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Migrant Farmworkers and Access to Health Care in Minnesota:
Needs, Barriers, and Remedies

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Abstract

Every year, migrant farmworkers (MFWs) travel from southern Texas to Minnesota to provide the temporary labor needed to harvest seasonal Minnesotan crops. Migratory agricultural labor exposes workers to increased risk of occupational hazards, communicable disease, and chronic illness. However, the agricultural industry does not offer employer-based health insurance to these seasonal workers, and provides wages insufficient to otherwise cover the cost of health care services. This research investigates the financial and non-financial barriers to health care for Minnesota's MFWs through interviews with staff from Migrant Health Service, Inc., the only federally-designated Migrant Health Center (MHC) in Minnesota. The findings show that language, immigration status, and affordability are three prominent barriers to health care for MFWs. While the Affordable Care Act increases their access by providing additional funding to MHCs, the law does not extend private or state-based insurance to many MFWs due to their immigration status. Thus, because of limited financial means, MFWs remain restricted to MHCs for health services.

Advisor: Terry Boychuk, Department of Sociology

Health care and immigration are two issues that have failed to benefit from political agreement or collaboration. This situation has held true throughout the passage of the most recent federal health care law, the Patient Protection and Affordable Care Act (ACA), as elected officials largely disagreed on how to include undocumented immigrants in health policy considerations. The issue boiled down to a matter of insurance eligibility: would undocumented immigrants be able to purchase health care coverage? While individuals without legal U.S. residence would remain ineligible for publicly-funded programs like Medicare and Medicaid, some liberal and Latino congressmen advocated for the right of undocumented immigrants to be able to purchase insurance through the Health Insurance Exchanges created by the ACA. However, conservatives from both parties wanted to restrict undocumented immigrants from any health services created by the new law (Jacobs and Skocpol 2010). The tenuous relationship between health reform and immigration policy became evident during President Barack Obama's speech at a joint session of Congress in 2009, when the president claimed that the proposed reforms would not apply to those who work and live in the U.S. illegally. This statement caused Congressman Joe Wilson (R-SC) to yell, "You lie!" from the floor, acting under the impression that the pending health reform allowed undocumented immigrants to purchase insurance through the Health Insurance Exchanges. Ultimately, the final bill omitted immigration issues from its content, as proponents feared that the inclusion would hinder the progress of health care reform. In the 2010 federal health care law, undocumented immigrants are not allowed to buy insurance through the exchanges, and are also banned from publicly-funded programs such as Medicare and Medicaid. Undocumented immigrants are also exempt from the ACA's insurance mandate, as well as citizens and legal residents making incomes so low that they do not have to file a tax return (currently \$9,500 as an individual and \$19,000 for married couples) (The Henry J. Kaiser

Foundation 2012a). However, this lack of insurance coverage majorly contributes to this group's overall poor health.

The controversy of immigration's place in health care holds significant importance for the migrant farmworker population. The U.S. Department of Labor has conducted the National Agricultural Workers Survey with three annual cycles of face-to-face interviews since 1988 (U.S. Department of Labor 2011). The 2007-2009 results indicate that almost half (48 percent) of migrant farmworkers are undocumented immigrants (Carrol, Georges, and Saltz 2011). The Congressional Budget Office estimates that the ACA will provide insurance to an additional 11 percent of the U.S. (from 83 percent today to an eventual 94 percent), but one third of the total population that will remain uninsured will be undocumented immigrants (Jacobs and Skocpol 2010). The U.S. agricultural industry depends on migrant labor, as the estimated 3 to 5 million migrant workers in the U.S. make up a third of the agricultural industry's labor force that produces the nation's food supply (Kandel 2008). American citizens have been evacuating the rural farmland since the beginning of the 20th century, due to both long-term agricultural depression from post-WWI overproduction and decline, and the subsequent Dust Bowl of the thirties that destroyed much of the rural landscape. Especially as the rural population has shrunk (today, just 18 percent of the total U.S. population lives in a rural area, when at the turn of the 20th century, 60 percent of U.S. citizens were residing in the countryside), the agricultural industry has had to rely on migrant farmworkers to harvest their crops in the absence of American farmhands (U.S. Census Bureau 1995; The World Bank 2011). Workforce shortages aside, studies from Virginia, Michigan, and Wisconsin have also shown that the presence of migrant farmworker employment increases the overall economic output of local communities

and adds state revenue and additional jobs to their community (Trupo, Alwang, and Lamie 1998; Rosenbaum 2001; Slesinger 2003). For ethical and economic reasons, increased access to health care for migrant farmworkers requires attention, as they remain medically underserved with marked health disparities.

Health Status of Migrant Farmworkers

According to the U.S. Department of Labor, a migrant farmworker is a seasonal laborer that must travel more than 24 hours from their permanent residence to their job (2010). Every year, between 20 and 35 thousand farmworkers migrate from southern Texas to Minnesota for seasonal employment in the cultivation of sugar beets, green peas, sweet corn, and other state crops (Contreras, Duran, and Gilje 2001; Ziebarth 2006). This migration pattern follows the harvesting periods across the country, as temporary jobs for planting, cultivating, harvesting, and processing standard crops depend on the region and season. The occupation creates substantial health disparities that typify the migrant population. Jobs in agriculture notoriously expose workers to harmful pesticides, and negative repercussions manifest in the forms of rashes, vomiting, headaches, and neurological damage. This chemical contact impacts every generation as well, as exposure has been linked to birth defects and many types of cancers (Hansen and Donohoe 2003). Propagated by low hourly wages and the lack of year round employment, migrant families are unable to afford quality housing. Close living quarters, poor temperature control, and more chemical exposure from tracking in pesticides on clothing harm the health of migrants at home as well (Arcury et. al. 2009). The proximity to others increases the rates of communicable disease, and these living conditions produce disease patterns that resemble those of the early twentieth century, characterized by parasitic infection, food and water borne illness,

and agitated states of chronic disease (Davila et al. 1995). Ironically, the migrant farmworker population lacks the ability to purchase and prepare nutritious food due to the insufficiency of available and affordable options, and also due to the constraints of their housing accommodations. Both occupational hazards and nutritional deficiencies provoke the need for emergency care; for Midwestern migrants, these incidents commonly include upper respiratory infections, back injuries, neck pain, hearing loss, dental problems, diabetes, and high blood pressure (1995). The migratory pattern itself accounts for the continuation of many health conditions. Research estimates pose that less than 15 percent of farmworkers receive regular health care, and without a consistent source of primary care, health issues like malnutrition and diabetes, communicable disease, and occupational harm from chemicals and machinery acutely impair the health status of migrant families (Castillo-Morales, Pergament, and Durkin 1995; Rural Assistance Center 2012). As a transient group of people, migrant farmworkers change their residences as the harvesting seasons change, and this situation inhibits sufficient state and federal attention to this population's health disparities. Furthermore, a widespread lack of health insurance contributes to their poor health, with 2000 NAWS data indicating that 85 percent of respondents were uninsured, compared to 37 percent of other low-income adults nationally (Rosenbaum and Shin 2005). With many population-specific factors working against them, migrant farmworkers annually traverse the country in a state of ill health.

