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## Medicaid and Migrant Farmworkers: Why the State Residency Requirement Presents a Significant Access Barrier and What States Should Do About it

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# MEDICAID AND MIGRANT FARMWORKERS: WHY THE STATE RESIDENCY REQUIREMENT PRESENTS A SIGNIFICANT ACCESS BARRIER AND WHAT STATES SHOULD DO ABOUT IT

*Malea Hetrick*<sup>†</sup>

## ABSTRACT

Medicaid is failing to meet the health needs of qualified migrant farmworkers because of their migratory lifestyle. This population moves frequently, following various agricultural harvests, and the state residency requirements imposed by Medicaid create a significant access barrier that most migrant farmworkers cannot overcome. Migrant farmworkers are unable to overcome the state residency requirement for several reasons: language and cultural barriers, the difficulty in applying, and statutory impediments such as the five-year ban and the proof-of-citizenship requirement. Several states have attempted to integrate migrant farmworkers into both their state-run Medicaid and general public health systems with varying degrees of success. Both Texas and Wisconsin have implemented creative solutions to this Medicaid coverage problem and these existing models will be examined for both strengths and weaknesses. Finally, after assessing whether the Equal Protection Clause of the Fourteenth Amendment requires that a state provide U.S. citizen migrant farmworkers with access to Medicaid despite their transient lifestyles, I will propose three possible solutions to the problem—the ACA Medicaid Expansion, a hybrid Wisconsin/Texas model, and individualized solutions tailored to each state.

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## INTRODUCTION

*The health care of farmworkers is an issue of human rights. We're exposing farmworkers to work-related health problems. We're exposing them to these dangers and then not providing them with access to health care to identify and solve their problems. The health of farmworkers is a moral issue.*

Dr. Ed Zuroweste, Medical Director<sup>1</sup>

Ramona and Consuelo are both farmworkers who have spent years working in agriculture in the United States.<sup>2</sup> Consuelo is a

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1. Dr. Zuroweste is a medical director at a Pennsylvania community health center serving migrant farmworkers. *Like Machines in the Fields: Workers Without Rights in American Agriculture*, OXFAM AMERICA, 17 (Mar. 2004), <http://www.oxfamamerica.org/static/media/files/like-machines-in-the-fields.pdf> (citing DANIEL ROTHENBERG, WITH THESE HANDS: THE HIDDEN WORLD OF MIGRANT FARMWORKERS TODAY 229 (1998)).
  2. Anecdotes from the *Stories From the Field* series are true stories from real farmworkers, living in the United States. David Bacon, *Stories From The Field: The Story of Ramona*, FARMWORKER JUSTICE, <http://www.farmworkerjustice.org/stories/ramona.html> (last visited

skilled grafter,<sup>3</sup> working with citrus and avocado trees, and has acquired her skill with years of practice.<sup>4</sup> She works both indoors and outdoors in a specialized field of agriculture.<sup>5</sup> Ramona worked over a decade as a fruit and vegetable picker, cutter, and packer.<sup>6</sup> The work Ramona did was what is more commonly imagined when one imagines migrant farm work—long days in the field, bent over picking or cutting produce from muddy patches of field.<sup>7</sup> Ramona worked with pesticides and needed to wear long sleeves and a handkerchief over her nose and mouth to protect her from the hazardous fumes.<sup>8</sup>

Both Ramona and Consuelo are married and both have children.<sup>9</sup> Both work hard for little pay.<sup>10</sup> But despite their apparent similarities, when it comes to health care, Ramona and Consuelo could not be more different. Consuelo is one of the lucky few farmworkers who have health coverage through their employers.<sup>11</sup> She has been at the Brokaw Nursery in California for over forty years, and she is now a permanent employee.<sup>12</sup> As such, she has health care for herself and she had health care for her children when they were young.<sup>13</sup> Her employer-provided medical insurance covered almost 90 percent of the costs when her young son died.<sup>14</sup> Consuelo considers “this kind of

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Apr. 3, 2015); David Bacon, *Stories From The Field: The Story of Consuelo*, FARMWORKER JUSTICE, <http://www.farmworkerjustice.org/stories/consuelo.html> (last visited Apr. 3, 2014).

