



Consensus Report

Of Local Agriculture and Labor Representatives

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Labor Representatives

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Executive Summary

To ensure a healthy and stable workforce for California's \$36 billion agricultural industry, it is imperative that farmworkers have access to health services that emphasize early and preventive education and care. Health care reform promises to improve the health of California's farmworkers, 70 percent of whom are uninsured, but it will take the **shared responsibility** of the workers, their employers, and the public which benefits from their labor to make the system work.

Representatives from growers, workers and public health have come together in three of California's most important agricultural regions (Salinas, Fresno, and Ventura) to examine the current approaches to health reform and see how they match up to a set of principles that would promote a **healthy agricultural industry and workforce**. The groups also explored other approaches to delivering primary and preventive health services to farmworkers.

It was agreed that **access to early preventive and primary care** is paramount for this largely immigrant, uninsured, low-income workforce. Health coverage which promotes prevention would need to be extended to all workers, including seasonal workers and to those who work for multiple employers. Similarly, all agricultural employers including farm labor contractors, would need to be part of the solution. The existing system of community farmworker health clinics should be the center of the delivery system with coverage extended into other areas as workers migrate for work.

As the health reform and immigration reform debates continue in Sacramento and Washington, D.C. there are key elements that could be adopted within proposed legislation, as well as farmworker health demonstration projects that could be implemented now and provide valuable lessons for health reform.

There are three opportunities that we can pursue within the current context of health policy debates to expand coverage and care for farmworkers in a cost-effective manner.

1. Develop pilot programs in several of California's agricultural regions to integrate the various funding streams currently providing for farmworker care, (e.g. employer coverage, emergency and full-scope Medi-Cal, employee payments, workers' compensation, local medically indigent funding and federal community clinic grants) and develop demonstrations of how basic coverage of essential primary and preventive services can be provided to farmworkers. Clinics could be the basis of these demonstration projects and by integrating federally funded migrant health centers with employer clinics, both federal and employer funding could be captured. Federal expansion funds for clinics are available and could be used to expand the network of migrant health centers.

These pilot programs could be incorporated as part of the State's request for a *Section 1115 Medicaid* waiver from the federal government. Since the federal government funds emergency Medicaid services for all eligible persons including the undocumented, these funds might be used for preventive services if the approach is shown to be cost-neutral.

2. *Should* health reform at the state or federal level become enacted with an employer “pay or play” mandate, provisions should be added to allow agriculture to design a plan that meets the needs of agricultural industry. This plan should:
 - promote prevention and primary care through community- and workplace-based outreach and education and very low co-payments to encourage early use of care;
 - build on, support, and expand the current network of farmworker clinics and provide incentives for expanded services delivery through expanded hours, mobile clinics, workplace based clinics, etc;
 - pool employer, employee and public funds to develop a coverage system that covers all agricultural workers who meet minimum employment requirements including seasonal workers and those who work for multiple employers;
 - include to all agricultural employers including farm labor contractors to participate in the plan.

The agricultural industry already has experience with multi-employer plans that should serve as a model for development of an industry-wide plan. Discussions should start now with potential partners.

3. While longer term solutions are being developed, programs that provide prevention education and services should be expanded. Programs such as community and workplace outreach, health screenings and referrals (similar to the Child Health and Disability Prevention program), and assistance through community based health promoters would ensure a healthy workforce. The current employer training sessions on injury prevention could also be utilized to include health promotion. Lastly, support for migrant health centers needs to be restored and enhanced.

Why is health coverage for agricultural workers important?

The United States needs a secure, dependable and domestic food supply. The country cannot afford to extensively rely on foreign food supplies any more than it can afford to continue relying on foreign sources of oil. A secure and dependable domestic food supply promotes safe, healthy produce for Americans and protects the country against potential foreign interference with our ability to feed our nation.

A vibrant agricultural industry both promotes a healthy economy for rural California and enhances the state's ability to preserve rural culture and open space in the state's surviving agricultural valleys.

For California's \$36 billion agricultural industry to be secure and economically viable we need a healthy and stable workforce. However, availability of health care for California's agricultural employees has historically been limited. Large and rising health care costs have made employer-based health coverage for farmworkers the exception, rather than the rule. For these low-wage workers, obtaining expensive private coverage is nearly impossible. Few farmworkers are eligible for public programs, in part because they are an employed population and are ineligible for welfare and in part because of their immigration status. For the most part, California farmworkers have relied upon a network of "safety net" clinics, hospital emergency rooms, and traditional healers. Unfortunately, many farmworkers simply do not receive any health care at all. Additionally, farmworkers are generally low users of the health system and thus delay care for preventable conditions, which leads to increased disability and costs in later years.

