New Models of Health Care Coverage for California Farm Workers

Stakeholder Advisory Group Meeting
Monday, October 28, 2013
10 am to 2 pm
Grower-Shipper Association of Central California
512 Pajaro St., Salinas, CA 93902

Meeting notes

Summary:

Approximately 35 persons attended the meeting representing agricultural employers, farmworkers, health providers, health plans, immigrant advocates, and data and policy experts.

The first session was a re-cap of data from the California sample of the National Agricultural Workers Survey. Approximately 18% of the 550,000 CA farmworkers receive employer coverage now. The Affordable Care Act will not provide much new coverage for three reasons: coverage limitations due to immigration status (prohibited from Medi-Cal, exchange subsidies), the small employer exemption, and the seasonality of the labor force. Updated data will be forthcoming. More information is needed on employer size, family immigration status, and options for coverage.

The second session was a roundtable discussion by participants on barriers and opportunities for farmworker health coverage. The participants noted a new sense of collaboration among previously antagonistic sectors (employers, workers, insurers) attempting to find common ground given the realities of agriculture and the ACA. The lack of accurate information is inhibiting choices by employers and workers alike. Several noted that solutions to covering undocumented workers will need to be on a county or regional basis and involve employers, employees, local providers and community efforts. Cost for workers and their families will be critical since coverage alone will not translate into appropriate care. Low take-up of expensive insurance will not increase access, so new models with up-front coverage need to be examined. We also need to look at family coverage since many workers are in families with mixed immigration statuses which might enable some members to enroll in different programs (e.g. Medi-Cal for children). Additional outreach and education to these families, some of who do not even speak Spanish, is necessary on a community level. Current immigration reform does not provide solutions for health coverage but coverage is necessary to maintain a stable and healthy workforce.

The afternoon sessions highlighted models of coverage that involved 1) employer provided coverage that was affordable for employers and employees and utilized existing safety net provider networks with inexpensive access to preventive and primary care, 2) employer provided care through employer clinics and preventive health education, with wrap-around major medical coverage and 3) community clinic based models with funding from employers and foundations.

Overall, it is clear that huge barriers remain for access to health care for farmworkers, there was a strong desire among all participants, from across sectors, to create solutions. A diversity of strategies, such as those highlighted in the afternoon, may provide important incremental improvements to the vexing issue.

Future meetings will delve deeper into new models of coverage in preparation of a policy paper analyzing options and a legislative briefing on the findings. The next meeting in a few months will be in the San Joaquin Valley.

Detailed notes

Welcome and Introductions:

Joel Diringer thanked The California Endowment for funding the project, Salinas Valley Memorial Health System for funding lunch, and the Grower Shipper Association for hosting the event.

Joel gave a history of the efforts to provider farmworkers with coverage including the Clinton-era migrant farmworker coverage plan in the Commerce Committee bill, Fresno County efforts in 2005 to identify models of coverage, as well as the efforts in Monterey, Ventura and Fresno Counties culminating in a legislative briefing in August 2009 on models of health reform. In more recent time, a major effort went into creating the Hacia Salud Health Plan to receive federal start up loans as a CO-OP plan, only to have federal funding eliminated as part of the January 2013 fiscal cliff legislation. With the delay of the large employer mandate under the Affordable Care Act (ACA), it is now time to re-examine models of providing care to the low-wage, immigrant agricultural workforce.

Data presentation by Ed Kissam, Werner-Kohnstamm Family Fund:

Ed Kissam presented data relying on the public California data subset from the National Agricultural Workers Survey (NAWS 2009).

ACA is perfect storm disaster for farmworkers with coverage limitations due to immigration status (prohibited from Medi-Cal, exchange subsidies), small employer exemption, and the seasonality of the labor force.

There are approximately 550,000 California farmworkers, 650,000 farmworker dependents – 1.2 million people. 98% of farm laborers are foreign-born, and approximately 70% are undocumented. About half of farmworkers work for small employers by ACA rules and are excluded from the ACA mandate. Probably 50% are seasonal workers. The subpopulation of those who work least days are most recently arrived, younger workers, women. Those covered by employer mandate typically older workers, many of whom are naturalized or covered under IRCA legislation. (More farmworkers becoming indigenous Mexicans, even more barriers to health care.) About 18% of CA farmworkers are currently covered by employer health insurance. Since this is already the case, will ACA broaden the number of farmworkers covered? Not clear that it will. 80% of children are born here, eligible for Medi-Cal. Not the case for spouses though – not a good situation for them.