3. Grafting is an agricultural technique by which cuttings, trimmings or roots of one plant are used as a means of plant reproduction, especially for those plants which do not have true seeds. Grafting is most commonly performed in the winter and early growing season, and it can be done for indoor and outdoor plants. See Ray R. Rothenberger & Christopher J. Starbuck, *Grafting*, UNIV. OF MISSOURI EXTENSION, <http://extension.missouri.edu/p/G6971> (last visited Apr. 3, 2015).
4. *Stories From The Field: The Story of Consuelo*, *supra* note 2.
5. *Id.*
6. *Stories From The Field: The Story of Ramona*, *supra* note 2.
7. *Id.*
8. *Id.*
9. *Id.*; *Stories From The Field: The Story of Consuelo*, *supra* note 2.
10. *Stories From The Field: The Story of Consuelo*, *supra* note 2; *Stories From The Field: The Story of Ramona*, *supra* note 2.
11. *Stories From The Field: The Story of Consuelo*, *supra* note 2.
12. *Id.*
13. *Id.*
14. *Id.* The only reason the insurance did not cover 100% of her son’s medical expenses was because the expenses were over the \$100,000 limit.

insurance . . . essential for a farm worker family, because medicine and doctor visits are so expensive . . . . That health plan was necessary to continue working.”<sup>15</sup> Consuelo’s employer-provided health coverage was a creative solution that Brokaw Nursery provided for its own farmworker employees.

Ramona, on the other hand, represents the majority of farmworkers. Although wearing long sleeves and a handkerchief would have protected her from the toxic fumes of pesticides, the handkerchief made it difficult to breathe, and the work was too hot for sleeves.<sup>16</sup> She now suffers from asthma, likely a result of pesticide exposure.<sup>17</sup> “[Her] hands got so swollen that [her] skin began to split. First they swelled up, and then they got extremely dry. [Her] skin would start to crack, and it was extremely painful. [She] never went to the doctor because [she] couldn’t afford to.”<sup>18</sup> Ramona’s employer did not provide health insurance, and because of the incredibly low wage she earned as a farmworker, there was no money to buy health insurance, after paying the rent, transportation costs, and food.<sup>19</sup> As she explained, “we live a stressful life because . . . this work is temporary. When the work runs out, [we] don’t have unemployment benefits . . . . It’s frustrating, because you don’t have a job or unemployment benefits, but the kids are sick, you have to pay the rent and the bills are piling up.”<sup>20</sup>

Ramona and Consuelo demonstrate the reality for the vast majority of migrant farmworkers. Their work is hard, low wage, and high-risk in terms of potential health consequences. Consuelo and her employer show that it is possible to provide health coverage for this population, while Ramona’s situation reflects the unfortunate reality for most farmworkers. Throughout this Note, migrant farmworkers, health coverage, and access to Medicaid will be discussed in statistics, subjected to constitutional analysis, and weighed financially and morally. Ultimately, however, these are individual people with real lives and real problems.

Migrant farmworkers have been largely grouped together with all immigrants, or at least with the undocumented immigrant

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15. *Id.*

16. Ramona worked in 110 to 115 degree heat. *Stories from the Field: The Story of Ramona*, *supra* note 2.

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.*

population.<sup>21</sup> However, the law distinguishes between seasonal workers and migrant farmworkers, primarily based on whether the workers must be away from his or her permanent place of residence.<sup>22</sup> For example, Consuelo has been with one employer for over forty years, and is most likely a seasonal worker for that reason.<sup>23</sup> Ramona worked multiple harvests, including grapes, onions, lettuce, broccoli, and almonds. She might have been classified as a migrant farmworker, if these harvests took place in different states.<sup>24</sup> While the national political conversation swirls around amnesty and citizenship rights, health care coverage and the new Affordable Care Act (ACA), and media rhetoric of economic burden and public welfare free-loading,<sup>25</sup> migrant farmworkers who are in fact citizens or legal residents of the United States become lost in the shuffle.<sup>26</sup> The conversation skips over them and they fall through the cracks. Largely unable to access public welfare benefits for which they qualify, U.S. citizen or legal resident migrant farmworkers are an incredibly vulnerable population, at risk for suffering significant health problems as a result of their work and