With the promise of "health reform" at the state and federal levels, it is important to raise the voice of the agricultural workforce and the agricultural industry to ensure that both short- and long-term solutions meet the needs of the workers and their employers. Through a series of local discussions with industry and farmworker advocates in three major agricultural regions in California – San Joaquin Valley, Salinas Valley, and Ventura County, we have discovered that the needs of the agricultural industry and its workforce are the same: affordable, comprehensive and quality health care. This paper:

- 1) Examines the nature of the agricultural workforce and the needs of the industry
- 2) Establishes a set of principles for health coverage for farmworkers,
- 3) Evaluates the major health reform approaches for their ability to meet the health care principles
- 4) Reviews alternative approaches to provide health care to farmworkers and
- 5) Recommends short- and long-term solutions for ensuring that health reform actually benefits the agricultural workforce.

California's Agricultural Workforce and Employers

An estimated 36% of the nation's farmworkers – approximately 650,000 individuals – are employed in California.¹ They work in many different occupations, in different agricultural sectors and are employed by a variety of employers (growers both large and small, farm labor contractors, packers, shippers, etc.). They also have different demographic characteristics (family status, length of time in US, immigration status, income, etc.), and widely differing uses of the health system.

There appears to be a continuum of farmworkers. On one side of the spectrum is the archetypal migrant following the crops, more typically male without accompanying spouse, and less likely to be connected to a community or a particular health care system. The migrant farmworker is more likely to seek only episodic care in extreme cases, and not seek or desire a “medical home.” One-third (33%) of all California farmworkers were migrant, having traveled more than 75 miles to obtain a job in U.S. agriculture, according to the National Agricultural Workers Survey (NAWS).

On the other end of the spectrum is the settled out farmworker who has a spouse and children, works throughout most of the year in the local area, often has children with health coverage and is more familiar with medical care in the United States. In the center are farmworkers in transition who may be mainly based in the local area but work elsewhere as necessary and also go home to Mexico during the winter months. Anecdotal reports, however, describe a steep reduction in these bi-national “shuttle” migrants as border security tightens and families are less likely to cross the border back into Mexico for fear of not being able to return.

What we know about farmworkers and their employers

Findings from the California Agricultural Workers Health Survey (CAWHS) published in 2000 and the National Agricultural Workers Survey in 2003-2004 show that farmworkers are mostly comprised of young, married, Mexican men who have little formal education and who earn very low annual incomes.

More than half of the farmworkers in California had no work authorization (57%), 10% were U.S. citizens and 33% were legal permanent residents according to the California NAWS data. Nearly two-thirds (61%) of California farmworkers in 2003-2004 reported they worked for their current employer on a seasonal basis, 20% said they were employed year-round, and 19% did not

¹ *The California Farm Labor Force: Overview and Trends from the National Agricultural Workers Survey (NAWS)*. Aguirre International, June 2005. Available at: <http://www.epa.gov/region09/ag/docs/final-naws-s092805.pdf>. The California Department of Food and Agriculture reports approximately 450,000 agricultural jobs. However, since workers are often part-time, seasonal and work for multiple employers, there are more agricultural workers than agricultural jobs.

know whether their current job was year-round or seasonal.² CAWHS puts the median annual earnings at about \$7,500-9,999 and NAWS estimates that 75% of individuals earned less than \$15,000 per year.

The “Average” California Farmworker

	Median Age	Foreign Born	Married	Male	Formal Education <6 yrs	Read Spanish Well	Mexican, Hispanic, Latino	Indigenous origin	Have Children
CAWHS 1999	34	92%	59%	64%	63%	50%	96%	8%	48%
NAWS 2003/04	32	95%	64%	73%	63%	57%	99%	16-20%	54%

Source: *Suffering in Silence* (2000), NAWS (2005)

Agricultural employers also are not a homogenous group. They range from large multinational growers who produce in multiple states and countries to small family farms who sell on the local market. There are many variations in between such as large coastal fresh produce growers to smaller family grape and tree fruit farmers in the central part of the San Joaquin Valley. Non-grower employers include packers, processors, and shippers. An estimated 37% of the agricultural workforce are employed by farm labor contractors (FLCs) (large and small) who contract with growers to provide crews for particular operations, (e.g. pruning, harvesting, weeding, etc.). FLCs are more likely to be used for the tree and fruit crops. The vast majority (85%) of farmworkers work for farms that employ ten or more workers according to the 2007 USDA Census of Agriculture.

Health of farmworkers

According to both NAWS and CAWHS only approximately 30% of California farmworkers have health insurance. Fewer than 15% had employer sponsored health coverage. Farmworker use of government programs is very limited – only 7 to 10% reported government supplied coverage. However, most farmworkers with children said that their children had coverage, primarily through government programs. The Farm Employer Labor Service (FELS) reported that in 2004, 40% of agricultural employers provide insurance for year round employees and 5% provided insurance for seasonal employees.