DOL is preparing the 2010-12 data set, and updated information will be forthcoming. We have submitted request for full data set to refine analysis: income distribution by type of employer, spouse status. No data on size of employer. Caution against using ACS census data – misses farmworkers – 23% of undoc farmworkers were missed in LA in 2010. CHIS data set also very problematic – misses farmworkers. Need data about # seasonal workers by employer size.

The new Deferred Action for Childhood Arrivals (DACA) does grant deferred action status with Medi-Cal eligibility in CA using state-only funds. About 20,000 farmworker qualify due to age/date of arrival – but they need high school degree/GED/voc enrollment. Maybe 4,000 could easily qualify; the rest will need to register for voc training/adult ed.

3 tasks ahead: continue with data analyses; conduct market research on whether farmworkers will opt in to insurance that costs money, and craft workable solutions.

Questions/Comments:

Average income of farmworker is $18,000 household. Includes seasonal and full-time and income from all sources.

Approximately 30% crop farmworkers are employed by farm labor contractor (FLCs) – younger, less often documented.

Joel clarified that seasonality affects whether you are a large employer: 50+ FTE equivalent employees, unless seasonal 120 days or less. If large employer, starting 2015, have to offer insurance to everyone, including seasonal employers. But waiting period – CA says 60 days though Fed says 90 days.

Ed McClements added that that if an employer doesn't know if worker will work enough hours, can have a measurement period/stability period which makes employers crazy. Employers want more simplified solutions. Probably won't be a major problem.

No regional breakout of data is available.

Any effort to distinguish seasonality by crop? No, and haven't seen it done. Can be done but needs non-public NAWS data set.

A lot of people say there are many small employers…. But ACA looks at who the owner is…. So labor contractors will look at all subsidiaries, small businesses all controlled by one owner. So may be more large owners than people realized. "controlled group rule" – ownership structure.

Reiter has over 50 partnerships. Using controlled group definition to have partnerships opt in or opt out. On average, $18,000 is reasonable income per employee according to their research. By crop: depends on which region. Oxnard is year-round, Santa Maria more seasonal, Watsonville a long season. Blueberries always seasonal, but other berries depends on the growing region.

Susan Gabbard is writing a paper on decline of migrant workers in U.S. Peak year was 1998, declined a lot since then. Used to be more than half moved, but due to fewer immigrants, post-9-11 restrictions, and people staying in one spot it is now approximately 25%. Migrants do earn less, but now may make up only 25% of farmworker population. Salinas is very integrated, with everyone moving to AZ and back, vertically integrated with executives, equipment, and farmworkers moving. Also extending seasons so people can stay in one place.

Reliance on FLCs have changed too. Many are staying with one FLC, not really migrants though work for different farms. (NAWS = 2 jobs greater than 75 miles apart)

On way to view migrant farmworkers is as regional commuters. How to look at farmworkers' families and households, children, rest of family not being eligible for Medi-Cal. Family structure within context of coverage.

Roundtable Discussion: Barriers, opportunities

Everyone in the room was asked to share their thoughts on barriers and opportunities to coverage and the role that their organization is playing.

Hillary Frazer: national level immigration reform is dead for the near term at least, interesting to look at the states that missed out on MC expansion – they're dealing with low-wage workers. She thinks of fw

similarities to other low workers. Mixed status is huge issue, how do we defragment families? A lot at regional and county levels – families trying to deal with a lot of programs simultaneously.

Dr. Ray Lopez: Liked what was said about keeping families together. His clinic doesn't see many younger kids because they are covered by MC. Our children are our future. Need to build it together, difficult to find cohesion when fragmented.

Cindy Valencia: ACA readiness project in Merced County. A lot of discussion about who uninsured are, barriers, coordinating efforts, preventative services and minimizing risk.