The Affordable Care Act emerged with the aim of improving the health of populations that have struggled from hindered access to health care. In this era of health care reform, a series of implementations will occur on both state and national levels to incrementally apply the text of the law, and this research aimed to discern whether the Affordable Care Act will work to

increase access to health care for the migrant farmworkers of Minnesota, a population characterized by health disparities from both occupational hazards and transient migration. The contemporary nature of this health care reform law warrants a policy analysis to evaluate its ability to increase health care access for a population that has historically encountered barriers to health care services. Thus far, previous research has exposed the poor health status of the U.S. migrant farmworker population, and in this decade, research has analyzed how the ACA will affect particular U.S. populations, including undocumented individuals. However, the particulars of the migrant farmworker population, including their transient nature, ethnic composition, and legal status (recall that only half of migrant farmworkers are estimated to be living undocumented in the U.S.), determine how the ACA will affect their access to health care. The relationship between Minnesota's migrant farmworker population and the ACA has thus far been unexamined. Minnesota's migrant workers maintain a trans-state identity, which influences the amount of state and federal attention they receive, and Minnesota depends on only one federally-funded Migrant Health Center organization. This research investigates the current barriers to health care for Minnesota's migrant farmworkers, and determines whether the implementation of the ACA will be effective in overcoming these barriers to increase the health care access of migrant farmworkers. To analyze the law's effectiveness, I sought the insight of Minnesota's only federally-funded Migrant Health Center, Migrant Health Service, Inc.

Access Defined

For policy analysis, it is important to define what is meant by increasing "access" to health care. Access is a commonly used term in public health circles, but the word alone is vague and indeterminate of specific measurements. Penchansky and Thomas operationalize the term

“access” into five observable categories measuring how well a health care provider “fits” the client’s needs (1981). To the authors, access prevails as a measure of the *availability* of existing health services and providers, where availability refers both to the number and type of resources offered. Secondly, *accessibility* (not to be confused with the more extensive term “access” currently under consideration) refers to the physical ability of the client to reach the location of the provider. *Accommodation* references the provider’s organizational system to receive clients, and whether this system matches the client’s needs (e.g. hours of operation, capacity for walk-in appointments, etc.). The *affordability* of health care calls attention to the ability of the client to pay for provider-offered services, and also to the methods the provider utilizes to accept payment. Lastly, Penchansky and Thomas include *acceptability* as a measure of health care access, which describes the clients and providers’ perceptions of one another and the actions they take as a result of these attitudes. While each of these measures of access undeniably affects the others (e.g. a shortage of physicians (less availability) affects the hours of operation at a local clinic (decreased accommodation)), the authors dissect an otherwise generalized term and create observable categories that can be used to analyze the specific outcomes of health care policies. This research utilizes these five measures of Penchansky and Thomas’ operational definition to determine whether the ACA works to increase access to health care for Minnesota’s migrant farmworker population.

This paper will detail the provisions of the ACA that specifically address access to health care for Minnesota’s migrant farmworkers and their families, which include the additional funding for Community Health Centers, and potential insurance coverage through Medicaid expansion and the Health Insurance Exchanges. Prior to discussing the federal law, however, this

paper will provide historical context for the U.S. migrant farmworker's health, supply previous literature on the barriers to health care that exist for this demographic, and present past and ongoing state-based programs that have attempted to remedy the inhibited health care access of migrant farmworkers. Then, from informational interviews with Migrant Health Center staff, this paper investigates the most prominent barriers of Minnesota's migrant farmworkers that deter access to health care today, followed by the ways that the ACA and federally-funded Migrant Health Centers address or fail to compensate for each. To conclude, this research will expose the persisting gaps in this latest chapter of health reform that do not address the hindered health care access for the migrant farmworker population, which perpetuate the health disparities that exist today.

Previous Literature

The health disparities between the migrant farmworker population and the average American household persevere owing to features specific to this population. The failings of past migrant health programs, the pervasive population-specific barriers to health care, and the insurance system to which they are unsuitable candidates make current health policy changes necessary to improve the health of this population. As the ACA unfolds in implementation stages, the provisions pertaining to this population's access need evaluation.

Historic Beginnings

Past policies have attempted to address the health needs of the migrant farmworker. The federal government became interested in protecting the health of temporary agricultural workers during the New Deal when the Farm Security Administration implemented rural rehabilitation

programs in direct response to the era's large increase in U.S. migrant labor. As the Dust Bowl took vast swaths of farmland out of use, farmers were transformed into migrant farmhands, and moved west to look for wages. Previously, the plight of the migrant worker had remained obscure to the mainstream public and policy makers, as the majority of workers were part of minority groups or foreign born. However, after the Dust Bowl, 85 percent of the migrant farmworkers were white, displaced Americans (Grey 1993). This proportion is in contrast with today's migrant farmworker population, as 2007-2009 NAWS data show that 72 percent of farmworkers were born outside of the U.S. and 68 percent originate from Mexico (National Center for Farmworker Health, Inc. 2012a). Society held migrant workers in ill regard in the Dust Bowl era and viewed them as squatters. Moreover, not all state governments could provide services for the sheer number of farmworkers living in deplorable conditions. The California State Emergency Relief Administration led the movement to assuage the situation, and in 1935, provided housing to workers using the federal and state rural rehabilitation funds to construct migrant camps alongside the crops. The Farm Security Administration later took up the project and built over 250 camps throughout the next ten years. The Administration expanded its role in the community and began to address population health by implementing a migrant health program in 1937. This measure assigned nutritionists and public health workers to address the health needs of camps, which was a crucial service for camp-dwellers, as their migratory residency status made them ineligible for many local and state health programs. The program evolved into Agricultural Workers Health Associations, which grew to encompass nurse-provided health education and a fee-for-service payment system for care from physicians. The demise of the Farm Security Administration and its programs came during World War II when

cost-conservative congressmen defunded the operation, and by 1946, all federal camps were boarded up and physicians relocated.

Barriers to Health Care Access

National estimates suggest that less than 15 percent of migrant farmworkers access regular health care services, and Carson, Snyder and Jensen identified three principal barriers to explain why migrant farmworkers in Pennsylvania seldom receive health care attention (2004). Through focus group interviews with 45 Latino farmworkers, 78 percent of which were born in Mexico, the researchers found that the most prominent barrier to health care is language. Many farmworkers do not speak English, which makes navigating the health care facility a complex process. Many clinics do not have bilingual staff or translators, meaning that patients may not even benefit from an appointment if they cannot comprehend treatment guidelines or the importance of follow-up care with the provider. The second barrier arises from the lack of health insurance, and analogously, the lack of financial means to afford care. Only 12 percent of the study's participants had health insurance, and the authors attributed this lack partly to the fact that almost 60 percent of the employers that contracted the study's Latino migrant farmworkers did not provide them health insurance. Additionally, many migrant workers believe they are ineligible for public insurance programs such as Medicaid, and therefore do not apply. This same behavior generates low rates of enrollment in other needs-based public programs (e.g. food stamps or the Women, Infants, and Children program). In the Pennsylvania study, the migrant workers frequently sent money to extended families in their home countries, so in fee-for-service situations without health insurance to cover the cost, they chose not to allocate their wages towards health services. The authors identified a lack of transportation as the final barrier to care.

