

Out of Sight, Out of Mind: The Implementation and Impact of the Affordable Care Act in U.S. Farmworker Communities

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Abstract: Farmworkers are a unique population within rural communities and are often overlooked and undercounted. They face significant disparities in health and health care access compared with the general rural population. One goal of the Patient Protection and Affordable Care Act (ACA) is to increase access to health care and health insurance for the country's most vulnerable and underserved populations. Farmworkers' numerous barriers to health care and health insurance remain, despite the ACA's progress. Apart from anecdotal accounts, we lack the necessary data to assess the ACA's impact on farmworker communities. This commentary imparts information about farmworker enrollment in and barriers to accessing health insurance, collected through individual conversations, focus groups, interviews, and informal surveys. Based on identified challenges and limitations, we make policy recommendations to assess and improve the implementation and relevance of the ACA in farmworker communities.

Key words: Farmworkers, health care, insurance coverage, Patient Protection and Affordable Care Act (ACA), community health centers, migrants, vulnerable populations.

In the U.S., there are approximately 2.4 million farmworkers,¹ and they are among the most vulnerable and underserved populations in the country. Much of what we know about farmworker health insurance enrollment comes from information collected by providers of technical assistance to community-based organizations, which provides a basic understanding of the successes and barriers faced by farmworkers when enrolling in health insurance. Yet gaps in knowledge about farmworkers' access to and utilization of health care hinder the development of targeted interventions that can be implemented on a large scale. This commentary will explore the impact of the Patient Protection and Affordable Care Act (ACA) on farmworker health insurance coverage and present policy recommendations to improve its implementation and relevance in farmworker communities.

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Farmworker Demographic Characteristics

According to the National Agricultural Workers Survey (NAWS), a survey of U.S. crop workers conducted by the U.S. Department of Labor, 82% of U.S. farmworkers are Latino,² with the vast majority (74%) being from Mexico.² Of the foreign-born population, 41% have been in the U.S. for 15 or more years.² Fifty-two percent are in the U.S. without authorization,² though this is likely to be an underestimation. H-2A workers, temporary non-immigrant agricultural workers, make up 2% to 5% of the general farmworker population.³ The number of farmworkers on H-2A visas has been growing steadily over the past 10 years. Since 2004, the number of certified H-2A positions increased 213% (from 44,619 in 2004 to 139,832 in 2015).³ Only 28% of farmworkers report being able to speak English well.² Spanish tends to be the dominant language, though there are increasing numbers of farmworkers from locations where other languages are spoken, such as Haiti and indigenous communities of Mexico and Guatemala.

Poverty is persistent in farmworker communities. Twenty-five percent of farmworker families have an annual income below the federal poverty level.⁴ Income estimates vary widely in farmworker communities depending on the state and crop. Many farmworkers work on a piece rate: the amount they earn corresponds to the number of buckets filled or pounds harvested.

The most reported health conditions in farmworker communities are diabetes, hypertension, and asthma.⁵ According to 2014 data collected by migrant health centers, clinics that receive federal funding to serve farmworkers and their families, 88,832 patients (11%) had a primary diagnosis of hypertension and 65,708 patients (8%) had a primary diagnosis of diabetes.⁵

Farmworkers' working and living conditions negatively affect their health. Housing is often overcrowded and substandard.^{6,7} They experience high rates of occupational illness and injury, such as pesticide exposure and musculoskeletal injuries. Agricultural work routinely ranks among the most dangerous occupations in the U.S. In 2014, the Bureau of Labor Statistics recorded that 143 farmworkers suffered fatal injuries, a 12% increase from 2013.⁸ Fatalities among workers in the agricultural sector ranked first among workers in all industries.⁸ It is estimated that reporting systems annually miss an average of 77% of occupational illnesses and injuries in agriculture.⁹

Farmworkers' Access to Health Care

Farmworkers are less likely to access health care than the general population. According to most recently analyzed data, 41% of farmworkers did not use U.S. health care services at all in the last two years,¹⁰ compared with 16.8% of the general population.¹¹ Community health centers, which include migrant health centers, reported serving approximately 20% of the total farmworker population in 2014.⁵ There are numerous barriers that contribute to the underutilization of health care services in farmworker communities: immigration status, language, transportation,^{12,13} socioeconomic status, cultural factors, and fear of the U.S. health care system,^{14,15} to name a few. In rural communities, there are few public transportation options. Farmworkers who do not

own a vehicle are not able to access health care services easily, often relying on friends or family for rides, or paying for private transportation. Due to transportation issues, some miss a full day of work for a medical appointment.