Susan Gabbard: It is positive that 18% of employers do insure workers right now. How do we build on that? Employer coverage is the major source of insurance. Employers may be a little more responsive to workers right now with shortages. Workers can always go to FQHC now, do have coverage though it's sliding scale. Payor mix for CHCs, migrant clinics may change as some people with private insurance will leave FQHCs. Barriers that keep workers away from FQHCs will continue.

Jo Ann Intili: Agrees with what Susan said. Payor mix is crucial issue, worry about effect of ACA on CHCs. Some in Alameda Co are closing. Counties having problems dealing with hospitals dumping on CHCs. Opportunity to bring communities together, have counties take systemic view with employers – this is our community viability, economic productivity requires healthy farmworkers.

Josue Chavarin: Looking at how counties have to decide what to do for undocs in next few months. LA, Alameda, Fresno, SF, SC, Sacramento, Yolo. Mixed status family issue: developing tools for partners. Problem that folks are eligible but confused about whether will impact immigration status.

Ambar Tovar: working with local counties for coverage. From grassroots perspective, this is an opportunity to inform undoc pop who is eligible and what services, at what level of documentation (citizen, doc, undoc). Barrier is immigration fear. Parents who are not enrolling kids.

Juan Uranga: Known from beginning that ACA wouldn't help undoc workers. Discussion should be how we can get other stakeholders to find other ways of providing insurance or health services to undoc workers. Boils down to political will. What can we as opinion makers from industry and advocate sides do to create this political will? Promising thing about this convening is getting substantive conversations between advocates and industry. If industry can view challenge as a challenge to their financial integrity and to their communities. Not an undoc worker issue – issue of what kind of community we want.

Dr. Max Cuevas: Complicates things that we don't have real numbers. Makes it difficult to plan policy. It's a local problem with local solutions. Tried to get employer financed mechanism, state trust fund - realized it needs to be local. Farm Bureau came together with FLC, CHCs, created a trust fund. Partly funded through foundations including Cal Endow. Came down to basic access to care. If Ag will be vibrant, needs healthy workforce. No one wants to deal with undocs politically. As CHC, don't know how many undocs they deal with – no good numbers.

Walter Ramirez: work with indigenous mono-lingual indigenous speakers. Big misunderstandings in indigenous and farmworker communities about how ACA will affect them. Some think that if they have Medi-Cal, they have to pay a penalty. No Mixtec or other indigenous language assistance with Covered CA.

Clint Hoffman: Projects within org targeting undoc. Early discharge outpatient clinics for self-pay with preventative care. Clinical network to coordinate care among providers to improve population health, partner with employers.

Alexis Guild: Access to info for farmworkers is major barrier. Misinformation, myths about ACA. Obligations for mixed families – liable for citizen children. CA has always been leader and hope is that solutions in CA can be applied to other states with similar challenges.

Bryan Little: Getting lots of questions from employers who are getting questions from workers. Ex: can I qualify for Medi-Cal? You'd think it would be practical to find a product that both employers and workers can afford. Who has this? (Joel: and provides access to care) If employer can offer health care, legal status doesn't matter. If insurance involves expense to worker, they may not take up the offer. "Nobody's undocumented. Everyone has documents."

Jim Bogart: Juan makes really good point that important opportunity for industry and advocates to come together on important issue. Also opportunity for advocates. Immigration reform is #1 issue for past 3 years – acute labor shortage. Industry wants access to legal, stable workforce. CA ag and central coast ag is challenged to compete with water issues, regulation, etc. All has to go together, be part of solution. Want to provide health insurance, but need an ag industry that is viable and sustainable.

Norma Forbes: Covered CA focused on coverage, but off track because issue should be affordable care. Have to make sure people know how to use health coverage to get into affordable care. She thinks people will just take their insurance cards to the ER without education. Have found in past that this is true. Need an integrated delivery system. FQHCs great but families can't afford sliding fee scale so families don't come back for preventive care.

Mike Meuter: Have had a couple of workers come to CRLA – had employer insurance, but they are feeling pressured to not enroll in employer-provided insurance and to enroll in exchange instead. Is this really going on?