The lack of health coverage poses a major barrier to care with just under half (49%) of California farmworkers reporting in NAWS that they used some type of health care service, whether from doctors, nurses, dentists or hospitals, in the U.S. at least once in the two years prior to their inter-

² The 2007 USDA Census of Agriculture reports that 57 percent of California farmworkers work fewer than 150 days per year in agriculture. Available at <http://www.agcensus.usda.gov/>.

view. Nearly two-thirds paid most of the bill out of their own pocket or used Medi-Cal (41% and 21% respectively). The greatest barrier California farmworkers faced in obtaining the health care was the cost, with 83% stating that health care was too expensive.

Nearly one-third of male farmworkers (32%) interviewed in CAWHS said they had never been to a doctor or clinic in their lifetime. In contrast, over one-third of female farmworkers (38%) reported having a medical visit within the five months prior to the interview. One-half of all male farmworkers (50%) and two-fifths of female farmworkers (44%) said they had never been to a dentist.

The majority of workers who sought health care (51%) went to a private doctor's office or private clinic and only 7% reported visiting a migrant health clinic according to NAWHS. Yet, California's federally funded migrant health centers reported that they saw nearly 350,000 migrant and season agricultural workers or dependents in 2007.³

Health status among farmworkers is low, especially given that it is a young, physically active, and working population.

- Nearly one in five men (18%) had at least two of three risk factors for chronic disease: high serum cholesterol, high blood pressure, and obesity (CAWHS).
- There is substantially greater incidence of high blood pressure among male farmworkers than exists among male adults in the U.S. population. For example, 33 percent of male farmworkers between the ages of 35 and 44 had high blood pressure, compared to 20 percent of males in the same age group in the general population (CAWHS).
- As measured by the Body Mass Index (BMI), 81 percent of male and 76 percent of female farmworkers had unhealthful weight. Overall, 28 percent of male and 37 percent of female farmworkers were obese (CAWHS).
- A significantly greater percentage of farmworkers showed evidence that they are likely to suffer from iron deficiency anemia than is the case for U.S. adults. For male farmworkers, the figure was about four times greater than that among males in the general U.S. population (CAWHS).
- Agriculture ranks among the most hazardous industries in the U.S. Nearly one in five (18.5%) of CAWHS subjects reported having had a workplace injury at some point in their farm work career that was covered under the California's Workers Compensation insurance system. In addition, farmworkers die from heat stroke at a rate nearly 20 times greater than for all U.S. civilian workers.⁴

³ U.S. Department of Health and Human Services, "Bureau of Primary Health Care Section 330 Grantees Uniform Data System Calendar Year 2007 Data California Rollup Report." Available at: http://ftp.hrsa.gov/bphc/pdf/uds/2007/07Rollup_StateCA_08Jul2008.pdf.

⁴ Centers for Disease Control and Prevention, Heat-Related Deaths Among Crop Workers ---United States, 1992—2006, Morbidity and Mortality Weekly Report, June 20, 2008. Accessed on May 19, 2009 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5724a1.htm>

Principles for ensuring health of agricultural workers

The local agricultural industry and farmworker advocates spent several months discussing how to keep the agricultural workforce healthy with affordable access to care. The following is a summary of principles that the local committees believed were critical for health reform to work for the agricultural workforce.

- Shared responsibility

For health reform to work for the agricultural industry and its workforce, it is necessary for agricultural employers (including farm labor contractors) and employees to share in the cost of making coverage available to all workers. In addition, it is critical that there also be public support to make health coverage available to low-wage workers in the volatile low-margin agricultural industry.

- Affordable cost

Costs need to be reasonable and affordable for employees and employers and out of pocket costs (e.g. deductibles, co-payments, etc.) should be structured to encourage early, preventive care.

- Comprehensive scope of benefits emphasizing prevention

The benefits need to be as comprehensive as possible to meet as many basic needs of families as feasible with special attention to preventive and primary care, and prescription drugs.

- Support for “safety net” programs and providers

The safety net of programs and services from which farmworkers and their families currently receive care should be protected, integrated, and strengthened. The farmworker clinics which provide cost effective models should be supported and expanded. Public programs should be designed to maximize the matching funds available from the national government.

- Broad eligibility for all workers

Coverage should extend to all agricultural employees who meet certain employment-related eligibility criteria, regardless of immigration status. With the reality that more than half of California farmworkers lack appropriate immigration authorization to work in the U.S., any health plan must disregard immigration status when determining eligibility. Otherwise, a large proportion of farmworkers will be excluded from care and preventive services.

Also, since many farmworkers are seasonal and work for multiple employers during a season, criteria need to be developed to determine eligibility (e.g. number of hours/days worked in agriculture or amount of income from agriculture in past 12 months.) It is also critical to ensure that the more than one-third of farmworkers who are employed by farm labor contractors are covered in a plan.

- Provision for portability and bi-national coverage

Coverage should be geographically portable for those farmworkers who migrate for work and spend time out of the state and country. Locally based plans need to provide for out of area benefits. Also, any plan should consider coverage for workers while they are in Mexico. These plans, available commercially, provide high quality care, but at a reduced cost.