Public transportation does not commonly exist in the rural areas where the agricultural industries are located, and many farmworkers lack personal transportation, thus making them dependent on a co-worker or friend's mode of transport. The authors' findings exposed that three of Penchansky and Thomas' five measures of access were compromised: Without a common language, staff that could communicate with the population were *unavailable*; without insurance, services were *unaffordable*; and without reliable transportation, providers were *inaccessible*. The results of their study showed that the merging of the current health system and the demographic elements of the migrant workers resulted in a poor fit and contributed to low levels of health care access.

State Remedies

An assortment of variables inherent to the migrant farmworker occupation limits the population's access to health care. The profession makes health care unaffordable on account of its low hourly wages and lack of employer-based health insurance. Furthermore, since employment only lasts as long as the seasonal harvesting period, the occupation necessitates continual movement across state borders in search of additional employment throughout the year. Migration prevents the attention of a consistent primary care provider and produces a multi-state identity that renders state-based programs inefficient to provide long term care for this temporary and mobile population. Some states have recognized the circumstances of migrant farmworkers, and have thus attempted to form programs with a higher degree of "fit" for the population's distinctive characteristics.

The Robert Wood Johnson Foundation partnered with the State of Florida Department of Health and Rehabilitative Services in 1994 to accommodate for the migratory characteristic of farmworkers and its affect on the population's health. The two organizations together piloted a tuberculosis-screening program in northern Florida to get treatment to the large number of migrants contracting TB that seasonally migrated north along the eastern coast. At the program's inception, medical and nursing staff screened migrants for TB at a weeknight clinic, where staff could provide treatment therapy and also address other medical conditions. In 1996, the program was able to secure a portable X-ray to screen migrants in the fields. The program coordinated care with the public health organizations of northern states, and in 1997, the State of Florida contracted an upstream coordinator to train outreach workers in North and South Carolina on how to conduct TB treatment therapy and patient education. Even after the Robert Wood Johnson Foundation grant had ended, the network of care coordination continued to expand. The State of Florida organized their efforts with the most northern state on the migrant stream by coordinating care with providers in New York. Overall, 93 percent of active TB cases continued their therapy. For latent cases, therapy adherence depended on the migration pattern of farmworkers: 86 percent of seasonal farmworkers who remained in Florida continued their therapy, while only 77 percent of migrant farmworkers who moved north continued their therapy (Robert Wood Johnson Foundation 2007).

More recently, the Texas Association of Community Health Centers (TACHC) established the Texas Migrant Care Network in 2008 as a Medicaid portability program. The network includes a series of health centers outside of Texas that have agreed to enroll as Texas Medicaid providers, and will therefore accept Texas Medicaid as a form of payment. These

health centers lie along the migrant streams that originate from Texas and move outward across the U.S., and include Migrant Health Service, Inc. in Minnesota. Medicaid portability is of utmost importance for low-income, mobile populations. Key migrant health stakeholders in Texas, including TACHC, convened in 2008 to discuss potential strategies for keeping migrant children insured (Coburn, Lara, and Blasi 2009). TACHC decided on the interstate provider network organizational model, instead of a Multi-State Medicaid card model that would allow for payment reciprocity between different states. The program has not expanded the Texas Medicaid program to include new eligibility groups; Texas Medicaid still limits eligibility primarily to low-income children, their parents, and pregnant women that are either U.S. Citizens or have been legally residing for over five years (Texas Association of Community Health Centers 2010). The program merely allows these same eligible persons to utilize their Texas Medicaid insurance benefits at specific providers while they are working out of state. This interstate provider network attempts to let eligible persons maintain their Texas Medicaid insurance throughout the year, regardless of physical location in the U.S. However, the majority of migrant farmworkers do not fit into the eligibility groups of Texas Medicaid, and the network only contains enrolled Texas Medicaid providers.

The Affordable Care Act and Migrant Farmworkers

The Patient Protection and Affordable Care Act passed into law on March 23, 2010. As alluded to previously, policies that would reference immigration were largely excluded from the text. However, the ACA does include two components that potentially affect the health of migrant farmworkers: additional funding to Community Health Centers, and increased access to health insurance options through Medicaid expansion and the Health Insurance Exchanges.

Migrant Health Centers. Decades after the Farm Security Administration intervened, barriers to health care still exist, and negatively affect the health of migrant farmworkers. The NAWS data from 2000 indicate that only 20 percent of migrant and seasonal farmworkers reported the use of any health care services in the preceding two years (Rosenbaum and Shin 2005). However, of those that seek services, many go to federally-funded Migrant Health Centers, which deliberately accommodate for these population-specific barriers. The creation of these centers stem back to World War II when the loss of manpower left the agricultural industry with an insufficiency of workers. To respond, the U.S. established the Bracero Program that brought 4.5 million guest workers from Mexico over 22 years to fill the labor void (Bracero History Archive 2013). In response to this large influx of farmworkers, the federal government assumed part of the responsibility for their care and passed the Migrant Health Act, which subsequently created the Migrant Health Center program in 1966. Included under the broad umbrella term of “Community Health Centers,” Migrant Health Centers will undergo considerable expansion through the ACA’s allocations of \$11 billion of new funding to these health centers. Beginning in 2011, the Health Resources and Services Administration (HRSA) will continue to distribute this health center funding over a five-year period, and expects to provide increased health care access to 20 million additional patients (National Association of Community Health Centers 2010). As a primary care provider location for many living in the rural environment, Community Health Centers increase the availability and accessibility of health care for areas with limited health facilities. Already, the ACA has allocated two grants totaling \$90,000 to Migrant Health Service, Inc., the only Migrant Health Center in Minnesota (Merrill 2011; Health Resources and Services Administration 2012a). Even though the total \$11 billion of funding is estimated to double the amount of patients at Community Health Centers

nationally, significant contention accompanied the financial allocations (U.S. Department of Health and Human Services 2010). For Community Health Centers to receive federal funding, they must comply with Title VI of the Civil Rights Act of 1964. Title VI requires that federally-funded organizations practice a nondiscrimination policy where they will not withhold services on account of a client's race, color, or national origin. Especially pertinent to the migrant farmworker population, Title VI allows Community and Migrant Health Centers to provide care regardless of citizenship status. Some members of congress (including previously mentioned Rep. Joe Wilson R-SC) staunchly opposed U.S. health care dollars being spent on "illegal" immigrants (Cover 2011). The ACA omitted immigration matters from its final product, and Migrant Health Centers are one of the few ways that health care access is made available to undocumented migrant workers residing in Minnesota. Specifically, HRSA-funded health centers treated 826,808 migrant workers and their families (of various immigration statuses) nationally in 2011, which HRSA estimates is one fourth of the total migrant worker population in the U.S. (Health Resources and Services Administration 2012b). While a range of estimates exists for the health care utilization and population size of migrant farmworkers, the ACA will benefit many by contributing additional funding to Migrant Health Centers.