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21. See Safina Koreishi & Martin Donohoe, *Historical and Contemporary Factors Contributing to the Plight of Migrant Farmworkers in the United States*, 5 SOC. MED. 64, 65 (2010).
  22. This matters in the context of access to Medicaid, because Medicaid has a state residency requirement.
  23. A seasonal agricultural worker is someone “who is employed in agricultural employment of a seasonal or other temporary nature and is not required to be absent overnight from his [or her] permanent place of residence . . . .” The Migrant & Seasonal Agricultural Worker Protection Act, 29 U.S.C. § 1802 (2011).
  24. A migrant farmworker is “employed in agricultural employment of a seasonal or other temporary nature, and . . . is required to be absent overnight from his permanent place of residence.” *Id.*
  25. Koreishi & Donohoe, *supra* note 21, at 65.
  26. SARA ROSENBAUM & PETER SHIN, KAISER COMM’N ON MEDICAID & THE UNINSURED, MIGRANT AND SEASONAL FARMWORKERS: HEALTH INSURANCE COVERAGE AND ACCESS TO CARE 5 (2005); Eric Hansen & Martin Donohoe, *Health Issues of Migrant and Seasonal Farmworkers*, 14 J. HEALTH CARE FOR THE POOR & UNDERSERVED 153, 154 (2003). The literature on migrant and seasonal farmworkers groups both populations together. Throughout this Note, many of the estimated numbers or percentages have been established by removing non-citizens, foreign-born, and undocumented populations from a larger categorization. Often, direct statistics about the number of migrant farmworkers were unavailable. Where a number is estimated via either this method or it is indicated as such in the source material, it is stated as estimated in the body of this Note.

for which they cannot receive Medicaid benefits due to their migratory lifestyle.<sup>27</sup>

Migrant farmworkers by definition live a highly transient lifestyle and spend a substantial amount of their time away from their home and permanent residence. Because of this, migrant farmworkers often struggle to meet the state residency requirement for Medicaid, and although they would otherwise qualify for the program, there is often no safety net in place to ensure Medicaid coverage.<sup>28</sup> Medicaid is failing to meet the health needs of this segment of the population, not because they are ineligible to receive Medicaid benefits, but because of their migratory lifestyle. Medicaid's state residency requirement is a significant barrier that many migrant farmworkers cannot overcome.<sup>29</sup>

Wisconsin and Texas have developed unique and noteworthy ways of meeting the Medicaid needs of U.S. citizen migrant farmworkers.<sup>30</sup> While these programs are commendable, there is still room for further modification to allow migrant farmworkers, who are otherwise qualified except for their migratory nature, access to the Medicaid system. It is not common for states to have special provisions to provide Medicaid benefits to migrant farmworkers; Wisconsin and Texas are exceptions to the general trend of extending Medicaid benefits only to bona fide state residents who can demonstrate their bona fide residency in their application for Medicaid, which is subject to state approval.

For migrant farmworkers, the Wisconsin and Texas models fill an important gap in Medicaid coverage where the federal government cannot mandate coverage. Not only is the ACA Medicaid expansion voluntary, but an Equal Protection challenge under the Fourteenth Amendment would likely fail. Infringing on the fundamental right of a class of people to travel—namely, newly arrived residents—requires a compelling state interest like fraud prevention and the application of strict scrutiny. However, even with a compelling state interest, the state must utilize the least restrictive means practicable when infringing on a fundamental right. A court would hold that a forty-

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27. KAISER COMM'N ON MEDICAID & THE UNINSURED, *CONNECTING ELIGIBLE IMMIGRANT FAMILIES TO HEALTH COVERAGE AND CARE: KEY LESSONS FROM OUTREACH AND ENROLLMENT WORKERS 1* (2011).

28. FARMWORKER JUSTICE, *MEDICAID AND MIGRANT AND SEASONAL FARMWORKERS 2* (2013).

29. The state residency access barrier is compounded for migrant farmworkers because of other factors uniquely expressed in the migrant community, including limited language and cultural understandings, fears related to immigration and deportation, difficulty in applying, and federal statutory requirements.