- Prevention education and beneficiary assistance

To ensure appropriate utilization of coverage and preventive services, farmworkers should be provided assistance in accessing services. With the high rates of preventable chronic conditions, the reticence to accessing care, and the unfamiliarity with the health system in general and health coverage in particular, a comprehensive beneficiary assistance should be made available. Prevention education and early use of health care will not only improve health but manage costs. Prevention education can be made part of mandated employer training that takes place for such things as heat stress and safe pesticide practices.

- Allow for integration with workers' compensation

To the extent possible and beneficial, health coverage should be integrated with workers' compensation coverage to provide employees with "24/7" coverage, and employers with a single, and more affordable, plan to administer. Pilot programs should be instituted to test the feasibility of this approach.

- Secure and stable food supply

California's \$36 billion agriculture industry feeds the nation with fresh produce, dairy and other commodities. For the industry to be sustainable, a healthy and stable workforce with access to preventive and curative health care is essential. On-site prevention programs and making clinical services available when needed would help ensure the health of farmworkers, and the agricultural industry.

The major legislative approaches to health reform

Health reform in California

The past two years have seen a multitude of health reform proposals at the state and federal level. In 2007, Governor Arnold Schwarzenegger declared the *Year of Health Reform* and after a year of intense negotiation, the Governor crafted a bill (ABx1 1) with Assembly Speaker Fabian Nunez. Unfortunately, the bill was defeated in the Senate Health Committee in early 2008. The compromise bill would have built on the current system and required employers to “pay or play” (i.e. provide coverage or pay into a state pool), required individuals to obtain coverage (with subsidies for most low income persons), expanded the state Medi-Cal and Healthy Families programs, and required health plans to offer guaranteed-issue products in the individual market.

In addition to the major legislation authored by the Governor and the Speaker, there were also two other approaches that either eliminated private health plans or would have eased regulatory requirements on health plans. The “single payer” bill (SB840) authored by Senator Sheila Kuehl (D-Los Angeles) would have virtually eliminated the role of private health plans and established a state administered plan for all residents. Despite repeatedly passing both houses, the policy bill was vetoed by the Governor but has been reintroduced in 2009 by Senator Mark Leno (D-San Francisco) as SB 810. The bill containing the financing mechanism of the single payer system through a variety of taxes and fees did not pass in the Legislature.

The “market reform” proposals were championed by the legislative Republicans and would have reduced regulatory requirements on health plans, increased choice of products and benefits, increased the use of health savings accounts to allow for access to more affordable health coverage. There were no mandates in the proposals. A version of these proposals has been introduced in 2009 by Senator Sam Aanestad (R-Grass Valley) as SB 92.

National health reform

Action on health reform in 2009 has substantially shifted to the national level. President Obama campaigned on a platform of health reform, and the Congressional Democrats have promised to move ahead with health reform before the end of the year. Although the specific bills are still being negotiated and drafted, there are several major approaches to health reform, most of which are similar to the California compromise in that they build on the current framework of health coverage.

President Obama’s campaign plan proposed expanding employer coverage through a “pay-or-play” approach for larger employers and a tax credit for smaller employers, expanding public programs for the uninsured, providing premium subsidies based on income and instituting an individual mandate to cover children. One controversial feature of the plan is the establishment of a public health coverage plan that would compete with private health plans in the newly created National Health Insurance Exchange. The President has indicated that he is flexible on reaching a compromise with Congress.

Each house in Congress is crafting various health reform bills with hopes of final passage by the end of the year. The “incremental” approaches that build on the current system are summarized here.

The Senate Health, Education, Labor, & Pensions Committee (HELP) has introduced the *Affordable Health Choices Act*. This bill requires all individuals to have health insurance and creates state-based American Health Benefit Gateways through which individuals and small businesses can purchase health coverage, with subsidies available to citizen and legal permanent resident individuals/families with incomes up to 400 percent of the federal poverty level. A public plan option would be provided in the Gateways. Employers larger than 25 employees who do not provide contribute at least 60 percent of employees’ premiums would pay \$750 per full-time employee who is not offered coverage. Medicaid would be expanded to all individuals with incomes up to 150 percent of the poverty level. The bill would develop a national prevention and health promotion strategy. Community health centers would receive significant additional funds. Insurance market reforms include guaranteed issue and renewal, allowing rates to incentivize health promotion and public reporting of medical loss ratios.

The Senate Finance Committee is developing a proposal that would also build on the current coverage system with a “pay or play” requirement for employers with contributions based on size, expanded public programs for low-income persons, national or regional health insurance exchanges to foster competition among insurers. Individuals would be mandated to obtain coverage, with significant subsidies for lower income families. Proven preventive services would be covered with incentives for healthy personal behavior changes. It is still not yet determined if there would be an option of public plan. The committee is attempting to develop a bi-partisan proposal.