Medicaid Expansion and the Health Insurance Exchanges. Previous literature on the barriers to care find that migrant farmworkers do not normally enroll in publicly-funded health insurance programs, and the Pew Hispanic Center similarly notes that foreign-born populations are over 2.5 times more likely than native-born citizens to be uninsured (U.S. Department of Health and Human Services 2012). The ACA addresses this situation by expanding Medicaid eligibility. Each state works with the federal government to jointly fund their own Medicaid

program, and each sets their own eligibility guidelines. The program normally covers low-income parents and children as well as a few other eligible groups. The original text of the ACA included a provision that would expand Medicaid's eligibility requirements nationally to qualify all individuals, not just parents and children, in households making up to 133 percent of the federal poverty level (in 2012, this amount was \$15,415 for an individual, and \$30,657 for a family of four (The Henry J. Kaiser Family Foundation 2012b)). The 2007-2009 NAWS data shows that the average migrant farmworker makes \$12,500-14,999 annually, and the average migrant farmworker family income is \$17,500-19,999. Though more recent income estimates are not currently available, numerous low-wage earning migrant farmworkers and their families would fall into this new financial category (Carrol, Georges, and Saltz 2011).

However, in the Supreme Court case of 2012, Medicaid expansion was one of the components of the ACA that was debated, and subsequently modified. The court's decision made the ACA's Medicaid expansion optional for states, and if states decided not to expand their Medicaid programs, they would suffer only the loss of the ACA's Medicaid expansion funds. The Medicaid expansion is set for implementation in 2014, and already, 25 state governors have articulated their state's positive support, and 15 governors have declared that they will not be participating (MacLaggan 2013). Texas, one of the states adamant about not participating, has the largest percentage of uninsured residents of any state, and also contains one of the largest migrant farmworker populations in the United States. The Texas Health and Human Services Commission estimates that half of the 24 percent of uninsured Texas residents would become insured under full Medicaid expansion (Suehs 2012). This expansion would also allow many migrant farmworkers traveling from Texas to be eligible for Texas Medicaid, and subsequently

receive affordable services throughout the Texas Migrant Care Network. While the Congressional Budget Office originally estimated that over the next ten years the Medicaid expansion would have accounted for an additional 17 million Americans qualifying for health coverage, the Supreme Court's ruling to make expansion optional on the state level has led the CBO to revised their estimate to only 11 million people gaining public coverage (The Henry J. Kaiser Family Foundation 2012b).

Apart from the national Medicaid expansion designated for 2014, the ACA has also allowed states to increase access to their program before this time. In 2011, this provision allowed Minnesota to expand eligibility to its state Medicaid program called Medical Assistance (MA) to cover childless adults that make up to 75 percent of the federal poverty level. Projected to cover more than 10,000 additional Minnesotans by 2013, the broadened MA program has potential to cover more migrant worker families even before federally-funded expansion in 2014 (Minnesota Department of Human Services 2012). However, it is important to note that due to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Medicaid programs can only cover naturalized U.S. citizens or legal residents who have lived in the U.S. for five years or more. Since 2009 in Minnesota, an exception to this rule now exists. The federal government signed the Children's Health Insurance Program Reauthorization Act to allow states to expand their Medicaid eligibility to cover legally residing low-income children and pregnant women that had been in the U.S. for less than five years, and Minnesota took this option (Mann 2010; Minnesota Statutes, Section 256B.06 [2012]). Undocumented workers still remain barred from publicly-funded programs.

The ACA also established the Health Insurance Exchanges, which are state-based competitive private markets to offer affordable insurance to those who do not have employer-based insurance and also do not qualify for publicly-funded programs. As a contrast to Medicaid, the Health Insurance Exchanges do not discriminate against clients on account of the amount of years they have lived within in the United States. All citizens and legal residents making between 100 and 400 percent of the federal poverty level are eligible for an exchange-created tax credit to subsidize the cost of purchasing health insurance. The tax credits are calculated based on the individual or family's annual income, and work to ensure that insurance premiums do not exceed a specific percentage of that income. For example, citizens and legal residents making up to 133 percent of the federal poverty level would receive a tax credit so that their premium did not exceed 2 percent of their annual income; for those making 133-150 percent of the federal poverty level, their premium would not exceed 3-4 percent; and so on for all citizens and legal residents making up to 400 percent of the federal poverty level (The Henry J. Kaiser Family Foundation 2012c). However, it is still unclear whether this premium will be affordable for low-earning migrant farmworkers that make under 100 percent of the federal poverty level, and are therefore not eligible for a tax credit subsidy. The ACA's insurance mandate exempts individuals with incomes so low that their health insurance premium would be over 8 percent of their annual income, which includes members of this group (U.S. Department of Health and Human Services 2012). It is important to note that undocumented immigrants are barred from access for the Health Insurance Exchanges. Table 1. summarizes the available insurance options and centers available to migrant farmworkers based on their legal status.

	U.S. citizen or legal resident living in the U.S. for 5+ years	Legal residents living in the U.S. for less than 5 years	Undocumented individual
Texas Medicaid	Yes, given age and income qualifications	No	No
Minnesota Medical Assistance	Yes, given age and income qualifications	Only pregnant women and children (due to CHIRPA)	No
Health Insurance Exchange tax credit	Yes, given income qualifications	Yes, given income qualifications	No
Community Health Centers	Yes	Yes	Yes

Table 1. Eligibility for migrant farmworkers based on legal status

Low-income citizens and their families make up half of the population that is expected to gain insurance coverage from the ACA, yet migrant farmworkers are characterized by other factors that restrict their access (Rovner 2012). As the signing ceremony of the ACA becomes history, the focus should shift from the past programs to the effectiveness of current policy in addressing existing barriers for this population. The ACA as it stands theoretically increases access to health care services for migrant workers through the growth of Community and Migrant Health Centers, and could potentially increase insurance coverage through Medicaid expansion and the Health Insurance Exchanges. However, the findings of this study reveal that the effects of this potential have been limited for the migrant farmworker population. This research assesses the effect of health policy on an underserved population's health care access, and will use the Migrant Health Center in Minnesota to analyze the ACA's effect on operational measures of access for the state's migrant farmworker population.