30. *See infra* Part IV.

five day period<sup>31</sup> for evaluating the bona fides of a Medicaid applicant's state residency is within the definition of "least restrictive," as it is a practicable time period for the state to evaluate the Medicaid application.

Part I of this Note defines the migrant farmworker population and gives some broad background information. Part II provides a summary of Medicaid, its relationship to and impact on migrants, and the relevant impact of the ACA. Part III discusses the access barriers that migrant farmworkers face when interacting with the public health care system. Part IV reviews the state models employed by Texas and Wisconsin in their attempts to provide access to Medicaid for migrant farmworkers. Part V addresses the expansion of Medicaid and whether it is legally required by the Equal Protection Clause and the policy rationales for and against expansion. Finally, Part VI suggests a number of proposals for extending coverage to migrant farmworkers.

## I. POPULATION DEMOGRAPHICS

*We're a forgotten community. We're invisible. We contribute to this country and should be protected by human rights everyone else in this country enjoys. We put the food on the table for everyone.*

Elisa, Farmworker<sup>32</sup>

Many in the United States already group migrant farmworkers with undocumented immigrants. It is, therefore, important to understand specifically which population is being discussed. The definitions for both migrant farmworkers and seasonal farmworkers can be found in the Migrant and Seasonal Agricultural Worker Protection Act.<sup>33</sup> A migrant farmworker is "employed in agricultural employment of a seasonal or other temporary nature, and . . . is required to be absent overnight from his permanent place of

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31. This time period is mandated by federal statute. CMS Determination of Medicaid Eligibility, 42 C.F.R. § 435.911 (2010).

32. David Bacon, *Stories from the Field: The Story of Elisa*, FARMWORKER JUSTICE, <http://www.farmworkerjustice.org/stories/elisa.html> (last visited Apr. 3, 2015).

33. See *Who Are Farmworkers?*, S. POVERTY L. CTR., <http://www.splcenter.org/sexual-violence-against-farmworkers-a-guidebook-for-criminal-justice-professionals/who-are-farmworker> (last visited Mar. 25, 2014); ROSENBAUM & SHIN, *supra* note 26, at 6; The Migrant & Seasonal Agricultural Worker Protection Act, 29 USC § 1802 (2012).



residence.”<sup>34</sup> A seasonal agricultural worker, on the other hand, is someone “who is employed in agricultural employment of a seasonal or other temporary nature and is not required to be absent overnight from his [or her] permanent place of residence.”<sup>35</sup> Thus, the key difference between a migrant and a seasonal farmworker is whether the work requires the worker to be absent overnight from his or her permanent place of residence. Additionally, although the terms are distinct, migrant and seasonal farmworkers are often grouped together in demographic surveys and data collection.<sup>36</sup>

Approximately 75 percent of the estimated three million migrant and seasonal farmworkers are foreign-born.<sup>37</sup> That means that an estimated 25 percent of all migrant and seasonal farmworkers, or roughly 840,000 individuals, are U.S. citizens by birth.<sup>38</sup> An additional 21 percent, or 630,000 individuals, are long-term permanent residents.<sup>39</sup> Of the foreign-born migrant and seasonal farmworkers, 74 percent have been in the United States for longer than five years.<sup>40</sup> The average age of all migrant and seasonal farmworkers is thirty-six.<sup>41</sup> Almost 80 percent are male and barely half are parents.<sup>42</sup> Thirty percent say they speak English well, and while the average migrant and seasonal farmworker has completed eighth grade, only 37 percent

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34. 29 USC § 1802 (2012).

35. *Id.*

36. A glance through the sources used in research for this Note shows that “migrant and seasonal farmworker” appears in most titles. Very few specified if the research was particular to one of the two groups. Finding research and information about the migrant farmworker population specifically, without considering the seasonal farmworkers, who are by definition separate, was a significant research impediment.