Once they arrive at a clinic, cost of care is often prohibitive. Eighty-seven percent of farmworkers identify cost as the main barrier to care.¹⁶ The most recent NAWS data, collected prior to ACA implementation, showed that only one-third of farmworkers had some form of health insurance.¹⁷ Community health centers have sliding-fee schedules that lower the cost of a health care visit based on a patient's family size and income. However, this discounted fee may still be too expensive, especially when follow-up appointments are necessary for treatment.

Farmworkers and the Affordable Care Act

One goal of the ACA is to increase access to health care and health insurance for the country's most vulnerable and underserved populations. Since the ACA's implementation in 2014, an estimated 20 million uninsured adults (ages 18–64) gained health insurance under the ACA.¹⁸ Among Latinos, the uninsured rate dropped 11.3 percentage points from 41.8% to 30.5%, corresponding to about four million Latino adults.¹⁸

Community health centers are an important safety net for farmworkers and other underserved populations. Their goal is to provide comprehensive primary care to all community members, regardless of insurance status or ability to pay. Migrant health centers address the unique health care needs of farmworkers and must include farmworker representation on the health center's board of directors.¹⁹ The ACA designated \$11 billion to community health centers to expand their services.²⁰ Since 2010, community health centers have received funding to open new clinics, expand services such as services for behavioral and oral health, modernize health records, and conduct outreach and enrollment.

Farmworker Eligibility

To purchase health insurance in the ACA's Marketplace (the Marketplace provides health plan shopping and enrollment services through websites, call centers, and in-person help²¹), an individual must be lawfully present in the United States and a resident of the state where he or she purchases health insurance.²² Undocumented individuals are not eligible to purchase health insurance in the Marketplace. To qualify for tax credits to lower the cost of the health insurance premium, an individual must be at or below 400% of the federal poverty level.²²

Depending on their immigration status, state of residence, and household income, farmworkers and their families may be eligible to purchase health insurance in the Marketplace or may be eligible for Medicaid. However, due to their immigration status,² the majority of farmworkers are not eligible for Medicaid or to purchase health insurance in the Marketplace, even at full price.²² Most of those who are eligible for the Marketplace (lawfully present farmworkers, including U.S. citizens, lawful permanent residents, and H-2A workers, among others) qualify for tax credits and cost-sharing reductions such as reduced co-payments and deductibles.²² Some farmworkers may be eligible for employer-provided health insurance under the ACA's employer shared-

responsibility provision. H-2A workers have rights and obligations under the ACA as lawfully present individuals while in the U.S. Because of their low wages, many qualify for generous tax credits. In North Carolina, the average H-2A worker pays less than \$25 a month for health insurance (M. Torres, personal communication).

Barriers to Farmworker Enrollment

Very little research providing either quantitative or qualitative data on farmworker health insurance enrollment has been published. Information on barriers to farmworker enrollment has been collected by Farmworker Justice through individual conversations, focus groups, interviews, and informal surveys. The following description of barriers represents a summary and generalization of these discussions.

The most persistent barriers to health insurance enrollment that have been reported by community-based farmworker-serving organizations are logistical challenges, non-portability of health insurance, and insufficient availability of in-person assistance. Logistical challenges include: lack of access to the internet or a computer; language barriers; and difficulty providing the necessary paperwork, such as pay stubs or immigration documents, when enrolling in health insurance. Often, farmworkers require multiple appointments with in-person assisters to complete enrollment, which can take up to an hour per application (M. Mann, J. Morrill, personal communication). There may be a need for multiple appointments when the applicant is unfamiliar with the process and does not bring the necessary information to the first appointment. Few rural Latinos have U.S. bank accounts²³ or credit histories, complicating enrollment in health insurance and payment of premiums.

For eligible migrant farmworkers, the lack of health insurance portability presents an enormous challenge to health insurance enrollment. Migrant farmworkers may work and live in three or four different states throughout the year. Health insurance purchased in one state is often inadequate in another state because a plan's provider network rarely extends across state lines. Migrant farmworkers may be able to re-enroll in health insurance when they move to a new coverage area but the complicated enrollment process deters many migrant workers, especially if they are only working in that area for a short period of time.