Research Design

Migrant Health Service, Inc. (MSHI) is the only Federally Qualified Migrant Health Center in Minnesota, and served as the focus organization of this study. Based in Moorhead, MN, the organization has nine separate clinics and two outreach advocacy sites across southern and western Minnesota and eastern North Dakota. Patients who qualify for subsidized care at MHSI include individuals and the families of individuals who have been employed in agriculture at some point in the past two years. The clinics receive payment from clients on a sliding-fee scale and also take insurance, if available. All sites accept Texas Medicaid as an enrolled Texas Medicaid provider in the Texas Migrant Care Network to provide Medicaid portability along the migration pattern of Minnesota's farmworkers. MHSI receives federal, state, and foundation grants to provide primary care services to an underinsured population, and have been in operation since 1973.

In this research, an analytical case study of Minnesota's Migrant Health Center organization was carried out to investigate how the Affordable Care Act and Minnesota state health policy have increased access to health care for migrant farmworkers. This focus provided the study with a subject that allowed for site-specific (Minnesota) and population-specific (migrant farmworkers) analysis. The participants of this study are not migrant farmworkers themselves, but rather the health workers that serve these communities, as they are in a position to understand how health care reform comprehensively impacts the access of this migrant population. The contemporary nature of the federal health care law has not allowed for adequate documentation on its population-specific effects, and this account seeks to provide details on the ways that it affects migrant farmworkers.

Interview participants were obtained through direct contact of the Migrant Health Centers using email and phone communication, and additional interviewees were obtained through a snowball sample method after initial contacts were made. Permission for subsequent academic use of interview content was given verbally. Original sources were not told about subsequent employee contact after referrals in order to ensure confidentiality. The findings come from six interviews with staff from four clinics of Migrant Health Service, Inc, which included members of the administration, medical personnel (e.g. nurse practitioners), and outreach workers.

The interview questions elicited descriptive accounts of serving local migrant farmworker populations. As the providers of care, these health care workers could judge whether new policy has actually provided increased health care access to patients. The interview questions sought to determine the barriers to health care that exist for this population today. Interview questions sought commentary on HRSA's involvement with their health center and how the health center's capabilities and faculties have changed since the ACA's passage. Interview questions also inquired about whether the recent changes in health policy at both the federal and state level have resulted in any modification in migrant farmworkers attaining insurance coverage. Responses exposed how the ACA and Migrant Health Centers address these needs and barriers, but also exposed persisting gaps in access that leave migrant farmworkers consistently vulnerable to poor health. In 2010, Migrant Health Service, Inc. saw 7,542 total patients, and 6,913 of those were categorized as migrant and seasonal farmworkers (Kaiser Health News 2012). Using the previous estimate that 20 to 35 thousand migrant farmers travel to Minnesota every year, Migrant Health Service, Inc. could be reaching between 20-28 percent of the total population.

Findings: Barriers, Remedies, and Persisting Gaps

To illuminate how the Affordable Care Act has affected migrant farmworkers' access to health care services in Minnesota, MHSI staff provided insight on how their own capabilities as a health center have changed to serve this population since health reform's passage. Interviews with staff revealed that three major barriers deter the migrant farmworker population from access, which are language, immigration status, and affordability. Specific components of the Affordable Care Act and Migrant Health Centers work to overcome these three barriers to access, but impediments remain that perpetuate the health disparities of this population. This identification allows the persisting gaps in health care policy to emerge in order to more comprehensively provide access to care for migrant farmworkers.

Research has estimated that only 13 to 15 percent of America's migrant farmworkers obtain health care services consistently, which means that nationally, less than one in six farmworkers receives regular health care (Castillo-Morales, Pergament, and Durkin 1995). NAWS survey data from 2000 show that only 20 percent of migrant farmworkers sought out any sort of health care in the last two years (Rosenbaum and Shin 2005), and HRSA estimates that Community Health Centers served about one fourth of the total migrant population living in the U.S. in 2011 (Health Resources and Services Administration 2012b). These low utilization rates beg the question, what factors prevent the majority of this population from accessing health care?

Language

The findings show that the first and most prominent barrier that keeps migrant farmworkers from seeking health care is language. All sites attributed the language barrier

between the patient population and medical staff as one of the most significant reasons why the migrant population does not seek preventive or immediate health services. Theresa from Site B spoke to this barrier that exists between migrant farmworkers and U.S. health care providers and said, “They can’t explain what they need and they don’t get it, or they just don’t go” due to the anticipation of communication failure. The majority of this population is Spanish speaking, which would make navigating a facilities using signs in English, articulating symptoms to medical staff, and comprehending treatment guidelines like prescription dosage or follow up appointments dispiritingly difficult. The language barrier of Minnesota’s migrants mirrors national data, as 2007-2009 NAWS results showed that 35 percent of interview respondents said they could not speak English “at all,” 27 percent said they could speak English “a little,” and 8 percent said they could speak English “somewhat.” This limited English capacity leaves only 30 percent of farmworkers responding that they could speak English “well” (National Center for Farmworker Health, Inc. 2012b). Because most health care providers across the nation do not have bilingual staff that can communicate in a language that is not English, these organizations have a decreased availability of interpreters who can meet their health needs. Disease treatment or prevention of behavior-caused illnesses requires a foundation of understanding between parties.

Immigration Status

Many farmworkers do not know how their own legal status will affect their ability to receive health care services, and some migrant farmworkers harbor the misconception that immigration officials coordinate with U.S. health centers. Monica from site A indicated that although immigration issues do not pose as large of a problem today as they have in past decades,

immigration status still deters many workers from getting care. She reported that migrant farmworkers with citizenship status seek medical attention at higher rates than undocumented migrant workers. Carol from site A explained the situation of “mixed” immigration families: “When the husband isn’t documented but the wife and kids are citizens, often times you might never have the husband come into the clinic, concerned about his immigration status. But that’s when you see the husband go to the emergency room because of out of control blood sugar.” For care outside of MHSI clinics, immigration status holds considerable importance. Interviewees shared that very rarely will a hospital have a charitable foundation in place that will waive the cost of care for low-income or uninsured patients, and for the majority of locations, legal citizenship is a requirement for charitable treatment services. Finally, Hannah from Site C drew attention to the fact that a migrant’s legal status can affect their state-based insurance eligibility. The law she was referencing was the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which limited Medicaid coverage to naturalized U.S. citizens or legal residents who have been within the U.S. for five years or more, therefore reducing affordability by lacking health insurance (U.S. Department of Health and Human Services 2012). Immigration status affects the frequency of seeking medical attention for undocumented and legally residing migrant workers due to decreased acceptability, and also affects the affordability of health services, due to limited insurance eligibility.

Affordability

In all interviews, cost emerged as the largest obstacle for migrant farmworkers, and materialized in three prominent ways as a lack of transportation, employer-based insurance, and state-based insurance. As agricultural employment provides low hourly wages that on average

place farmworkers under the federal poverty level, this low-income population has limited options in an expensive health care system. Federally-funded health centers report some demographic data to HRSA, and the 2011 HRSA Uniform Data System Report showed that over 91 percent of patients who received services at MHSI were making at or below 100 percent of the federal poverty level, and 99.61 were making at or below 200 percent (Health Resources and Services Administration 2012c).