The chairs of the three House committees with jurisdiction over health reform have developed a joint proposal in HR3200, the *America's Affordable Health Choices Act of 2009*, to overhaul the health system. The Tri-Committee (House Ways and Means, Energy and Commerce, and Education and Labor Committees) bill builds on the employer-based coverage system, Medicare, Medicaid and CHIP with a significant role for both public and private coverage. The bill will require all individuals to have health insurance and create a Health Insurance Exchange through which individuals and employers can purchase health coverage, with premium and cost-sharing credits available to citizen and legal permanent resident individuals/families with incomes up to 400 percent of the federal poverty level. A public health plan would be offered through the Exchange. Employers would be required to provide coverage to employees or pay into a Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Medicaid would be expanded to all eligible persons up to 133 percent of the federal poverty level. Preventive services with proven effectiveness would be covered. Community health centers would receive a \$38 billion augmentation over the next ten years. Insurance market reforms include guaranteed issue and renewal, no pre-existing condition exclusions and an 85 percent medical loss ratio.

Other bills pending in Congress include:

- HR676 – The *United States National Health Insurance Act* is a federal “single payer” bill that eliminates private coverage and established a tax funded system of health coverage.
- HR2414 (Berman D-CA) and S1038 (Feinstein D-CA) the *Agricultural Job Opportunities, Benefits, and Security Act of 2009* (AgJOBS). AgJOBS is a bipartisan bill that enjoys broad support in Congress. The AgJOBS compromise was carefully negotiated by the United Farm Workers and major agribusiness employers after years of intense conflict. AgJOBS is endorsed by major labor and management representatives, as well as a broad spectrum of organizations, including Latino community leaders, civil rights organizations, religious groups and farmworkers themselves. AgJOBS would provide a legal, stable labor supply and help ensure that farmworkers are treated fairly. AgJOBS contains two main parts:
 - An “earned legalization” program enabling many undocumented farmworkers and H-2A guest workers to earn a “blue card” temporary immigration status with the possibility of becoming permanent residents of the U.S. by continuing to work in agriculture and by meeting additional requirements; and
 - Revisions to the existing H-2A temporary foreign agricultural worker program.

Under AgJOBS, an employer would be required to provide workers compensation insurance, but no provision is made for health insurance. Also, those workers who are granted legal status under AgJOBS would be subject to the same five-year bar that precludes newly arrived legal immigrants from obtaining Medicaid (Medi-Cal in California) assistance.

How do these approaches meet the needs of the agricultural workforce?

A. “Incremental” proposals

The “devil is in the details” with the proposals and the bills are still undergoing revisions. For this reason, the local committees have reviewed the current approaches for their relationship to our principles.

- **Shared responsibility:** all of the incremental health reform proposals provide for a sharing of responsibility with both employers and individuals contributing towards health coverage, with government assistance through direct subsidies or favorable tax treatment.
- **Affordable cost:** the proposals have not yet developed specific estimates for employers and employees. However, they all contain some cost control mechanisms. Some attempt to bring down costs by having increased competition among health plans, while others require health plans to spend a certain percentage of their income (e.g. 85%) on medical costs, rather than administration and profits. Some proposals invest heavily in health information technology to bring down costs in the future, others attempt to reform the medical malpractice system and reduce medical errors. All the plans make some attempt to improve the health of Americans through preventive programs, thus reducing the demand for medical interventions.

Regardless of the cost control mechanisms, the bottom line to the employers and employees is how much they will have to spend. Given the very low incomes of the agricultural workforce and the low margin of the industry, the costs must be affordable for health reform to be of value. We know from focus groups in Fresno, that agricultural workers felt that they were able to pay up to \$50 per month for family coverage. In addition, the plans with very high deductibles, some exceeding \$3000, would render the coverage of limited use to agricultural workers who cannot pay out of pocket for care.

- **Comprehensive scope of benefits emphasizing prevention:** The scope of benefits have not been determined for the plans. The national proposals defer defining the exact scope of benefits to a council or establish tiers of coverage. A focus is placed on preventive services that are proven to be beneficial. It is uncertain whether dental or vision will be covered under the national plans. The Schwarzenegger/Nunez plan did not cover dental or vision. Preventive services appear to be covered, with minimal or no co-payments under the Obama, House and Senate proposals.
- **Support for “safety net” programs and providers:** The incremental proposals rely on expansion of the national Medicaid Program (Medi-Cal in California) to cover more low-income persons. However, the current prohibition on eligibility for undocumented persons would diminish the value of this benefit for most agricultural workers.

On the provider side, both the House Tri-Committee and the Senate HELP committee bills provide for significant enhanced support for community health centers and rural health clinics. It is unclear how public hospitals and clinics would be affected by the proposal but presumably a reduction in uninsured persons would reduce the uncompensated care provided at public facilities.

- **Broad eligibility for all workers and their families:** The proposals have not yet reached the level of detail to define who is an eligible employee or who is an employer. It is yet to be determined how much time a worker must be employed for a particular employer or in an industry. Nor are their definitions of who is an “employer of record” which is an issue in agriculture with the large percentage of the workforce employed by farm labor contractors.

