



Impacts of the Affordable Care Act on Farmworker Health Access

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- To Jo Ann Intili, my co-trustee at WKF, for leading us forward in ongoing efforts to understand the ways in which ACA are likely to impact community health centers and entire communities
- To Don Villarejo, farmworker researcher par excellence, who first put this issue on our “radar screen” , a few years back
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5 Key Areas of ACA Impact

- On farmworkers' eligibility to purchase subsidized health insurance on state exchanges
- On farmworkers' Medicaid eligibility
- “Play or pay” provisions' direct impact on agricultural employers' offers of health insurance to their workers
- Confusion among agricultural employers and FW's re complex and changing regulations for employer coverage (e.g. delay to 2015 for employers with up to 100 FTE, “measurement period calculation” methods, insurance policy specifications)
- Impact of perceived and actual ACA provisions on community and migrant health centers' patient mix and ability to provide service to low-income farmworkers (sustainability)

ACA Impact on FW Families' Access to Subsidized Health Insurance

- Complex impacts depending on the legal status of the individual farmworker and family members in relation to household size, income, annual pattern of work
- Impacts are modulated by each state's stance vis-à-vis expanded Medicaid and treatment of PRUCOL individuals
- Local impacts vary due to county approach to indigent health care—both sub-population priorities and covered services
- Overall access to subsidies varies for different FW sub-populations: women vs. men, older vs. younger workers, parents, children, lower vs. higher income households

Subsidized Insurance and Medicaid: Great Potential, Limited Promise

- Based on family income, almost all (at least 85%) of FW families would qualify for subsidized health insurance. More than half (58%) would qualify for Medicaid.
- But farmworkers without legal status cannot receive subsidies or qualify for Medicaid (except for a limited sub-set of services).
- But even if there is immigration reform, newly-legalized FW's would remain ineligible for subsidized insurance until 5 years after they achieve LPR status (in 5-10 years)
- States can make a significant impact—e.g. California allows DACA recipients, maybe other PRUCOL, to qualify for Medi-Cal.
- In California, SB 1005 “Health for All” (Lara), introduced February 14, would solve the basic problems.

State Health Exchanges and Medicaid: The Tattered Safety Net

- Nationwide, half of U.S. farmworkers lack legal status. In the Pacific Seaboard region, more—about two-thirds of FW's (67% in California, 59% in the Northwest) lack legal status
- About three out of four farmworker children are U.S.-born and eligible for Medicaid or subsidized insurance—but 22% of the children lack legal status.
- Younger FW's, women raising children on their own (about 8% of the farm labor force), the most seasonally-employed workers, the poorest families, and migrants least often have legal status
- Scope?: Are FW's the “canary in the mine” showing us the problems workers in other immigrant-dominated low-wage occupations (e.g. restaurant workers, construction) will face?

Beyond the farm labor force in a typical rural agricultural town: community-wide impacts

Age Group	Unauthorized immigrants as % of community residents
5 or under	2.6%
6–12 years old	12.7%
13–18 years old	20.0%
19–24 years old	49.3%
25–34 years old	44.2%
35–44 years old	20.7%
45–64 years old	15.2%
65+ years old	---

Based on New Pluralism data from Arvin community survey (2005–2006), Ed Kissam presentation, APHA, 2010

Impacts from the employer mandate: Exclusions due to employer size

- In 2015, only employers with 100+ FTE workers need to offer their workers insurance. In 2016, employers with 50+ FTE workers must offer insurance.
- With labor costs amounting to 40–50% of total labor-intensive farm production costs and with a FTE farmworker costing about \$23,000/yr. “small” farms are those with less than \$2.4 million in annual sales and “medium-size farms” are those with \$2.4–4.8 million.
- So, in 2015, between 60–80% of Pacific Seaboard workers will work for an employer who doesn’t need to offer them insurance. In 2016, the number of FW’s excluded from the mandate because their employer is “small” drops to “only” 40–60%. That is--only about 275,000–400,000 FW’s.

Additional Factors Affecting FW Coverage, Uptake, and Ripple Effects on Community Health Centers

- **ELIGIBILITY** In addition to a worker's employer's size, their approach to "measurement method" re seasonal and part-time workers determines if he/she must be offered coverage
- **UTILITY** Seasonality of a FW's employment determines whether employer-provided insurance has utility in improving access to health care. Real problems for semi-seasonal workers
- **AFFORDABILITY** Earnings, family composition, health status, and cost of premium vs. deductibles impact attractiveness of health insurance offered by an employer
- **ORGANIZATIONAL IMPACTS** Changed regulatory environment and resulting employer and farmworker choices affect community and migrant health clinic patient mix, utilization, and revenue

How Many FW's will be excluded from employer coverage as “not full-time” workers?