June Ponce: Agree with Bryan. Agree that more growers need to be part of the conversation. Not that many growers in this conversation. This is the time to have the industry talk to government. Growers don't speak health care language. We care for our employees and we are the communicator to the farmworkers. Want to capitalize on immigration and health care. There is a labor shortage, want employees to work for us.

Juan Guerra: Reiter Affiliated Companies (RAC) believes this is bigger than us, bigger than our own costs. Have been offering benefits to everyone for many years. Waiver for capped plans didn't get an extended, so moving to a more expensive health plan. Who will pay for this? Employee has to pick up some of this – employee cost is doubling for next year. Have to be creative because a lot of people cannot afford that plan. Focus on preventive care. Biggest issue is sustainability. Have to find balance between caring about people and sustaining the business in the long run. Back to what Norma was saying, it's about affordability of care. Operating in CA very expensive, very challenging. It's not just about health care, it's about the whole ag community, the industry.

Kiwon Yoo: Will be focusing on how to deal with remaining uninsured in S. CA. Wants ideas. Have restaurant industry, garment industry as other example of industries with low-wage uninsured workers.

Lilia Chagolla: Medi-Cal managed agency. Huge concern about providing access for undocumented. Have very small program – Healthy Kids -- to provide health insurance to undoc children – privately funded,

has funding issues. Opportunities are to maximize enrollment of currently eligible and those eligible in 2014, especially those in mixed-status families. Partner with FQHCs to keep families together.

Ed McClements: One of biggest ACA problems is it only penalizes large employers for not offering insurance. Insurance can be very expensive with premium of up to 9.5% of income. If employee refuses, employer off hook and employee gets no subsidy. Employer not responsible for spouse. Employer only has to provide plan that pays 60% actuarial value. Can leave huge cost for employee in addition to premiums. Who cares about seasonality, etc. when plan still has a $5,000 deductible? Regs have turned in favor of business getting out of responsibilities. Good news is that every ag worker is a documented worker, so there is an opportunity. Dozens of ag employers want a solution, wants to make this work.

Patrick: Three barriers: 1) advocates of health care reform have been unwilling to be flexible for populations like ag. 2) For people who are exchange-eligible, lack of state-wide or multi-state option is a problem for migrants. People who migrate between regions and states. Border region issues. 3) Utter lack of understanding by policy makers and media who oversimplify situation. Their lack of understanding leads to confusion in general populations. Opportunities: ACA has anti-discrimination provisions – companies will have to think about covering everyone. Also, "skinny benefit plans" may be of benefit to farmworkers. One insurer just rolled out one of these plans. Third, forcing collaboration between historically antagonistic interests. His board is half employers, half union, plan represents farmworkers. Seeing new conversations.

Mike Courville: Thinking about the regionality of the issue, fact that workers can opt out of ag industry if not enough benefits, employers have to be able to afford the benefits. Like the trust idea. FQHCs great but not preventative. What would a trust look like, and how would it take into account migration?

Bob Severs: He is working with employers to develop employer-sponsored plans. Affordability is key. Partnered with large FQHC to be primary network for Kern County farms, private doctors will serve as back-ups, specialists. Working to keep their solution affordable. Needs to be way to modify the plans for farmworkers.

Ronald Coleman: Excited about new coverage options. Dismayed about the people who are excluded. CA probably has highest # of mixed-status families. Barriers to enrollment: fears, transportation, etc. Gov. Brown signed bills to reduce these barriers. Like to hear about what is working.

Sandy Young: Remember that our whole concept of health is wrong, focus on all the wrong things. That's why it's not affordable. Then small picture: patient advocates/promotoras are key piece. In Oxnard, done a lot at clinics, but want people to know about all the options for families – patient advocates need professional status, providers and clients can go to them and they are empowered to help people utilize system.

Laura Berumen: Need to build on existing structures. Have unique low-wage workforce that crosses to US every day – residents of Mexico. But there's also US insurance you can use across border in Mexico, very cheap. Maybe that can be expanded.

Dr. Mark Juretic: 25 patients weren't seen today because he's here. Norma is right that starting Jan. 1, the newly-covered are going to show up in the ER. Problem #1 is there are not more doctors to cover the newly Medi-Cal eligible. Problem #2 is Covered CA isn't paying enough. He's heard Medicare minus 20%. So where will those patients go? What will the quality of care be?