The issue of undocumented workers is more complicated. The national health reform plans cover only citizens and legal permanent residents and it unknown how they would handle undocumented workers. Under the Schwarzenegger/Nunez proposal, employers would have been required to provide coverage for all their workers or pay into a pool. Individuals would have been required to obtain coverage, but the subsidies in the pool for low-income workers would not have been available to undocumented persons. However, the lowest-income individuals (under 250% of the federal poverty level – approximately \$25,000 annual income for an individual) would have been exempt from the mandate to

purchase coverage if the cost exceeded 5 percent of their income (\$1250 per year). The proposal would have made counties responsible for care to undocumented immigrants.

While the AgJOBS bill for legalization of currently undocumented farmworkers does not contain provisions for health insurance, both the health reform bills and the AgJOBS bill could be reconciled to have the agricultural employers provide health coverage should a “pay or play” provision be inserted in the health reform legislation.

- **Provision for geographic portability and bi-national coverage:** If national plans were created under a national health reform proposal, the coverage would presumably be available wherever the agricultural workforce was working in the country. State plans, particularly with managed care, might restrict services to a geographic area with limited out-of-area coverage. Health plans could provide for bi-national coverage as some of them do now.
- **Prevention education and consumer assistance:** The health reform plans have increasingly recognized the value of health promotion and disease prevention. The Schwarzenegger/Nunez plan had specific “wellness” provisions. The President’s plan requires coverage for prevention services and disease management programs, and there are provisions in the other plans. The plans have yet to address the issue of consumer assistance in navigating the new systems.
- **Integration with workers’ compensation:** The federal proposals do not address workers’ compensation as these have generally been state issues. The Schwarzenegger/Nunez proposal also did not address integration of workers’ compensation. However, it is possible that agricultural employers would see an advantage to making workers’ compensation more affordable which would free up funds for health coverage.
- **Secure and stable food supply:** None of the proposals directly address this issue but those that encourage and fund prevention and provide easy access to necessary clinical services will support the health of the agricultural industry and its workforce.

B. “Single payer” approach

While the “single payer” approach would provide the broadest benefits to all California residents, including undocumented residents, it also appears to be the least feasible in the current political environment. “Single payer” is a complete upheaval of the current system of health coverage and eliminates employer-supplied and private coverage in favor a publicly-financed system that provides full benefits to all residents with the broadest range of providers. Interestingly, some analyses find that the “single payer” approach provides the greatest coverage at the least cost in the long run. Yet, while the policy bill has passed a number of times and it has always been vetoed. The financing vehicles have never passed. It also faces considerable challenges

which would require a long implementation period and substantial changes in existing federal law.

C. Market reform approaches

The “market reform” approaches would make insurance more available and more affordable, but they would not provide major benefits to low income workers. While more affordable for employers, these plans often have minimal coverage and high cost sharing through deductibles and co-payments. The use of tax incentives such as health savings accounts would be of little benefit to low income workers who have little extra cash for savings and pay minimal amounts for taxes.

Alternative models for care and coverage

While most of the health reform proposals have focused on expanding insurance coverage to the uninsured, there are other models that would also facilitate care for uninsured farmworkers.

Care through established provider networks. One new model for expanding care to low income uninsured persons is Healthy San Francisco, a program designed to make health care services accessible and affordable to uninsured San Francisco residents. It is not insurance, but provides access to health care services for lower-income uninsured residents through the County’s hospital and clinic system, as well as other providers. Uninsured city residents, regardless of immigration status or pre-existing conditions are eligible.

Funding for the San Francisco plan is through individual fees and an “employer spending requirement.” Individual fees include quarterly payments (\$60 for those just above the poverty level and up to \$450 for persons with the highest incomes), and a co-payment at the time that services are rendered. The employer requirement mandates that medium (20-99 employees) and large employers (over 100 employees) spend at least \$1.23 or \$1.85 per hour, respectively. The employers may spend these amounts on health coverage or care for their employees, or choose the “city option” and pay the amount to the city which will enroll eligible employees in Healthy San Francisco or provide a medical reimbursement account. If employers choose the “city option” the employees receive a 75% discount on their participation fees. Legal challenges to the employer spending requirement are ongoing but have not been successful.

A plan analogous to Healthy San Francisco was considered by the Agricultural Worker Health and Housing Commission in 2007. The proposal was to create a primary-care based system for farmworkers with the purchase of additional catastrophic coverage. Funding presumably would have come from both employers and employees who would purchase the coverage, rather than pay into a pool under a “pay or play” health reform plan. The primary-care system would have been the network of migrant health centers that currently see the population.

A similar program, the Clinicas plan, was launched by Western Growers in Ventura County in 1994, which provided coverage for care at the local migrant clinic as well as access to specialists.