37. *Farmworker Health Factsheet: Demographics*, NAT’L CTR. FOR FARMWORKER HEALTH 1 (2012), <http://www.ncfh.org/docs/fs-Migrant%20Demographics.pdf>. Between 72% and 75% of migrant and seasonal farmworkers are foreign-born, which translates to between 2,160,000 and 2,250,000 people.

38. *Who Are Farmworkers?*, *supra* note 33. According to the Southern Poverty Law Center, U.S. citizens make up 25% of the total migrant and seasonal farmworker population. An additional 21% are long term permanent residents, often called Green Card holders, and another 1% of farmworkers have some other kind of work authorization to be legally present and working in the United States.

39. *Id.*

40. *Demographics*, *supra* note 37, at 2. Seventy-four percent of the foreign-born farmworkers amounts to 1,665,000 individuals.

41. *Id.*

42. *Id.*

have made it past ninth grade.<sup>43</sup> Twenty-five percent say their job is year-round, and for those who do not have a year-round job, just 5 percent are covered by employer-provided health insurance.<sup>44</sup> Eighty-five percent completely lack health coverage,<sup>45</sup> while 10 percent say they have their own coverage, and the remaining 5 percent report Medicaid coverage.<sup>46</sup> Fifty-three percent of migrant and seasonal farmworkers are undocumented.<sup>47</sup> Forty-two percent (or 1.26 million) of migrant and seasonal farmworkers are migrant workers, meaning that they are by definition required to be away from their permanent place of residence overnight.<sup>48</sup>

While migrant and seasonal farmworkers live in all states, they are heavily concentrated in particular states.<sup>49</sup> Specifically, this population has been historically concentrated in California, Florida, Georgia, Michigan, North Carolina, Oregon, Washington, and Texas.<sup>50</sup> This is significant for migrant farmworkers seeking Medicaid benefits. Although Medicaid is a federal program, each state can set its own eligibility requirements, and each time an individual moves to a new state, he or she must usually reapply in that state for Medicaid benefits.<sup>51</sup> These eight states with the highest concentrations of migrant farmworkers are more likely to face the issue of migrant farmworker eligibility, or ineligibility, based purely on the sheer number of migrant farmworkers within their borders.

Furthermore, migrant and seasonal farmworkers are obviously very involved with the agricultural industry, which is heavily dependent on manual labor.<sup>52</sup> The agricultural industry and its

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43. *Id.* at 2-3.

44. *Id.*

45. ROSENBAUM & SHIN, *supra* note 26, at 1. The national average for low-income adults completely lacking health coverage is 37%. *Id.*

46. *Id.* at 12.

47. *Who Are Farmworkers?*, *supra* note 33.

48. *Demographics*, *supra* note 37, at 2 (defining a migrant as someone who has traveled at least 75 miles for work in the past year).

49. ROSENBAUM & SHIN, *supra* note 26, at 9.

50. *Id.*

51. *Medicare-Medicaid General Information*, CTRS. FOR MEDICARE & MEDICAID SERV., <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/MedicareMedicaidGeneralInformation.html> (last modified March 30, 2015).

52. Jean C. Bokinskie & Tracy A. Evanson, *The Stranger Among Us: Ministering Health to Migrants*, 26 J. CHRISTIAN NURSING 202, 202 (2009) (“[O]ver 85% of fruits and vegetables produced in the United States require hand-picking or cultivation.”)(citation omitted).

laborers are also subject to particular work-related health issues.<sup>53</sup> “Migrant workers labor in all seasons and weather conditions, including extreme heat, cold, rain, and bright sun. Work often requires stoop labor, working with soil and/or heavy machinery, climbing, and carrying burdensome loads, all of which lead to chronic musculoskeletal symptoms.”<sup>54</sup> Because of frequent work with plants, migrant farmworkers are very susceptible to skin rashes and, in the case of tobacco farmworkers, to “green tobacco sickness,” which is nicotine poisoning contracted through skin by contact with the tobacco plant.<sup>55</sup> Next to construction work, agriculture is the most dangerous occupation, with 780 deaths and 130,000 disabling injuries in 2000, although these numbers might reflect under-reporting of actual deaths and injuries.<sup>56</sup>