Transportation. First, an unreliable mean of transportation compromises the ability to reach health services. Many farmworkers do not own personal transportation and travel with others along the migratory stream. Interviewees also alluded to a common dilemma wherein the father uses the family car to get to and from work, leaving the mother and children without means to get to the clinic for care. Sites further noted that the industry farms are located in significantly less-populated rural areas, where public transportation that could be used as an alternative to private transportation normally does not exist. Migrant farmworkers experience limited accessibility to health care providers due to wage-related limited personal transportation.

Employer-based insurance. Aside from creating difficulties in actually reaching the clinics, cost also hinders migrant farmworkers from receiving health services because they are unable to pay for them. Overall, sites estimated that between 80 and 95 percent of their patients lacked health insurance, compelling patients to pay high costs out of pocket for medical attention (the 2011 Uniform Data System Report from HRSA showed that 87 percent of MHSI patients had no health insurance (Health Resources and Services Administration 2012c)). Across all sites, staff consistently spoke of the lack of insurance offered by the growers who employ migrant

workers. Growers will employ farmworkers for the time it takes to harvest and process their seasonal crop, which usually lasts one to four months. The short duration of agricultural employment keeps growers from offering any benefits to workers, including health insurance. Hannah from Site C claims that growers don't prioritize providing health insurance due to these short labor intervals. Monica from site A asserts, "[Migrant farmworkers] are not going to be here long enough to use the benefits, so [the growers] are not going to provide it." This information mirrors the national aggregate data from the 2007-2009 National Agricultural Worker Survey that shows only 5 percent of farmworkers who work seasonally reported being covered by employer-based insurance (National Center for Farmworker Health, Inc. 2012b). The temporal aspect of the agricultural seasons keeps farmworkers employed for only a short period, but it also causes farmworkers to change employers frequently due to the seasonality of crops. Carol from Site A mentioned that farmworkers can work for multiple growers in one annual cycle, which would seriously complicate the employer-based insurance model if a worker had 4-5 employers in one year. Jeanette from site A declared that, in her experience, no one in the agricultural industry "provides health care insurance at all, and never have they." She believed this is due to the expense that it would place on growers. Medical attention becomes unaffordable without health insurance to cover some of the expense of treatment. Theresa from Site B noted that the lack of health insurance limits the amount of medical care that migrant workers receive because "they can't afford care. They don't have jobs that can help them." This statement is true across the country, but specific to Minnesota, statute only requires employers to provide insurance to migrant farmworkers that they "recruit," meaning those that they additionally offer housing or a transportation expense to incentivize employment (Minnesota Statutes, Section 181.73 [2012]). The statute dictates, "No such insurance need be purchased for

employees performing exclusively agricultural labor” as defined by the *Internal Revenue Code* of 1954. The definition of agricultural labor is expansive and includes any step in crop cultivation, from planting to packaging (26 U.S.C. 3121 [2012]). The employers of Minnesota’s migrant population are not required to provide health insurance to their labor force, which drastically limits affordability of health care when forced to pay out of pocket.

State-based insurance. Monica from site A asserted that although all of her patients would financially qualify for Medical Assistance (MA), Minnesota’s state-funded Medicaid program, other qualifications keep them ineligible. MA covers pregnant women, children, parents whose children are dependent on MA, people living with disabilities, and, because of the ACA, childless adults making up to 75 percent of the federal poverty level. However, due to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Medicaid programs can only cover naturalized U.S. citizens or legal residents who have lived in the U.S. for five years or more. Yet, since 2009, an exception to this rule now exists in Minnesota. The federal government signed the Children’s Health Insurance Program Reauthorization Act to allow states to expand their Medicaid eligibility to cover legally residing low-income children and pregnant women that had been in the U.S. for less than five years, and Minnesota took this option (Mann 2010; Minnesota Statutes, Section 256B.06 [2012]). However, undocumented immigrants, and newly immigrated men and non-pregnant women still remain without MA eligibility.

The seasonal pattern of farmworkers accounts for both their lack of employer-based insurance and also their state-funded insurance options. MA only functions as a payment method within state borders. Interviewees explained that if these southern-Texas migrant workers applied

for MA upon arrival to Minnesota, the application would take a paperwork-processing period of one to two months that could potentially extend longer than the harvest season, i.e. time spent in Minnesota. Applying to the MA program would therefore be ineffectual, as migrant farmworkers only temporarily reside within Minnesota, and cannot use their Minnesota-based MA outside of the state for the rest of the annual cycle. Each site asserted that the vast majority of the patients at their clinic migrated from southern Texas, which accounts for the fact that the very few patients that do have insurance are enrolled in Texas Medicaid. Carol from site A also said that the few families with Texas Medicaid “think they’re going to stay healthy. They say, ‘We’ll go [to Minnesota] for two months, and see the doctor back in Texas.’ Something happens, and they come in [to our clinic], but they need additional care.” However, since they aren’t enrolled in Minnesota MA, they are unable to seek services outside the scope of services offered by MHSI because they don’t have insurance that any other provider will accept. While Migrant Health Service, Inc. is a part of the Texas Migrant Care Network, and can therefore take Texas Medicaid as a form of out of state insurance, Monica from site A says that,

A lot [of community health centers] don't, and patients don't seek services because they don't want to lose their Texas Medicaid. When their insurance isn't transferable, it's hard for people who are moving all the time. Once they're here, they might not go straight back to Texas. They might go to Michigan, Washington, Iowa... any number of states along the way. They don't go straight back and forth.

If migrant farmworkers are already insured under Texas Medicaid, enrolling in MA is not practical. The temporary nature of their occupation doesn't keep migrant farmworkers in Minnesota long enough to utilize MA, and it is reasonable to keep Texas Medicaid because they will eventually return back to Texas every year.

However, if a migrant farmworker were to decide to apply to Medical Assistance (for instance, a pregnant woman seeking time-sensitive prenatal care), the complexity of the application process can be yet another barrier to obtaining insurance, and subsequently, affordable health care. Jeanette noted that many of the patients they see at site A drop out of formal education at 6th grade, so literacy becomes an issue if a patient were to fill out the paperwork on their own. Carol from site A said that some of the state health insurance programs require documentation, which provides additional difficulties for families that do not travel with their tax returns from the previous year. Some individuals and families have incomes so low that they are not required to file tax returns, either. Altogether, state-based insurance does not work to cover the cost of services for undocumented immigrants and for the majority of legally residing immigrants who have been in the U.S. for less than five years, which perpetuates a lack of affordability for the high costs of health care.

To summarize, the three major obstacles barring access to health care for Minnesota's migrant farmworker population are language, immigration status, and affordability; the last due to the lack of employer-based or state-based insurance options. These population-specific barriers have predominantly limited the health care options of migrant farmworkers; however, Migrant Health Centers have provided access to this population by specifically accommodating for each of these barriers.

Migrant Health Centers

Each interviewee indicated that their clinics serve as the primary source of health care for local migrant farmworkers that do seek care. Thus, these sites harbor the most potential for

addressing the poor health of migrants who travel to Minnesota. These rural Minnesotan Migrant Health Centers tailor their approach of providing health care to overcome the typical barriers of this population.