Joel: heard a lot about community solutions, regional solutions. A lot about families and mixed immigration status. Growing collaboration, recognizing symbiotic relationships and looking for solutions that work.

Presentations on New Models of Coverage:

Ed McClements's – Employer based coverage

The Hacia Salud Health Plan was set up to be funded as a CO-OP under the ACA. It had many attributes: Board members would be plan members. Used FQHCs as providers to keep families together. Joint employer and employee funded insurance. At least "bronze" level care but low deductibles and copays. Expanded mobile medical clinics to worksites, promotoras. Hired actuarial consultants. Now, with CO-OP funding not moving forward: need political will, like state of CA telling Feds we need a waiver to create a statewide network outside of the ACA for ag workers and other low wage workers. www.haciasalud.org. Ask Ed if you want the summary from the first application. Their application was revised to only focus on certain counties rather than statewide.

Bob S: Are you thinking of resuscitating the model? Don't have the money for the set-aside (actuarial reserves) to become an insurer. But employers could be self-insured, implement the model with safety net providers. It's possible to work with ACA to create a plan that pays more of the front-end costs than the bronze plans.

Patrick: Wouldn't you anticipate resistance from commercial insurers, who are resisting coops? No, because industry-wide effort over multiple third party administrators (TPAs). A lot of interest from employers and providers.

Joel: Seasonality issue? Statewide network of communication between community clinics/FQHCs would help, then TPAs, ag associations, UFW – anyone offering a health plan – could use. Same provider system as Medi-Cal.

Mark Juretic: How was it funded? Hadn't been totally determined yet. Want safety net providers to participate, knowing this population would show up in their ERs anyway. Trade off that providers would have a seat at the table, integrated into plan decision making.

Ed Kissam: Who pays the premium for seasonal workers? Have to work out these details. If working multiple places in same month, would be difficult to fund. If no paycheck at all, more of a problem. COBRA, exchange?

Model included urban areas too, didn't just include ag. Could include higher level executives, but assume they would have choices and contribute money. Non-discrimination.

Susan Gabbard: What did you get deductible and employer costs down to? Can go very low and still meet 60% actuarial value, but have to not cover certain areas. Ex: Could do $100 ded and $20 copay, but no in-hospital coverage. Joel: 10 essential health benefits don't apply to large group plans, just 60/40 coverage.

Juan Guerra, Reiter Affiliated Companies – Employer provided care and coverage

What can we do as industry to move forward? Reiter looked into Hacia Salud's model, but we didn't share urgency because offering benefits to entire population already. His model would add more benefits, they would be interested down the road. Would like to talk about strategy of 60/40 offerings.

Economies of scale allows us to sustain benefits. 25,000 employees annually. Committed to make difference in community in terms of health. Two initiatives: Sembrando Salud program and clinics. Worth the investment.

Have offsite clinics, La Clinica FreSalud, in Oxnard, Santa Maria, Watsonville, and partner with Western Growers in Salinas. Include office visits, lab work, generic medications, x-rays for virtually free. Employees pay $2/4/6 week for self/spouse/dependent care. Can walk in or set up appt. Leave clinic with medications, referrals set up. Saw 20,000 patients [und up] in 2012. Projected 22,000 in 2013. Will be a lot higher in 2014 because of ACA.

Challenge with ACA: had to change plan design. Was a $25,000 cap plan; had ACA waiver but expires. Unlimited plans far more expensive. Employee only premium going from $32 to $64/month. Anticipate that some won't be able to afford it. Hope that clinics can still support employees who cannot afford insurance. Looking for ways for clinics to be more efficient. Reiter is picking up 80% of cost of more expensive insurance.

Sembrando Salud: program in fields to get people to change behaviors, including exercise/physical therapy, healthy cooking. Diabetes is biggest problem. Also build sense of community – makes people happier, get help, healthier work environment. Program has run for four years now. Designed curriculum with UC Davis, piloted in 2009-10. Expanded to Mexico. Creating healthy ranch communities. Working with other employers to spread implementation and create bigger impact.