It did not provide for hospital coverage. The low cost plan was funded by employers and currently has approximately 2000 agricultural workers enrolled.

Employer supplied care and coverage. One major California grower, Reiter Affiliated Companies, has established its own clinics for employees and their families in coastal California. The clinics provide for primary care and access to specialists. Employees may choose to join the clinic system for a small fee, and may also choose from additional options for expanded coverage.

Another major grower, Tanimura & Antle (T&A), provides medical, dental, vision and life insurance benefits to its 2100 employees. T&A has a fully insured plan for its administrative/confidential/year-round employees and a self-funded insurance plan administered by Blue Cross for its seasonal agricultural work force. They also have a Mexican Panel plan available for all employees through United Ag. All employees pay co-premiums and are provided with an Employee Assistance Program.

Other companies are self-insured – they pay for a certain amount of health care and maintain catastrophic insurance to cover some of the larger claims. They often use the services of a health plan to administer the self-funded plan.

Coverage through groups of growers. California agriculture in California has had experience with “multiple employer welfare arrangements” (MEWAs) which are membership organization of employers that provide insurance benefits to its members’ employees. There are only five MEWAs in California with most of the covered workers in the agricultural industry: Western Growers Assurance Trust is the largest MEWA in California and covered nearly 100,000 members as of January 2001; United Agricultural Employee Welfare Benefit Plan and Trust covered over 53,000 persons as of March 2003.⁵ MEWAs have been controversial in the past due to a history of financial instability, although a 2001 Department of Insurance report found that the agricultural MEWAs demonstrated satisfactory financial integrity and were particularly helpful in making coverage available to agricultural laborers.

Both Western Growers and United Ag offer coverage to part-time and seasonal farmworkers and have multiple levels of coverage, including low-cost, bare bones coverage. The insurance is portable among employers who participate in the MEWA. Pricing is competitive with other health plans.

Migrant health centers. Federal and state funded migrant health centers have long served as the backbone of health care for California’s farmworkers. Federal grant funding is provided to California clinics that serve migrant and seasonal farmworkers. In addition, California’s Seasonal Agricultural Migratory Worker (SAMW) Program was created in 1977 to improve and increase

⁵ See, generally, Insurance Markets: Groups Purchasing Arrangements: Implications of MEWAs, California Health-Care Foundation, July 2003. A recent Los Angeles Times article reported that the United Agricultural Benefit Trust currently coverage 15,000 workers. “United Benefit Agricultural Trust Spotlighted as Model for Healthcare Cooperatives,” Los Angeles Times, August 6, 2009.

accessibility to comprehensive primary and preventive health care for the farmworker population. In fiscal year 2008-2009, the SAMW program provided \$6.8 million to 79 clinics to fund approximately 235,000 encounters. These funds were eliminated in the current budget.

Where to from here?

As the health reform efforts wind their way through the state and national legislative bodies it is imperative that the needs of the agricultural workforce be considered and integrated into the plans. In the interim, it is also critical to continue with the efforts to expand access to care through current, as well as new and innovative, programs that serve agricultural employees. These efforts must continue on the local, state and national levels.

There are several opportunities of which we can take advantage.

1. Develop pilot programs in several of California's agricultural regions to integrate the various funding streams currently providing for farmworker care, (e.g. employer coverage, emergency and full-scope Medi-Cal, employee payments, workers' compensation, local medically indigent funding and federal community clinic grants) and develop demonstrations of how basic coverage of essential services can be provided to farmworkers. These plans would emphasize prevention education and primary care. Clinics could be the basis of these demonstration projects and by integrating federally funded migrant health centers with employer clinics, both federal and employer funding could be captured. Federal expansion funds for clinics are available and could be used to expand the network of migrant health centers.

These pilot programs could be incorporated as part of the California's request for a Section 1115 Medicaid waiver from the federal government. Since the federal government funds emergency Medicaid services for all eligible persons, including the undocumented, these funds might be used for preventive services if it is shown to be cost-neutral.

These programs would be overseen by a board or commission that would be responsible for maintaining fiscal integrity, evaluating the cost effectiveness and health outcomes, and ensuring that services are accessible and affordable.

2. *Should* health reform at the state or federal level become enacted with an employer "pay or play" mandate, provisions should be added to allow agriculture to design a plan that meets the needs of agricultural industry. This plan should:
 - promote prevention and primary care through community- and workplace-based outreach and education and very low co-payments to encourage early use of care;
 - build on, support, and expand the current network of farmworker clinics and provide incentives for expanded services delivery through expanded hours, mobile clinics, workplace based clinics, etc;

- pool employer, employee and public funds to develop a coverage system that covers all agricultural workers who meet minimum employment requirements including seasonal workers and those who work for multiple employers;
- include all agricultural employers including farm labor contractors to participate in the plan.

The agricultural industry already has experience with multi-employer plans that should serve as a model for development of an industry-wide plan. Discussions should start now with potential partners.