Communicating in Preferred Language

The 2011 HRSA Uniform Data System Report indicated that over 90 percent of MHSI patients were of Hispanic or Latino identity (Health Resources and Services Administration 2012c). To combat the language barrier that might otherwise prevent comprehension between the Spanish speaking population and the staff, MHSI employs year-round interpreters and bilingual employees. Carol from site A said that 60 percent of the staff at her site is bilingual, which makes all the difference when “listening to some of these families going into a local clinic. They come into our health centers and we try to make them feel comfortable and that their care is very important to us.” The administration at each site looks at language proficiency when hiring new staff, because the ability to communicate facilitates better care coordination and is favorable to patients. Hannah from Site C spoke to MHSI’s ability to overcome language obstacles even outside of the clinical facility. While providing their own bilingual workers on site, they’ll send what they call Bilingual Health Operators to meet patients at specialty clinics to help interpret at these locations. As the majority of Minnesota’s migrant farmworker population is Spanish speaking, Migrant Health Service, Inc. increases the availability of providers that can effectively serve this population.

Nondisclosure of Immigration Status

MHSI counters the barrier of immigration status through their nondiscrimination policy mandated by Title VI as a federally-funded organization. As the organization cannot discriminate on account of race, color, or national origin, the staff is not required to ask for citizenship status or legal documentation, and only ask for patient information that concerns the nature of treatment. This policy was actually a source of concern during the formation of the Affordable Care Act, as a few congresspeople doubted President Obama's assertion that the health reform bill would not provide services to "illegal" immigrants within the U.S. However, health centers across the nation are still not required to collect citizenship data, and they supply medical attention to patients regardless of their immigration status or that of their families. This policy allows undocumented farmworkers to perceive MHSI as a more acceptable provider, without fear of deportation or legal ramifications.

Affordable Services

Overcoming Transportation Issues. Using the HRSA funding provided by the ACA, MHSI purchased two brand new mobile units to reach patients outside of their permanent clinics. This increases accessibility by decreasing the distance patients must travel to seek services. The units take into account the location of the provider and the location of the client, and bring the care to the patient.

Minnesota Medical Assistance for the Uninsured. While Migrant Health Centers cannot change the lack of employer-based insurance, they do facilitate the enrollment process of state-based insurance for qualified patients who could benefit from gaining Medical Assistance.

When asked whether they try to enroll any of their uninsured patients in MA, Carol from site A said,

We do try to coach them through [the insurance enrollment process]... it does take a long time. It's a lengthy application, mostly checkboxes. Families think, we don't need it, we'll just work for a couple months, and they don't think they'll need to see a doctor, until they have an accident or get sick. We do try to encourage folks to register [for MA] when they come in. I personally see it as a benefit because a lot of our patients have chronic health disease. It's good to have reimbursement from the state to provide the care. It helps our bottom line.

For those who would benefit from Minnesota-based insurance, such as pregnant women, the Migrant Health Centers facilitate a smoother application process by utilizing community health workers and bilingual outreach staff. These positions, funded by the Minnesota Department of Human Services, navigate the Medical Assistance paperwork for the patient, translate for nurses, explain prescription directions, perform breast exams, and organize referrals to specialty clinics. Migrant Health Centers are able to increase access to patients by making services available that meet the client's specific language needs. She additionally mentioned that MA will retroact applications, meaning that if a patient had just had a costly emergency room visit, the state would cover the cost of that care if the patient obtained MA within three months of the incident. Qualified Minnesota migrant workers with large emergency expenses would benefit from the presence of a health insurance guide. MHSI produces an availability of staff that can meet the population-specific needs of migrant farmworkers.

Sliding Scale Payment Systems and Other Free Programs. For the 87 percent of patients lacking any kind of health insurance, out of pocket fees for health care services would be

largely unaffordable for this low-income demographic. However, MHSI has combated the barrier of cost for uninsured patients by establishing a sliding scale payment system at their clinics. HRSA funds 75 to 80 percent of the organization's budget, which heavily subsidizes the cost of care for patients. Instead of charging the standard cost of each service, the sliding scale system enables patients to only pay an amount in accordance with their annual income. If a patient's family annually makes up to 200 percent of the federal poverty level, they pay nothing more than an \$8-10 co-pay. This income bracket includes virtually all of the migrant farmworkers that sought care at MHSI in 2011 (Health Resources and Services Administration 2012c). Patients do not need to present documentation of income to receive this financial benefit, just as they do not need to provide their legal status at the clinic. For specialty services outside of the scope of services offered at MHSI, such as optometry, X-rays, or lab tests, the clinics have a voucher program in place to assist their patients in affording outside care. The patient pays the same \$8-10 co-pay for a voucher that covers up to \$150 of the medical bill from an outside clinic. The voucher normally covers a portion of the fee, but the remainder of the bill is left for the patient to pay out of pocket, and interviewees indicated that this financial burden sometimes deters farmworkers from seeking specialty care outside of the Migrant Health Center. MHSI also provides generic prescription medications to patients through a \$10 Self-Pay Drug Plan to provide affordable pharmaceutical therapy to this population. Through this program, the MHSI clinical staff can prescribe a generic medication to the patient, and the patient can present that voucher-prescription to a local pharmacy along with \$10. HRSA and MHSI work together to provide affordability in spite of the large proportion of uninsured and low-earning migrant farmworkers.

Carol from site A believes that the majority of migrant farmworkers in their area seek out MHSI for its affordable reputation. She said that even in rare cases when migrant farmworkers show up at the local emergency department for standard care, the ER will refer migrant workers to MHSI because “[the emergency department] likes to get paid, and our families can’t afford that. They would refer, and they know our hours and where our offices are.” At sites B and C, staff also asserted that their clinics provide the majority of care for their migrant populations, even in cases when the patient initially seeks help from another location such as the emergency room. Theresa of Site B said of their patients:

They sometimes are desperate and they go to the ER, but they don't qualify [for insurance] because they're illegal. If there's extensive amounts of money involved, they're kind of out. That's why they should come here, see if we can't help them first. Some go to the ER because they don't know where to go, and we try to deter them so they come here.

Hannah from Site C indicated that because the clinics are nurse-managed and do not always have a doctor on site, their staff will triage and decide whether or not the patient requires attention by an emergency department physician. The local emergency departments and the Migrant Health Centers coordinate to provide the most appropriate care for patients, and Migrant Health Centers create an affordable option for non-emergency level care to the population.

Additionally, the state of Minnesota provides a few options for certain qualifying members of the migrant population. Sites spoke to the benefits of the SAGE cancer-screening program run by the Minnesota Department of Health. The program covers the cost of pap smears and mammograms for low-income women over the age of forty making an annual salary within

guidelines of the program. Sites also said that they refer their patients to the free immunization programs for uninsured and underinsured children at public health centers in their region.

