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Medical Insurance Coverage and Usage Among Farmworker Families: A Case Study

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Studies of farmworkers nationwide have documented the many obstacles they face in obtaining medical services. Few studies, however, have looked at the intricacies of medical insurance coverage among this population, for example, at the difficulties farmworkers experience in obtaining care when covered. The following in-depth sampling of farmworkers suggests that public and private health insurance regulations limit not just access to, but actual use of, medical services regardless of insurance and migration status. An evaluation of public and private medical insurance with regard to provision of care identified obstacles to the use of medical services by this rural, low-income, working-poor California population.

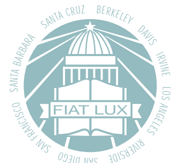
The California farmworkers in this study potentially were more likely than other farmworkers to have medical coverage, in that low-income legal residents are usually eligible for public medical coverage. They were also a relatively stable farmworker population; almost all were residents of subsidized apartment units (which are obtainable only by the head of household showing proof of legal residence). Most of the families sampled resided in subsidized government housing units in Santa Clara and Riverside counties.

Methods

Qualitative and quantitative research methods and data analysis procedures were integrated into a multimethods approach: interviews, participant observation, content analysis of taped interviews, and descriptive statistics generated from survey data of farmworkers, primarily from southeastern California. From August through September 1996, 31 farmworker households migrating from southeastern California were interviewed "upstream" at the Art Ochoa Migrant Housing Center in Gilroy. From February 1997 through June 1999, 99 additional farmworker households were interviewed in Mecca, located in an unincorporated rural area of southeastern Riverside County. Mecca represents a valuable field research site because the farmworker households are concentrated geographically and the community is 95% Latino (91% are of Mexican ancestry). This unique concentration makes it easier to conduct research over time, establish trust, and observe differences through agricultural cycles and fluctuations at both peak and low seasons. Data were collected on 560 people (238 adults, 322 dependents) in the 130 households. Farmworkers home-based in Mecca work primarily in the Coachella Valley. Families who migrate from Mecca during the summer often travel north to Gilroy, Huron, Fresno, or Bakersfield.

A household was designated as migrating (74) or nonmigrating (56) depending on whether one or more members traveled outside the home-base area for agricultural work during the 1995, 1996, 1997, and/or 1998 seasons. Excluded from the study were single migrant males, homeless farmworker families who lived in makeshift conditions, and families in which all members were undocumented.

The interview questions were designed to elicit farmworkers' experiences in seeking medical services when migrating versus when working at home-base. Data were collected on demographics, work histories, medical service use, experiences with medical providers, use of traditional "folk" practitioners, and use of public services.



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Findings

The following findings on this unique farmworker sample have significance for California health policy, particularly toward care in relatively isolated rural areas.

Coverage

Coverage was only moderate: 152/238 adults (64%) (79/130 women, 61%; 73/108 men, 68%) and 214/322 children (66%) reported having a public, private, combined public-private, or Mexican medical insurance plan at the time of the interview.*

Insurance coverage for dental, vision, and mental health services was rare even for this relatively stable population. Less than 10% of the 560 subjects had any of these types of coverage. Even with dental and vision coverage, the lack of providers in isolated rural regions makes obtaining treatment difficult.

The public medical insurance programs reported by farmworkers were Access Plan of Arizona, California Children's Services, Child Health and Disability Prevention, Medi-Cal (Inland Empire Health Plan, Molina, Fee for Service, Managed or Restricted Medicaid), the Medically Indigent Adult Program [MIAP], Medicare, and Supplemental Security Income (SSI).

The private programs were Blue Cross, Golden Ace Farms Group, Great West Health Plan, Health Net, Health Net Select, Metra Life, Pan Pacific Benefit and Administration, Pru Care HMO, PTA Arizona, the Robert F. Kennedy Farmworkers Medical Plan, SMA Healthcare, Transwestern, United Agriculture, and Western Growers.

Few families had continuous health insurance coverage for at least six months for all members. This was the case both for families with private insurance, for whom dependent coverage may be limited, and for families covered by public programs, for whom the different immigration statuses among family members determine the type of public medical program for which each family member is eligible.

*These totals—152 and 214—count the few instances of public-private coverage as single policies. In the separate public and private coverage counts, however, public-private coverage has been counted twice, once in each category. Thus, the accurate figure of 64% of adults covered appears to become 68% when the separate public (21%) and private (47%) percentages are totaled.

Obstacles to Care Under Public Coverage

Only 21% of adults (50/238)—23% of women (30/130) and 19% of men (20/108)—had public medical insurance, compared to 39% of children (124/322). The following findings highlight barriers to the use of public health insurance that farmworkers encountered.

Those with Medi-Cal were limited to the county where they applied. If a household migrates for employment to another county, the family needs to re-apply, as cases are seldom transferred between counties in time for insurance to be used. For migrating families, public coverage is restricted by interagency policies and practices that make it difficult to transfer caseloads and eligibility information between counties.

Family members with Medi-Cal usually lost benefits during peak season because their income rose. Thus, these household members had no coverage when their occupational risk was at its highest.

The frequent recertification required under the public MIAP and Medi-Cal programs—every 45 days in most counties, or quarterly at a minimum—discouraged many from obtaining and continuing medical insurance.

Treatment for non-life-threatening emergencies and tertiary/specialized care was often restricted by each county's interpretation of its legal responsibilities to families covered by county-based MIAP and state-supported limited-scope (restricted) Medi-Cal.