Patrick: Have you seen benefits on workers comp side? Yes, from clinics and Sembrando Salud. 15-20% reduction in past couple of years. Expect another 10% reduction with program implemented everywhere.

Juan U: Like that it is a peer-to-peer program. One of our promotoras is doing this program for you. Juan G: Yes, people don't trust white-collar workers.

Jo Ann: what about stress, not being integrated into community? Menu of options includes EAP – dealing with stress, especially during peak times. Crew leaders experience high stress. Jo Ann: does that include adult literacy? Not formally. Informally, outreach team does help workers. Partner with other organizations. Outreach team also helps on issues like sexual harassment, single mothers.

June Ponce: Their company is a partner. They have a fair in Watsonville to learn about resources. Our employees who went through the program looked very glad that the owners were involved in the awards at the end.

Juan G: 4,400 people show up to Oxnard employee fair to learn about services. 3,000 in SM. 3-4,000 in Watsonville. Close to 12,000 employees show up.

What if employee goes to hospital? Ray Lopez: Plan will cover hospital. If not covered, emergency Medi-Cal. We're here for them, so get people in on the same day, and treat people with cultural humility. About the connection – their "lean" philosophy deals with productivity, efficiency, front line people should be a part of it, getting people in when they are sick. Try to prevent people from going to hospital. Get people education and medication right then.

Juan G: We're here because of them, not "for" them. Clinic tries to prevent hospital, but we want to get to point where people don't have to go to clinic – SS does this. Caring for our people.

Walter Ramirez: Have you shared this with other growers, and what is their reaction? Yes, the vision is to externalize the program. We gathered 10-15 other growers in room, explained benefits, they are listening. They need the cost/benefit, so we're working on numbers – increased productivity, decreased time off…

Juan G: 2014 – working on making things run more efficiently. Tried hard to reduce cost of premiums on new plans. With Western Growers on Cedar plan, with our clinics as primary care – that saves the company $1 million. It's a much better plan than before. Also making shift, understand population more. So trying to move to self-insured plan. Consolidating carriers to get price reductions. Offer dental, vision, EAP, clinics, major medical. Looking to keep clinics for uninsured employees.

Dr. Max Cuevas – Clinic based models

Operates network of community health centers (CHCs). See about 144,000 patient visits annually, 10 clinics. 61,000 patients. Partnered with CHCs of five other counties (Santa Cruz, San Benito, San Luis Obispo, Santa Barbara, Ventura) to create a network of health centers for ag workers. Also tourism industry, construction. A while ago, got involved in legislation to have cultural and linguistic competency. Saw that med schools not producing doctors for rural CA, who spoke languages, set up a pilot project to recruit physicians and dentists in Mexico. UC system blocked this, saying their doctors not good enough. Now we know we don't have enough doctors for ACA, looking at this initiative again.

In 2005-06 CA shut down funding migrant health program, forced people to rely on sliding scales. So he approached legislator to set up trust fund. Had reimbursement rate of $72.50 per visit, including labs, etc. People have been asking to resurrect this trust fund concept. Looking at bringing it back, with additional CHC partners.

2014: old model was to set up HMO, put funds in reserve. Or physicians' network, make deals with health plans. New models: ACA allows networks of doctors to cut deals with health plans alone [how is this different?], need ability to put people in a hospital also. Experiment with HMO in Ventura County. Another experiment with health plan deal for services, with one or two local hospitals. Low-cost approach, quick, with local resources. Could replicate in each county. Everything is wide open, changed rules on how things could be put together, need to work quickly to put together sustainable models. Quality is important. Have a credentialed network.

Closing comments:

Sorry for running out of time. Great collaboration and ideas from disparate sectors.

Follow-up: we will synthesize what we have heard, get out minutes and themes, highlight what needs more work, name four or five things, spend more time investigating things you have buy-in about.

We will reconvene the Stakeholder Advisory Committee in a few months in the San Joaquin Valley (probably Fresno). We will be working on a policy report and legislative briefing to follow the advisory group meeting.

Additional information can be obtained from Joel Diringer, Diringer and Associates at joel@diringerassociates.com; 805-546-0950.