- February 12th final IRS regulations likely allow exclusion of many FW's who work 195 days or less for an employer as “part time” from the mandate. This means that at least half (~48%) of FW's may not get employer coverage because they are seasonal.
- The complexity of the IRS regulations re employer options for “measurement period” , treatment of new vs. current employees makes for uncertainties about exactly how many FW's will be deemed “part-time”—in 2015. And it's even murkier in 2016.
- Some experts believe the good news is that when employer policies are renewed, insurers may require that at least 70% of the employer's workforce be covered to issue a policy. This may induce some employers to be more generous in deciding which seasonal workers are “part-time” or “full time”

Will employer coverage really be available? If so, how useful will it be?

- It is not totally clear exactly how many FW's with 200+ total FW days each year would be covered by their employers.
- About one-third of these close-to full-time workers with the most days of FW work/yr. have two or more employers, e.g. 70 days for an Oregon strawberry farm, 130 days in a nursery
- Even FW's with the steadiest employment may end up being unemployed for 1-3 mos./yr. and cease to be eligible for the employer's policy during that period.
- Assuming agribusiness employers pass on the maximum ACA-allowed share of the insurance premium to their workers (9.5% of earnings), a typical FW earning about \$18,000/yr. would need to pay about \$1,700 for a Bronze policy with a \$5,000 deductible.
- Affordable? Attractive? Manageable? Not really...especially since the mandate does not require the employer offer health insurance to cover a spouse.

Uncertainties in Estimates of ACA Impact: Overlap of FW sub-groups vis-à-vis access



- NAWS provides reliable estimates of overlap between seasonal workers and legal status, as well as income, family size, and demographic characteristics
- But USDA/ERS farm taxonomy makes estimation of the overall proportion of workers working for “small” or “medium” size employers as defined by ACA challenging. USDA data is not linked to NAWS and has no detail on demographics, legal status, worker earnings, FW household composition

Different Pathways for Access to Health Care: Most of them Problematic, Some Blocked

Via mandate and subsidized when out of work	Only via mandate, <u>not</u> when out of work	Only access to subsidized coverage or Medicaid	No ACA access at all—limited as medical indigent
<ul style="list-style-type: none"> ✓ Employer=big ✓ Status=legal ✓ FW=semi-seasonal ✓ or non-seasonal 	<ul style="list-style-type: none"> ✓ Employer=big ✓ Status=not legal ✓ FW= semi-seasonal ✓ or non-seasonal OR ✓ spouse works has insurance from work (indirect) 	<ul style="list-style-type: none"> ✓ Employer=not-big ✓ Status=legal ✓ Income= low or medium OR ✓ Employer= big ✓ Status=legal ✓ FW=seasonal ✓ Income= low or medium 	<ul style="list-style-type: none"> ✓ Employer= not-big ✓ Status=not legal OR ✓ Employer= big ✓ Status= not legal ✓ FW=seasonal
Mostly older, more full-time, legal FW's	Income-sensitive and intermittent, problems for semi-seasonal	Skews toward legal and low-income. bi-modal distribution--very young, middle-aged	Undocumented working for small employer or seasonally for large

Estimated 2015 Distribution of FW Access via ACA (“small” and “medium” employers excluded)

Access within the overall farmworker population	
No option—no access to subsidy or employer insurance	57%
Via mandate—no access when seasonally unemployed	10%
Via mandate—access to subsidy when unemployed	5%
No mandated employer insurance but can access subsidies	28%
No definite access—spouse works, is covered by employer	2%

**Model assumes 70% of FW's employed by “small” or “medium-size_ employers (<100 FTE), that 48% are considered part-time due to seasonality, that 67% lack legal status and that the workforce of small, medium, and large agribusiness employers are similar in seasonality of employment and legal status to the overall FW population (actual distribution is unknown)*

Estimated 2016 Distribution of FW's ACA Access (only "small" employers excluded)

Access within the overall farmworker population	
No option—no access to subsidy or employer insurance	46%
Via mandate--no access when seasonally unemployed	21%
Via mandate--access to subsidy when unemployed	12%
No mandated employer insurance but can access subsidies	20%
No definite access—spouse works and is covered by employer	2%

**Model assumes 40% of FW's are employed by "small" employers, that 48% of FW's are considered "part-time" due to seasonality, that 67% lack legal status and that the workforce of small, medium, and large agribusiness employers are similar in seasonality of employment and legal status to the overall FW population (actual distribution is unknown)*

Policy and Practical Issues: Net Result of the Employer Mandate on FW Health Access?