MHSI counterbalances the population-specific barriers that migrant workers normally encounter when seeking health care. The clinics provide greater access through their efforts to increase every measure classified by Panchansky and Thomas. By providing interpreters and bilingual staff, the clinic increases the amount of available health care employees that can meet their language needs. The sliding scale payment method and voucher programs increase affordability for a predominantly uninsured and low-income population. Compared to other providers, MHSI comes across as more acceptable, because immigration status does not influence the amount of care received, nor does it provide legal ramifications for clients. The ACA's grants to MHSI totaling \$90,000 additionally fueled this increase in health care access, as the grants have provided the salaries to hire more staff and extend hours of operation. Site A noted that currently, it takes 2-4 weeks to get an appointment at their clinic, and Site C similarly claimed that their next available appointments are a month down the line. Being able to employ more staff will allow for more patient appointments and longer hours of operation, thus increasing accommodation, and this especially will tailor to migrants since their employers do not provide paid time off. The ACA grants also funded two new mobile units to amplify the accessibility of their services for their patients, and the capital gains will help to reach migrant workers without transportation, or who live far from the permanent clinics. Along with new mobile clinics, the grants also financed a mobile dentistry operation containing five sets of portable dental equipment including chairs, lights, x-rays, stands, and a van to transport the appliances. These newly funded actions enhance the ability of Migrant Health Service, Inc. to

serve this population. Migrant Health Service, Inc. as a health care provider has formulated their operation to combat the issues of language, immigration status, and affordability; and successfully establishes a high degree of “fit” between client population and provider. Therefore, the ACA’s additional funding to Community Health Centers additionally increases access for Minnesota’s migrant farmworkers, as the Migrant Health Center provides services using a population-appropriate method.

Persisting Gaps in Current Health Policy

Regardless, the era of health care reform has not provided suitable ways to insure the migrant farmworker population. The ACA, with its lofty goals to supply an additional 16 million Americans with health insurance in the next ten years, does very little to provide this mobile and low-income population with health insurance. Recall that enrollment in a state-based insurance program requires a processing interval of one to two months. By this time, a migrant family’s employment in Minnesota has most likely ended, meaning that they have already moved on to the next state in the agricultural employment circuit, or have already returned to southern Texas. Therefore, the ACA’s Medicaid eligibility expansion does not do enough to ensure that more migrant families obtain insurance, as Minnesota’s MA does not function outside of state borders. Especially after the Supreme Court’s decision in 2012 that allowed states to choose whether or not they will participate in the 2014 Medicaid expansion, many migrant farmworkers that would have been eligible will not be, since Texas has adamantly stated that it will not be participating. The home state of Minnesota’s migrant farmworkers will not be providing more migrants with coverage that could be used both in Texas and along the Texas Migrant Care Network through Medicaid portability. Because Minnesota’s state-funded insurance only covers patients when

they are within that state, the system is incompatible for the temporary agricultural industry worker. There is no reciprocity agreement with the Texas Migrant Care Network; MHSI takes Texas Medicaid, but Community Health Centers in Texas do not take Minnesota's Medical Assistance. The consensus from the interviews was that neither the 2011 state Medical Assistance expansion nor the ACA's nationwide Medicaid expansion in 2014 would do anything to provide a greater number of migrant farmworkers with health insurance in Minnesota. Expanding the financial qualifications for state-based insurance programs misses the mark in providing insurance to a migratory population that is largely ineligible due to immigration status. Additionally, the Health Insurance Exchanges do not provide tax credits to subsidize the cost of health insurance to either undocumented workers or to individuals or families that make at or below 100 percent of the federal poverty level. As 91 percent of MHSI patients in 2011 were within this financial category, it seems that the health insurance exchanges in 2014 will not provide insurance to this very low income population that are almost 50 percent undocumented. As a final obstacle to insurance coverage, the ACA requires that employers with 150 or more staff provide health insurance, but omits seasonal employees who work for that employer less than 120 days in a year (Simas 2013). This effectively keeps migrant workers excluded from employer-based, state-based, or private health insurance options, thus maintaining the high cost of health care for migrant farmworkers and perpetuating illness and disease.

Conclusion

Currently, ACA appears to only slightly impact the health care access of Minnesota's migrant farmworker population. While the ACA increases funding to organizations serving this population, it fails to provide employer-based, state-based, or private health insurance to migrant

families. This lack of insurance, and therefore lack of affordability, limits migrant farmworkers to Migrant Health Centers for their point of care. However, the bilingual staff, the nondiscrimination policy, and the sliding scale payment system are components specifically tailored to the migrant farmworker community to address the existing barriers of language, immigration status, and affordability. As Migrant Health Centers have manifested as the current best option for providing health care to this population, since care from other providers is unaffordable, it is important that the organizations are able to run at capacity to provide for the population of migrants passing through the state in search of agricultural employment. Lobbying organizations at the state and national levels have advocated for the improvement of Community Health Centers, including the MN Association of Community Health Centers, and the National Association of Community Health Centers. However, the focus patient population of Community Health Centers is much larger than migrant farmworkers alone, which additionally accounts for the absence of the migrant population in health care policy formulation. There are very few Community Health Centers that specifically serve migrant-only populations compared to more diverse populations, and the decreased visibility of this population also may also contribute to their de-emphasis in health care legislation.

Health care and immigration must harmonize to provide the U.S. agricultural industry with a healthy workforce. As a measure of how well federal health care reform overcomes the barriers for migrant farmworker population, this research shows that the efforts of the ACA to provide increased affordability are limited. Further projects on this subject could include tracking the changes in patient load after the ACA grants. Financial resources can affect positive change if they transform into additional staff hires and effective programs that increase patient load.

Additional projects might include a historical evaluation of Minnesota's legislative relationship with migrant workers to analyze what has been effective on the state level. Currently, state grants that help the migrant population have diminished, as the Migrant Health Grant Program run through the Department of Health was defunded in 2011 (Office of Rural Health and Primary Care 2011). MHSI was the sole recipient of this grant since the 1970s, which had recently provided them with \$100,000 to operate a mobile unit five months out of the year.

Future research must also include continuous assessment of the Affordable Care Act's implementation stages. This examination would explore whether the Health Insurance Exchanges will be useful for migrant farmworkers with citizenship or legal residence making over 100 percent of the federal poverty level. The ACA poses to increase the number of rural providers, possibly within the proximity of migrant farmworkers, through the National Health Service Corps program, which would additionally affect the availability of providers. This continuous assessment can inform future legislative recommendations that more acutely address the health disparities of migrant farmworkers. As this era of health care reform has not shown cooperation between health care and immigration, Migrant Health Centers embody the unique method for treating low-income migrant farmworkers of all immigration statuses. For now, it is important that Migrant Health Centers are widely publicized to legal and undocumented migrant workers alike, as they have the best potential to reach this medically underserved community. At present, strengthening Migrant Health Centers appears to be the most realistic attempt to reach more than a quarter of the migrant farmworker community.

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