Migrant farmworkers are six times more likely to have tuberculosis than the general population, and “parasitic infection rates are eleven to fifty-nine times higher than in the general population.”<sup>57</sup> According to the Environmental Protection Agency (EPA), about 300,000 farmworkers suffer from acute pesticide poisoning each year.<sup>58</sup> This population suffers from the highest rate of toxic chemical injuries of any population in the United States, and long-term toxic chemical exposure can cause permanent neurological deficiencies and cancer.<sup>59</sup> Due at least in part to the lack of access to preventative care, farmworkers are more likely to be diagnosed for cancer at a later date than the non-farmworking population, and in general, farmworkers develop many types of cancer at a higher rate than non-farmworkers.<sup>60</sup> Farmworkers are also the most likely group in the United States to suffer from dermatological disorders, and they are four times more likely to suffer from heat-related illnesses.<sup>61</sup>

Migrant and seasonal workers face significant and particular work-related health risks. They are at a higher risk for health problems related to chemical exposure, such as cancer; serious

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53. Alice Larson, *Environmental/Occupational Safety and Health*, in MIGRANT HEALTH ISSUES 8, 8-9 (Nat’l Ctr. for Farmworker Health, Inc. ed., 2001).

54. Hansen & Donohoe, *supra* note 26, at 155.

55. *Id.*

56. *Id.* at 155-56. The construction field had 1220 work-related deaths in 2000.

57. *Id.* at 156-57.

58. *Id.* at 157.

59. *Id.*

60. *See id.* at 159

61. *Id.* at 157-158.

musculoskeletal injuries; traumatic injuries including amputations, respiratory and skin problems; and infectious diseases including tuberculosis.<sup>62</sup> But even while typically concentrated in a handful of states, migrant farmworkers struggle to obtain Medicaid benefits because of the transient nature of their work as farmworkers.

## II. MEDICAID OVERVIEW

*Despite the low wages and below poverty annual earnings, farm workers rarely access the safety net intended to cushion the blow of poverty for the working poor.*<sup>63</sup>

U.S. Dept. of Labor Report to Congress

Medicaid is a government-provided health insurance program for low-income families.<sup>64</sup> The funding comes from both the federal and state governments.<sup>65</sup> The level of federal funding varies from state to state and it will vary further depending upon a state's acceptance of the Affordable Care Act (ACA).<sup>66</sup> The federal government has established a few restrictions, but Medicaid is predominately state-administered.<sup>67</sup> Each state sets its own eligibility requirements, coverage options, and procedural rules.<sup>68</sup> Usually, a state will establish

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62. LARSON, *supra* note 53, at 9.

63. *U.S. Dep't of Labor Report to Congress: The Agricultural Labor Market - Status and Recommendations*, U.S. DEP'T OF LABOR (Dec. 2000), [https://migration.ucdavis.edu/rmn/word-etc/dec\\_2000\\_labor.htm](https://migration.ucdavis.edu/rmn/word-etc/dec_2000_labor.htm).

64. *See Medicaid & CHIP Coverage*, HEALTHCARE.GOV, <https://www.healthcare.gov/do-i-qualify-for-medicaid/> (last accessed Apr. 5, 2015); *U.S. Dep't of Labor Report to Congress: The Agricultural Labor Market - Status and Recommendations*, UC DAVIS, [https://migration.ucdavis.edu/rmn/word-etc/dec\\_2000\\_labor.htm](https://migration.ucdavis.edu/rmn/word-etc/dec_2000_labor.htm), (last accessed Mar. 17, 2014).