The federal welfare reform legislation of 1996 has resulted in fewer options for public benefits coverage for recently arrived legal immigrant families, who previously would have been eligible for most public medical insurance programs.

Many farmworkers found the eligibility process difficult and confusing and reported a lack of awareness of available programs among farmworker advocates.

Obstacles to Care Under Private Coverage

Although many more adults had private insurance (111/238, 47%), the following complaints indicate barriers that hindered their use of these medical care programs.

Limitations on dependent coverage restricted use of various programs, while high deductibles and

co-payments often led to more out-of-pocket expenses. Some farmworkers ended up paying completely out of pocket, as they seldom met the deductible in the time period required.

In some cases, having marginal, limited, employee-based private medical insurance may have disqualified farmworkers and their dependents from more comprehensive public insurance.

Several widely available plans offered full coverage when the worker or family members went to Mexico for care. While appreciated by those who lived near the U.S.-Mexico border, this benefit was not a useful option for those who did not.

Utilization of private insurance by migrating farmworker households was limited by distance from permitted providers, few transportation options, and geographic restrictions in the policies.

Policy Recommendations

For the 366 people with medical insurance, coverage was often discontinuous, restricted, partial, and underused. The following recommendations are offered as strategies to improve health care delivery to farmworkers and other low-income workers in rural areas of California.

1. Streamline and standardize the Medi-Cal eligibility and application process.

Because the 1996 welfare reform law gives states the option to restrict Medicaid for legal immigrants, and California has adopted restrictions on an issue-by-issue basis, many members of farmworker families face new restrictions based on their status as noncitizen legal residents. If they are sponsored, recently arrived nonrefugee immigrants may face new hurdles when applying for federally subsidized medical programs, as the sponsor's income is taken into consideration in determining eligibility. Further, because these laws change constantly, farmworkers fear using public medical services even when qualified. They and their advocates are uncertain about how receiving such services will affect their application for permanent residency or American citizenship, and/or their ability to reunite with family members from their home country.

- ▶ Advocates and policymakers need to address these concerns so as to clarify eligibility and consequences for applicants, primary health care clinics, and other safety-net providers serving this population.

The eligibility/application process for the county MIAP and for Medi-Cal is cumbersome. First, managed Medi-Cal (which provides medical services through a public or private HMO) restricts access to services by requiring farmworkers and dependents to seek care in a particular clinic in a given county. Second, farmworker household income varies greatly over the year, and families usually lose Medi-Cal and/or MIAP benefits during peak season, when their income rises. Benefits should allow for continuity of care if a farmworker family's income rises. Third, applications are long, the Spanish translations are confusing, and clients must repeatedly fill out the same forms because files are purged regularly.

- ▶ The process could be simplified by (1) shortening the application(s) and providing better translations; (2) determining eligibility once a year (rather than as often as every 45 days) by basing it on a household's annual income; and (3) making MIAP and Medi-Cal eligibility statewide, not county-specific. Farmworkers and other migrating residents should be excluded from the geographic limitations of Medi-Cal Managed Care.

There are at least 20 subsidized public health programs for various segments of the low-income uninsured. However, they are an uncoordinated patchwork, each with separate administrative processes and confusing, sometimes conflicting, eligibility requirements.

- ▶ Efforts should be made to make the programs' coverage a seamless system.

2. Fund and train community health workers to help farmworkers apply for, obtain, and increase their use of private and public medical insurance.

- ▶ Clinic providers and advocacy groups have historically functioned as direct liaisons with farmworkers, but inadequate funding has kept them from effectively fulfilling this role.
- ▶ Community health workers should be trained to deal with the bewildering array of both private and public medical insurance programs in order to teach farmworkers and their family members to do so.

3. Establish a commission to examine binational medical insurance practices.

Private U.S.-based medical insurance companies (e.g., Transwestern) pay 100% of medical costs if farmworkers get medical care in Mexico. Because there are likely to be legal questions when private U.S. medical insurance plans apply on both sides of the border, a binational commission could examine and plan for potential issues related to quality of medical care, fair reimbursement practices, and geographic and provider restrictions.

4. Direct adequate resources to improve rural-based medical and dental education in California.

- Via state-supported clinics, offer medical students, dental students, mental health professionals, social workers, and public-health nurse practitioners the opportunity to participate in a rural internship with Community and Migrant Health Centers throughout California. This may not only increase interest in practicing in a rural area, but also strengthen academic and research linkages with providers in these isolated clinics, which will need additional funding to provide training opportunities.
- Offer medical schools an incentive to develop a comprehensive rural residency program for primary care internists interested in rural health care. Currently, this type of residency training does not formally exist in the southeastern and northernmost areas of California.
- Initiate and support a collaboration among researchers from California medical schools, public health schools, social science schools, and computer science schools to create a centralized medical records database for Community and Migrant Health Centers through which farmworker records can be accessed wherever they need care. Moreover, since managed care requires productivity reports, the need for data extraction is great. Researchers at public universities have the resources to develop such a software package for these clinics.

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5. Consider the utilization patterns and needs of consumers in determining the types of medical services to provide.

- Give high priority to funding culturally appropriate dental, mental health, and substance-abuse programs in isolated rural communities.
- Reexamine the concept of community clinics with primary health care services in isolated rural areas. Farmworkers use services primarily when they are already sick. Hence, access to urgent care or specialty-based ambulatory medical clinics is also needed in isolated rural locales, including areas where farmworkers reside.

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The California Program on Access to Care provided support for this Brief and for a more detailed policy report, which will be available on the CPAC website (http://www.ucop.edu/cprc/cpac.html) in pdf format.

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