- As a result of ACA rules, 15% of FW's in the Western U.S. might be offered a policy by their employer in 2015, about 33% in 2016 (at least for part of the year).
- But net impact of the ACA employer mandate rests on how many of the newly-covered lack legal status, how many are seasonally unemployed, the take-up rate, and how many already had coverage.
- The mandate may provide FW's who work less than full time only intermittent coverage. FW's with legal status can turn to the exchanges or Medicaid when unemployed but those who can't are left without coverage while out of work.
- One-fifth (19%) of FW's already get coverage from their employers. Most who are determined to be "full-time" under ACA rules will be those already covered by their employer (typically those working >200 days/yr., often older, with legal status)

Policy and Practical Issues: Which sub-populations are left without any access?

- Overall More than half (57%) of FW's are left totally out in the cold in 2015, and in 2016 slightly less than half (46%) are. Who are they?
- The more seasonally-employed and the undocumented The older FW's with legal status typically secure a bit more work. Many are part of an employer's "core labor force".
- Women with children Many work only seasonally or have more intermittent employment due to problems of child care, transportation. The employer mandate does not require spouses be covered.
- Aging post-IRCA long-term settlers who no longer are as competitive in the labor market as they once were and who arrived too late for amnesty
- Migrants, especially the recently-arrived younger FW's—solo males but, also, young indigenous families. These vulnerable groups already have great difficulty "navigating the system"

Harsh ACA impacts on mixed-status and seasonally-unemployed FW households

- Complex decisions in HH's where one or both adults lack legal status and/or where one or more children lack status
- Assessing trade-offs between affordability and utility of insurance offered by employers for different sub-groups of workers and implications for diverse HH configurations
- Confusion dealing with the patchwork quilt of varying provisions for access to free services for medically indigent individuals in different locations (type of services covered? eligibility guidelines? Application procedures?)
- Immigration reform legislation has promise. But it is currently not likely to include provisions allowing immigrants in the process of legalizing access to health care (e.g. the political demise of Senator Hirono's Amendment 16 to S. 744)

The Possibility of a Service Network Stretched to the Breaking Point?

- Need for greatly increased FW outreach and education about how to navigate the system, answers to questions from families experiencing problems, trouble-shooting
- Demands on health center personnel to be even more productive--more patient case management, paperwork burden transitioning between payment sources, higher rates of non-payment among patients who pay for their own care
- Other health providers (hospitals, private providers) steering patients to health centers as providers of last resort
- Problem-solving and support for patients who have long, long waits for specialty services, advice/consolation for those for whom there are no options
- Outreach, intake, advice to migrants re different rules and procedures in different states and counties.

Potential Organizational Impacts and Promising Strands of Advocacy

- Difficult relationships with partner organizations as a result of competition, “cherry picking” patients, unrealistic county or state-level planning as a result of complex/shifting regulations
- Increased staff burnout and turnover due to increased workload?
- Unwelcome implementation of “fiscal triage” by ceasing to offer some types of services, creating new procedures to assure payment, or restricting service to some
- The argument for states to fund services for those barred from subsidized insurance or without access to an employer policy is stronger than ever (“Health for All” SB 1055 in California)
- States pressuring the feds to fill the gaps in ACA may hold out promise. A good deal of dialogue on the need for impact assistance to states for non-LPR’s is already underway as part of discussions of planning for immigration reform implementation

Conclusions

- A small minority of FW's and their dependents will benefit from ACA—primarily the families with legal status, more stable jobs, and higher incomes. The majority will find their access to health care unchanged or worse.
- ACA has been oversold as a “solution” to FW's (and other undocumented immigrants') problems accessing affordable health care. Provisions re the employer mandate and access to subsidized health insurance are both very problematic.
- For the moment, community/migrant health centers and policy advocates will need to work hard to create solutions and help farmworkers navigate the treacherous terrain of ACA
- The ball is now in the states' court, given the problematic intersection of federal policy on health care and immigration. State funding may perhaps be feasible, state pressure on the federal government for fiscal solutions will mount.

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