3. While longer term solutions are being developed, programs that provide prevention education and services should be increased. Programs such as community and workplace outreach, health screenings and referrals (similar to the Child Health and Disability Prevention program), and assistance through community based health promoters would ensure a healthy workforce. The current employer training sessions on injury prevention could be expanded to health promotion. Lastly, support for migrant health centers needs to be restored and enhanced.

Conclusion

For agriculture to survive in California, a stable and healthy workforce is crucial. This means that health care for farmworkers must be available, affordable and appropriate. Health reform and immigration reform have the potential to benefit the agricultural workforce but it must be structured to meet the needs of predominantly immigrant, low-income farmworkers and the economically fragile industry in which they work. By emphasizing preventive and primary care delivered in culturally appropriate, community based settings, health reform can benefit the agricultural workforce and ensure a safe and healthy domestic food supply.

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The California Endowment has teamed up with Joel Diringer, JD, MPH of Diringer & Associates and three local coalitions to comprehensively address the issue of farmworker health coverage in California. The project set out with the goal of ensuring that all agricultural workers in California have access to health coverage and that coverage is affordable and tailored to the needs of the agricultural industry. The innovative, collaborative approach has brought together three local agriculture/worker coalitions to examine health reform proposals, find common principles and make recommendations on how they can strengthen farmworkers and the agricultural industry for the larger purpose of food security and sustainable agriculture. The work of the coalitions has found the generous support of their local assembly members Juan Arambula (31st District), Pedro Nava (35th District), and Anna Caballero (28th District).

The three regional efforts for farmworker coverage include Fresno Healthy Communities Access Partners, Ventura County Ag Futures Alliance Healthcare Committee and Salinas Valley's Center for Community Advocacy. These groups consist of broad-based coalitions of stakeholders with interests in agricultural worker health coverage with representatives from the following sectors: growers, farm labor contractors, agricultural worker advocates, migrant farmworker clinics, health insurance – public and private, policy analysts, and county health officials.

In Fresno County, the coalition was spearheaded by Fresno Healthy Communities Access Partners (HCAP). HCAP is a six year old nonprofit organization consisting of eleven health care and community organizations working together to improve access to health care for medically underserved communities in Fresno and the San Joaquin Valley. For more information, please visit <http://www.fresnohcap.org>.

Efforts in Monterey County were led by The Center for Community Advocacy (CCA). The Center for Community Advocacy trains farmworkers to form and lead neighborhood-based tenant and health committees who advocate for improved housing and health conditions for farmworkers and other low-income families in Monterey County and Santa Cruz County. For more information, please visit <http://www.cca-viva.org>.

Finally, in Ventura County The Ag Futures Alliance (AFA) took the is a county-based collaboration between farmers, ranchers, farm-workers, conservationists, and civic leaders who share a desire to build a vibrant, healthy, and durable food system. The first Ag Futures Alliance was started in 2000 in Ventura County, California when leaders in the farming community decided to engage farming critics in process of sharing views, trust-building, and ultimately identification of common ground. In the years since the founding of the AFA movement, new alliances have been formed in Ventura, Santa Barbara, and Yolo Counties. For more information, please visit <http://agfuturesalliance.org>.

Fresno, Monterey and Ventura Counties

The coalitions participating in this effort were selected because they are crucial for the agricultural industry in California. Combined these three counties appropriately represented the diversity of California's agriculture and can serve as the foundation of finding comprehensive solutions for farmworker coverage.

According to the Department of Food and Agriculture, by revenue Fresno County is ranked first in California with almost \$5 billion dollars annually, followed by Monterey County at third and Ventura County at eighth. Combined revenue for the three counties approaches \$10 billion annually and thus comprises more than a quarter of the entire state production while employing more than a quarter of the state's farmworkers. The three counties are also the biggest producer of 25 of the state's 70 top commodities, the second biggest producer of 19 commodities, and the third biggest producer of seven commodities.

Farmworkers constitute a major part of the local economies and labor forces. In the combined tri-county area, farmworkers amount of more than 10% of employees reaching well over 20% in Monterey County according to the Employment Development Department.

In Fresno County, California's most productive agricultural county, production is dominated by several high-value crops including grapes (\$562,751,000), almonds (\$494,500,000), tomatoes (\$402,141,000), poultry (\$389,147,000), and cattle and calves (\$317,074,000). Total production amounted to \$4,843,392,000 in 2007. Monterey County, due to its mild coastal climate, is crucial in the production of leaf lettuce (\$630,370,000), head lettuce (\$443,920,000), strawberries (\$439,796,000), nursery (\$339,225,000), and broccoli (\$234,400,000). Total production reached \$3,489,923,000. Ventura County, another coastal county accounted for \$1,505,588,000 in revenue in 2007. The most important crops included strawberries (\$318,301,000), lemons (\$191,552,000), celery (\$144,313,000), woody ornamentals (\$143,788,000), and tomatoes (\$102,426,000).