Role of Outreach and Enrollment Programs in Farmworker Communities

Since 2014, farmworkers have enrolled in health insurance due in large part to the efforts of in-person application assisters across the country. Community health centers and other community organizations receive ACA funding for outreach and enrollment services in their communities. These outreach and enrollment services provide education and in-person assistance to individuals seeking health insurance. In-person assistance has been a very effective tool to enroll individuals in health insurance through the Marketplace, especially in farmworker communities. In North Carolina, for example, health centers estimate that Spanish-speaking application assisters helped approximately 2,000 H-2A workers enroll in health insurance in the Marketplace (A. Pollard, personal communication). In California, one health center's in-person assister program helped

approximately 600 farmworkers enroll in health insurance or Medicaid (F. Aguilera, personal communication).

In 2015, the Centers for Medicare and Medicaid Services (CMS) awarded \$67 million in navigator grants to support outreach and enrollment efforts in 34 states.²⁴ States with their own Marketplaces, such as California, invested their own funds to support outreach and enrollment in health insurance. Since 2013, the Health Resources and Services Administration has provided ongoing outreach and enrollment funding to community health centers. Despite these investments, in-person assistance in farmworker communities is in short supply. Farmworkers require enrollment assistance that is tailored to the specific needs of the community. Instead of limiting outreach and enrollment to the clinic, in-person assisters at migrant health centers conduct outreach and enrollment at workers' homes and work sites. Furthermore, enrollment services in farmworker communities provide assistance beyond the health insurance application. In-person assisters provide education about the U.S. health care system prior to enrollment and help enrolled workers connect to health care services, pay their premiums, and understand notices from their health insurance plans and the Marketplace post-enrollment. To educate and enroll hundreds of workers in a single area may require thousands of visits by application assisters (M. Torres, personal communication), which can strain outreach and enrollment resources and reduce the time that outreach services spend on general health education. Farmworkers tend to live a long distance from social service providers, significantly adding to the time assisters devote to enrolling farmworkers in health insurance (J. Morrill, personal communication).

Assisters in communities where farmworkers arrive outside of open enrollment, particularly migrant and H-2A workers, often do not have the resources to educate and enroll all of the eligible workers, especially within the 60-day Special Enrollment Period. Communities with large numbers of H-2A workers must contend with additional challenges due to the special circumstances of these workers, including widespread misinformation about their rights and responsibilities under the ACA. In-person assisters must devote additional time and resources to ensure the workers have the information and opportunity to enroll in health insurance within their allotted enrollment period.

Evaluating ACA Efforts in Farmworker Communities

The necessary data to assess ACA efforts in farmworker communities or the contribution of the ACA to health insurance coverage in farmworker communities have not been collected. We can only glean its impact through information we collect from migrant health centers and community-based organizations. This lack of data is not limited to the ACA. Generally, there is incomplete information on farmworkers in the U.S. Even though farmworkers are a vital part of the national economy, service providers, advocates, researchers, and state and federal governments are only able to estimate the size of the farmworker population.

Farmworker Data Collection and Limitations

Community health centers collect data on their patients using the Uniform Data System (UDS). These data ensure compliance with health centers' legislative and regulatory

requirements, identify trends over time, and inform health center performance and operations.²⁵ Using the UDS, health centers identify their farmworker patients. However, this information is not always recorded in the patient registration forms used by health centers. It should also be noted that only a small percentage of farmworkers and their family members (approximately 20%) sought care at a health center in 2015.⁵

The most often cited data come from the NAWS, which is the most comprehensive survey of U.S. farmworkers. It is an employment-based, random-sample survey of U.S. crop workers that collects demographic, employment, and health data.²⁶ Data are collected in face-to-face interviews throughout the year. The survey questions collect valuable information on respondent demographics; recent employment and migration history; work characteristics, including earnings, benefits, and availability of water and toilets; basic medical history and use of health services; housing characteristics; income and assets both inside and outside of the U.S.; and immigration status. Data collected, analyzed, and presented using the NAWS inform federal programming targeted to farmworkers.

The NAWS has its limitations, especially when assessing health insurance coverage. The sample size of the NAWS is small, a limitation acknowledged by the Department of Labor. Of the estimated total farmworker population (approximately 2.4 million¹), the NAWS only surveys between 1,500 and 3,600 workers each year.²⁶ Due to the small sample size, analysis combines two years of data.²⁶ Two years of data are equivalent to up to three-tenths of a percent (0.28%) of the total farmworker population. Further, NAWS survey participants are interviewed at their work place rather than at their home, a unique feature of the NAWS that differentiates it from other federal surveys. Interviewers need the permission of the employer, potentially creating a biased sample. Employers who welcome the NAWS interviewers may be more likely to comply with federal wage and hour and safety standards, provide benefits, and introduce other factors that positively affect the health and utilization of health care services of their workers. Finally, the NAWS does not survey H-2A workers. Although they are a small portion of the farmworker community, their exclusion affects the assessment of health insurance coverage among farmworkers, as H-2A workers are lawfully present and required to enroll in health insurance while in the U.S. However, justifying collection of this data is challenging due to the low percentage of H-2A workers relative to the general farmworker population.

