Sacramento, CA, 2002)
[48] State Medicaid Director from Timothy Westmoreland, http://www.cms.hhs.gov/states/letters/smd12400.asp (Dec 4, 2000)
[49] Harvesting Solutions, op. cit.

enrollment expires, at which time families who continue in-state reapply for benefits using normal in-state procedures. Wisconsin also has adopted an income eligibility calculation methodology which permits families to annualize their income in order to avoid months of ineligibility as a result of fluctuating earnings.[50]

While Wisconsin has pursued a reciprocal rapid in-state enrollment approach, Texas attempted an initiative which mirrors the Wisconsin method and applies the out-of-state coverage option to promote continuous access to coverage even during periods of work. In 2001, the Texas legislature enacted legislation to study an out-of-state portability demonstration project for migrant farmworker children; under the demonstration, the state would ensure coverage on an out-of-state basis when migrant farmworker children traveled, signing up out-of-state providers and compensating them for customary, not merely emergency services.[51] The pilot project achieved significant "upstream" participation by out of state physicians and hospitals in several dozen states and involved only a small and manageable number of children. But state efforts to take the model "to scale" for all migrant farmworker children failed when no satisfactory full-risk contractor could be identified.[52] The effort also revealed small but important state-to-state variations in children's eligibility, benefit packages, program management problems created by the lack of a unique farmworker identifier, and challenges in making out-of-state provider payment systems work smoothly. During the pilot phase, Texas and Michigan (more than three-quarters of whose migrant farmworkers come from Texas) prepared for an expanded collaboration; however, the failure of the Texas program to achieve full implementation has set back a collaborative effort.

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[50] Id.

[51] Federal rules on payment for out of state care allow states to honor such out of state claims for covered services in numerous circumstances beyond documented medical emergencies. Out of state payments may be made when "it is the general practice for recipients in a particular locality to use medical resources in another state" or when "medical services are needed and the recipient's health would be endangered if he were required to travel to his State of residence," or when "the state determines on the basis of medical advice that the needed medical services or necessary supplementary resources are more readily available in another state." 42 C.F.R. §431.52(b).

[52] Id.

Lessons Learned and Options for Reform

From these state experiences, certain lessons can be gleaned. The first is that there are indeed handles for making Medicaid work better for eligible farmworkers and their families. Whether a state uses the Wisconsin approach or the Texas strategy, Medicaid coverage potentially could be made significantly better. Wisconsin relies on fast-track access to enrollment in strategic locations (e.g., migrant health clinics, programs serving farmworkers), coupled with the adoption of a "card swap" rule. Texas has attempted, at least in the case of chlldren, to operationalize a "traveling Medicaid card" through broader standards for out-of-state coverage and active efforts to identify and enroll participating providers.

At the same time, the limits are clear. The Wisconsin model of simply exchanging an in-state card for an out of state card for the duration of eligibility works well in states with relatively generous coverage limits but not in those with more stringent rules. (These states might adopt more generous income and asset evaluation rules for families engaged in farm labor, using their inherent discretion to devise financial eligibility standards). The Texas model requires an active effort to identify out-of-state providers and a claims administration intermediary.

Were HHS to spearhead an active collaboration between the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA), both approaches would be more feasible. In order to facilitate the Texas model, CMS and HRSA could identify a regional intermediary capable of processing out-of state claims for participating states, arranging networks of participating migrant health centers and other providers, arrange for the provision of information for traveling families, and issue guidelines explaining the expanded use of the out-of-state coverage option. Costs associated with such an expanded effort would appear to be directly related to state Medicaid administration and thus eligible for coverage. In a similar vein,

CMS and HRSA could embark on a "Wisconsin" strategy for states that instead opt to fast-track enrollment and adopt eligibility standards suitable to families whose incomes are derived through seasonal agricultural work. Guidelines explaining a fast track enrollment option, options for altering existing eligibility criteria, and identifying health centers and other farmworker programs to serve as enrollment sites, all might provide a useful stimulus.

Were CMS and HRSA to engage in such a coordinated strategy, states would have two feasible approaches to easing entry into Medicaid and better coverage during periods of enrollment. Well thought out strategies, coupled with greater attention to the problem of coverage, could be expected to have some impact over time.

In the long run however, it is evident that problems of legal status, categorical Medicaid barriers, and frequent movement combine to make the potential for improved Medicaid coverage for this especially vulnerable slice of the low income population limited at best. A more long term solution might be to couple Medicaid access efforts with a federal insurance program, administered by a national intermediary, that could enroll and cover families on a nationwide basis, thereby permitting interstate movement and portable benefits. Such a program could provide a coverage level similar to the State Children's Health Insurance Plan, i.e., health benefits pegged to an actuarial standard for family coverage, with premiums and cost sharing tied to income. Enrollment could be limited in the aggregate, as is the case with SCHIP, with enrollment through sites that are strategically accessible to the population.

For over 40 years, the health of migrant and seasonal farmworkers has received national attention. The latest effort to address the needs of MSFWs can be found in the Congressional study mandate enacted in 2002. The evidence reviewed in this analysis suggests the importance of an intervention and a range of viable options, including more energetic Medicaid interventions and other programs to complement Medicaid's reach. More active attention to overcoming Medicaid

barriers, coupled with a national program that uses a nationwide intermediary to bring benefits to families, would help surmount the inherent difficulties for this population created by state borders and state-based healthcare programs, a state based approach which builds upon Medicaid and SCHIP is feasible and consistent with state efforts generally to make greater use of private intermediaries to administer benefit arrangements. The health needs of migrant and seasonal farmworkers are considerable, but their numbers are relatively modest. Equally important perhaps, there is already in place a reasonably well established primary care provider network experience in quality and efficient care of the population.

It is also evident that additional and important data would greatly inform any effort to expand insurance coverage for MSFWs. The fact that the Department of Labor has ended the only survey specifically focused on farmworkers serves as an unfortunate reminder of the ease with which this critical yet marginalized population can be overlooked.