Health Care Coverage for California Farmworkers:

Improving Access in This Era of Health Care Reform

Thursday, July 10th, 2014
1:00 – 3:00 PM
California State Capitol, Room 112

Summary

I. Welcome & Introductions

Joel Diringer, JD, MPH, Diringer & Associates:

- *Review of agenda, housekeeping items*

Richard Figueroa, **The California Endowment**:

- TCE has a long history of working on farmworkers issues
- The work we have done on farmworkers health coverage falls under the broader focus of ACA implementation
    - Looking not only to have conversation, but also impact Statewide "Health Care 4 All" campaign

II. Background on Farmworkers Health Coverage

Ed Kissam, Werner-Kohnstamm Family Fund:

- There are about 600,000 farmworkers in California;
    - ¼ are women, most are married but a significant minority are single female household heads
- Although California farmworkers are less seasonal than other states, there is still a significant number that work less than 191 days per year who are deemed "seasonal" under the ACA
- 2/3 of farmworkers have less than 9 years of schooling; 9/10 speak little or no English
    - So navigating complicated system is difficult
- More than ½ fall under the national poverty guidelines and most would qualify for public health based on income
- 28% are covered by health insurance, of those with coverage 1/5 are receiving health insurance from their employer

- ¾ of farmworkers' children are US born, but that leaves 100,000 children without legal status that don't get coverage
- 21% of Californians under 65 lack insurance – in contrast, 46% of farmworkers fall into that category
- About one-fifth (21%) of the directly-hired workers get coverage from their employer but only 2% of those employed by FLC's do.
- Those that qualify for deferred action can get access to public coverage in CA, but most do not
    - 80% don't meet education or residency requirements for deferred action
- In 2015, looks like only 1/3 will have access to employer sponsored insurance (modest increase from the current 28%); another 10% of seasonal workers will be able to get coverage while working, but will lose that coverage when they transition employers`
- Some of the concerns with Covered CA plans are affordability and also appeal; in addition, it's hard for this population to navigate the various policies and changes in health care

III. Employer-Supplied Health Coverage

Ed McClements, Barkley Insurance:

- There is a great lack of understanding in terms of the details of the ACA; there have also been changes in regulations (i.e. seasonal worker/ seasonal employee definition)
    - Difficult to advise employers when rules continue to shift under our feet
- Most of the employers we work with are large employers; they are willing to work with us to insure that they are doing what they can to support coverage for workers, but there are still barriers

Jon Alexander, Western Growers:

- Have been busy implementing policy changes and working towards educating employers, enrollees, as well as internal staff through webinars, forums, etc.
- Looking for solutions that work for both sides
- Believe that employer sponsored coverage will be our best opportunity/ primary vehicle to provide coverage to workers due to immigration status
    - Immigration reform isn't gaining much traction in Congress
- Another alternative will be SB 1005 – Lara "Coverage for All"; in addition, there can be opportunities leveraged from the 1332 Waiver

Patty Benkowski, Western Growers:

- Mission of Western Growers was to serve agricultural workers
- Part of the challenge is that workers don't make enough money to afford some of the other plans (e.g. the Bronze plan under Covered California) – how can we create a product that workers can afford but also provides an appropriate level of care?
    - Pursuing private contracting and sponsorship of private clinics to serve this population
    - Created Cedar Health and Wellness Plans to meet worker needs
- Learned that transportation is a problem for this community, so if a person is unable to get care locally they will probably not get care at all
- Goal was to directly contract so we could participate in the pricing and insure that the price we give employers is affordable

- Goal is to work with local primary care clinics to increase access

Greg Jocelyn, United Ag:

- 44% of their plans had annual max
  - Premiums have doubled, if not tripled; Costs not passed along this year to employers due to sufficient reserves
- A real challenge is coming up - finding affordable plans that will also serve folks appropriately

Patrick Pine, RFK Jr. Health Plan:

- One of the unique challenges we face, is that most plans had fixed multi-year employer contribution contracts and when the law passed it didn't have any exceptions for this
  - Contracts need to be re-negotiated
- For multi-state employers and migratory employees, there is no good multi-state option
- Interested in:
  - Pursuing applications that may be beneficial to this community
  - Addressing challenges in finding funds to provide additional staffing in local clinics
  - Political consideration of creating a federal stop-loss for catastrophic coverage
  - Investment in public health

IV. Public Coverage

Betzabell Estudillo, CA Immigrant Policy Center:

- *Reference slides from "Undocumented and Uninsured: SB1005 Health for All"*
- 3-4 million will continue to be uninsured, about 1.4-1.5 million will be undocumented
- Undocumented people have Band-Aid care
  - Varies from geographic area, availability etc.
- SB 1005 – Health for All Act
  - Bill would provide coverage to all Californians despite immigration status through:
    - Providing full-scope Medi-Cal
    - Create a mirror/ parallel exchange
- Bill went through the Senate Health Committee with a lot of community engagement and momentum
  - 6/1 vote sent the bill to the Appropriations Committee, where it was suspended
  - There was not enough cost off-set at the time to move the bill forward
- We are looking at some other ways we can get the bill to move forward
- Cost Analysis of the Medi-Cal piece:
  - About $350-$360 million net increase in spending to implement and expand Medi-Cal to all Californians, but this is only a 2% increase of what the state currently spends on Medi-Cal
    - $0.02 to every dollar
  - An estimated 1.3 million persons would be expected to be eligible; of those, 690,000 – 730,000 individuals would be expected to enroll in 2015
- CA receives federal matching funds to provide emergency care to Californians – can leverage those funds for a wrap-around program
- Another cost-off set would be to generate revenue – tax, county realignment, etc. '
  - *Other cost off-sets are included in the UCLA brief*

Gilbert Ojeda, California Program on Access to Care (CPAC):

- *Reference slides from "The Safety Net: Health in California Counties Under the Shadow of ACA Implementation"*

V. Direct Care for Farmworkers

Ben Flores, Ampla Health:

- With health care reform, there is still a question of who pays for it?
- No funding for indigent care, which is a challenge
    - We are partly funded through the Dept. of Human Services but contrary to popular belief, this funding is very small – we largely rely on Medi-Cal and other type of insurances

Dr. Max Cuevas, Clinica de Salud del Valle de Salinas (CSVS):

- In Monterey County, the need for expanding clinics is great; we served 60,000 people in the past year
- 45% of the folks who come in are uninsured, 65% of agricultural workers lack insurance
- 85% of ag workers fall under the federal poverty level
- It costs our system just over $500 to provide services per year, per person
    - Need to look at how we can drive this cost down without compromising quality of care
- Need to invest in the people that are here working, building our economy – despite legal status
    - But the bottom line is who is going to pay for health care?

Corinna Adams, Reiter Affiliated Companies:

- Range between 3,000-25,000 people who we work with to offer employment, benefit services, etc.
- ACA hit us hard – had to take away the cap plan, etc.
- We have own our own private clinics and use those as primary care facilities for farmworkers
    - A significant amount of cultural development needs to happen
    - Leveraging opportunities in Medi-Cal, etc.
        - Added patient coordinators to help folks find programs in the community to address specialty care, fill out applications, etc. (help them through the processes)
    - Working towards extending, changing clinic hours to better serve this population
    - Getting people involved in physical activity, healthy nutrition programs etc.
        - Working towards lowering health costs over time

VI. Where Do We Go From Here?

Joel Diringer:

- Summary of issues discussed:
    - Availability of coverage is often based on status (immigration documentation, seasonality, employer size)
    - Affordability of coverage and care
    - Provider networks

    - Funding
- Solutions:
    - Immigration reform
    - Expanded public benefits (e.g. SB1005)
    - Re-investment in the Migrant and Seasonal Agricultural Worker Program at the state level
    - Providing direct care through migrant health centers, health plan provided networks, etc.
    - State Innovation Waiver Section 1332 under the ACA
        - Opportunity to waive strict ACA requirements to bring together something that works well for this population by aggregating employer contributions with Medi-Cal (restricted scope and full scope), migrant health center provider network and perhaps Medi-Cal plans to provide full year coverage.

VII. Q&A Discussion

- **Q:** We have local initiatives (Medi-Cal health plans) that are county driven, and many plans have put their own money into support – have we given thought about talking to them about creating partnerships? Leveraging local resources and building on existing models that are working well…
    - **A:** Those conversations are going on; we could look at this as another vehicle
    - **A:** Local thinking creates local results
- **Q:** With regards to the provider network, are you doing any kind of monitoring to insure adequate services and cultural competency?
    - **A:** To a certain extend; contracted networks usually have their own monitoring and tracking system; but networks are receptive to input from plans
    - **A:** Generally, with a private network, you have more control in this area
- **Q:** What strikes me most is the large number of farmworkers who don't know their symptoms, and if they are aware they don't know what to do about it; secondly, there are communities where there is not a single provider
    - How do we build the knowledge and build the access to care?

Meeting minutes and handouts are posted at: http://diringerassociates.com/farmworker-health/


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