Policy Recommendations

The ACA has the potential to greatly improve health insurance access in farmworker communities. Given the barriers to enrollment and the lack of data in farmworker communities, we offer the following policy recommendations.

First, every Marketplace should offer at least one health insurance plan that provides a regional or national network of health care providers for eligible farmworkers who migrate from state to state throughout the year. These workers deserve full and easy access to health insurance across state lines and this may best be achieved by increasing their access to national or multi-state plans. The ACA's Multi-State Plan (MSP) is one option to enhance access to regional and national networks of health care providers.

The MSP is overseen by the U.S. Office of Personnel Management (OPM).²⁷ It is called a multi-state plan because OPM operates the program in multiple state Marketplaces. The goal of the MSP is not necessarily to provide a multi-state network of providers. While some of the MSP options offer in-network care out-of-state, not all do. As phased-in expansion continues, OPM should encourage current and new MSP health insurance issuers to offer plans that include regional and national in-network coverage and are affordable for farmworkers who migrate throughout the year.

Second, CMS and state agencies should include farmworker community organizations among the priority organizations for the allocation of in-person assister funding. The Centers for Medicare and Medicaid Services awards grants to support outreach and enrollment efforts across the country.¹⁹ While the funding targets organizations serving vulnerable and underserved populations, few farmworker-serving organizations received CMS funding in 2015. There should be more funding available through CMS to support ACA outreach and enrollment efforts by community health centers and community-based organizations in farmworker communities. These organizations are best equipped to address the specific needs and challenges of farmworkers. Furthermore, communities with large migrant populations who arrive outside of the annual open enrollment period should receive additional support for those months between open enrollment periods to ensure that all eligible farmworkers are able to access in-person assistance and enroll in health insurance within the 60-day Special Enrollment Period.

Third, H-2A workers should receive information about the ACA from their employers and the U.S. consulates. Few H-2A workers are aware of their rights and responsibilities under the ACA while they are working in the U.S. Prior to arriving in the U.S., H-2A workers receive information about their labor rights from the U.S. consulate where they receive their visa. H-2A workers should receive similar information about their rights and obligations under the ACA. Consular officers should encourage them to find in-person enrollment assistance in the U.S and provide them with information about how to enroll. Early access to accurate information will expedite the enrollment process once they arrive in the U.S. Workers should also receive information about their obligation to enroll in coverage from their employer upon arrival at their work-site. Employers should work with health centers and other local enrollment entities to arrange for ACA education and appointments with application assisters within the first month of H-2A workers' arrivals.

Fourth, in order to assess the implementation and impact of the ACA in farmworker communities, we must collect more and better information about farmworkers in the U.S. Federal agencies that develop surveys of U.S. workers should include farmworkers as a priority worker population. First and foremost, the NAWS must be better funded to increase the sample size. Sampling should be expanded to include workers when they are not at work and who interviewers do not need permission to access. Funding should also be provided to NAWS to more accurately measure health insurance enrollment of farmworkers. For example, supplemental funding should be provided by CMS to collect data on health insurance. The NAWS currently receives supplemental funding from federal agencies, such as the National Institute for Occupational Safety and Health and the Health Resources and Services Administration, to collect data on occupational health and access to health care, respectively.

Finally, to improve access to health care and the overall health of the U.S. farmworker population, there must be comprehensive immigration reform that provides undocumented farmworkers and their families a path to citizenship and full membership in our society. Farmworkers' precarious immigration status creates fear and mistrust, deterring farmworkers and their families from accessing health care services or enrolling eligible family members in health insurance. Comprehensive immigration reform should also ensure that all newly legalized workers are eligible for health care, removing barriers that currently exist for certain immigrants to access Medicaid and other health benefits.

Conclusion

To increase farmworkers' access to health insurance and health care, national and local policies should be implemented that address the challenges unique to rural communities. While there are successful ACA-related programs, such as in-person assister programs, they are not always appropriately designed for the most vulnerable populations. Moreover, other policies, including immigration policy, impede access to health care. Farmworkers are an essential part of our communities. The men and women who harvest the fruits and vegetables that support our health deserve access to quality health care so they can be healthy themselves.

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