65. *See id.*

66. *Id.*

67. FARMWORKER JUSTICE, *THE AFFORDABLE CARE ACT AND FARMWORKERS: ACCESS TO HEALTHCARE 1* (2013).

68. *Id.* Before the ACA, states set the vast majority of eligibility requirements, including which categories of people were to be covered. The ACA was supposed to standardize many of these requirements, like the income level, and extend coverage to demographic groups, like non-disabled, childless adults. However, because of the voluntary nature of the ACA Medicaid expansion, this standardization is not necessarily a nationwide standard. *See also Eligibility*, MEDICAID.GOV, [medicaid.gov/affordablecareact/provisions/eligibility.html](https://www.medicare.gov/affordablecareact/provisions/eligibility.html) (last accessed Mar. 17, 2014).

income requirements, as well as state residency requirements, when deciding which categories of people are to be covered by its Medicaid program.<sup>69</sup> While states have valid reasons for establishing various requirements including resource allocation and fraud prevention, the existing requirements have significant drawbacks in many states which prevent otherwise qualified applicants from getting Medicaid coverage. Some of these requirements, which put migrant farmworkers at a structural disadvantage by the simple set-up of a state's Medicaid program, include how state residency is measured and how income is calculated.

#### A. *Medicaid for Migrants*

The federal government imposes very few restrictions on Medicaid. However, and significantly for migrant farmworkers, the federal government does set an “immigration status” requirement.<sup>70</sup> Only U.S. citizens or immigrants who fall within a specific immigrant category may apply for Medicaid.<sup>71</sup> Such special immigrant categories include asylees and refugees, survivors of trafficking or domestic abuse, recipients of Deferred Action for Childhood Arrivals (DACA), and lawful permanent residents.<sup>72</sup> However, most of these special immigrants must also meet the second significant federal limit for immigrants: the five-year ban on federal means-tested public benefits like Medicaid.<sup>73</sup> This five-year ban requires that once an immigrant has received a qualified status,<sup>74</sup> he or she must wait five years before becoming eligible for Medicaid benefits.<sup>75</sup> There are, of course, exceptions to these Medicaid rules, but these are the federal default rules: immigrant status or proof-of-citizenship, and a five-year ban.<sup>76</sup>

The state requirements are where most migrant farmworkers will suffer the most confusion and frustration. Unlike the federal

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69. MEDICAID AND MIGRANT, *supra* note 28.

70. *Id.*

71. *Summary of Immigrant Eligibility Restrictions Under Current Law*, U.S. DEP'T HEALTH & HUMAN SERVS., <http://aspe.hhs.gov/hsp/immigration/restrictions-sum.shtml> (last updated Apr. 28, 2011).

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.* Immigration is a complicated area of law; some specific details of immigration law will be explained further throughout this Note since they affect migrant farmworkers' access to Medicaid. However, a comprehensive overview of immigration law is beyond the scope of this Note.

76. *Id.*

requirements, which are few and standardized, states are free to establish their own requirements and procedures.<sup>77</sup>

### B. ACA Impact

The Affordable Care Act (ACA) was passed in 2010 and mostly came into effect in 2014.<sup>78</sup> One of the objectives of the ACA is to expand and standardize state Medicaid programs by extending coverage to non-disabled, childless adults and setting the income requirements to 133 percent of the federal poverty level.<sup>79</sup> While the ACA would in theory help meet the needs of U.S. citizen migrant farmworkers, the Medicaid expansion included in the ACA is not mandatory.<sup>80</sup> States can opt out of the ACA Medicaid expansion and forego additional federal funds.<sup>81</sup> A state's decision to opt out of the ACA Medicaid expansion, and thus forego these additional federal funds, is not an insignificant decision. The amount of money tied to a state's decision to expand or opt out is in the billions of dollars.<sup>82</sup> For instance, Florida, a state with a significant migrant farmworker population that has indicated that it will opt out, will forego over \$5 billion in federal funds.<sup>83</sup> Georgia and North Carolina, states that also have substantial migrant farmworker populations and have decided to opt out, will each forego \$2 billion as a result of their decisions to opt

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77. *Id.*

78. THE AFFORDABLE CARE ACT AND FARMWORKERS, *supra* note 67; GENEVIEVE M. KENNEY & MICHAEL HUNTRESS, U.S. DEP'T OF HEALTH & HUMAN SERV., THE AFFORDABLE CARE ACT: COVERAGE IMPLICATIONS AND ISSUES FOR IMMIGRANT FAMILIES (Apr. 2012).

79. THE AFFORDABLE CARE ACT AND FARMWORKERS, *supra* note 67; *see also* Eligibility, MEDICAID.GOV, [medicaid.gov/affordablecareact/provisions/eligibility.html](http://medicaid.gov/affordablecareact/provisions/eligibility.html) (last accessed Mar. 17, 2014).

80. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2601 (2012).

81. *Id.* at 2607.

82. Reid Wilson, *Study: Refusing Medicaid Expansion Will Cost States Billions of Dollars*, WASH. POST, Dec. 6, 2013, <http://www.washingtonpost.com/blogs/govbeat/wp/2013/12/06/study-refusing-medicaid-expansion-will-cost-states-billions-of-dollars/>. For an easy-to-read chart showing the amount of money that states opting out will forego, *see New State-By-State Analysis: States Rejecting Medicaid Expansion Under The Affordable Care Act Are Costing Their Taxpayers Billions*, COMMONWEALTH FUND, Dec. 5, 2013, <http://www.commonwealthfund.org/News/News-Releases/2013/Dec/States-Rejecting-Medicaid-Expansion-Costing-Taxpayers.aspx>.

83. Wilson, *supra* note 82.

out of the ACA Medicaid expansion.<sup>84</sup> Texas might miss out on over \$9 billion in federal funding if the state stands by its decision to opt out of the ACA Medicaid expansion.<sup>85</sup> To put this in context, Texas spent \$29.4 billion on Medicaid in 2011, which includes the federal funding and the state funding of the program.<sup>86</sup>

It will be up to each individual state to accept or reject the ACA Medicaid expansion, and if a state rejects expansion, then to continue setting its own Medicaid requirements. Of the eight states<sup>87</sup> with the historically highest concentrations of migrant farmworkers, only California, Oregon, and Washington are currently planning to expand Medicaid under the ACA.<sup>88</sup> Michigan plans to adopt a modified ACA, which will use the 133 percent federal poverty level and will apply to adults under the age of sixty-five.<sup>89</sup> Thus, the ACA will not unify or simplify Medicaid, a federal program administered by the individual states. Americans trying to access Medicaid in the various states will still have to navigate a complicated system. This system of “fifty individual state Medicaid programs”<sup>90</sup> will be further complicated for those who move frequently, as they will still be required to re-apply in

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84. *Id.*

85. *Id.*

86. *Texas Medicaid & CHIP in Perspective*, TEXAS HEALTH & HUMAN SERV. COMM’N. 8-3 (9th ed., 2013), [http://www.txohc.org/PDFsPPs/Texas%20Medicaid\\_CHIP%20Pinkbook.2013.pdf](http://www.txohc.org/PDFsPPs/Texas%20Medicaid_CHIP%20Pinkbook.2013.pdf).

87. ROSENBAUM & SHIN, *supra* note 26, at 9 fig. 4 (showing that California, Florida, Georgia, Michigan, North Carolina, Washington, Texas and Oregon are the states with the highest percentage of migrant farmworkers).

88. *Medicaid Expansion Map*, COMMONWEALTH FUND, <http://www.commonwealthfund.org/Maps-and-Data/Medicaid-Expansion-Map.aspx> (last visited Apr. 10, 2015) (providing an interactive map indicating each state’s current position on the ACA Medicaid expansion and the impact of their position on that state’s uninsured population). Although Texas has indicated it will not accept the ACA Medicaid expansion, Texas does have its own program for qualified migrant farmworkers. The Texas Migrant Care Network will be discussed in a Part IV.

89. HOUSE FISCAL AGENCY, A SUMMARY OF H. B. 4714 AS PASSED BY THE SENATE, (Aug. 29, 2013), *available at* <http://www.legislature.mi.gov/documents/2013-2014/billanalysis/House/pdf/2013-HLA-4714-D0B38F1F.pdf>.

90. Ann Marie Marciarille, *Symposium: The Next Four Years: A Cross-Practice Analysis of Legal Issues Relevant to this Presidential Term: Article: Let Fifty Flowers Bloom: Health Care Federalism After National Federation of Independent Business v. Sebelius*, 81 UMKC L. REV. 313, 313 (2012).

their new state and re-qualify based on the eligibility criteria established by that state instead of federal and uniform eligibility criteria. While the ACA was intended to standardize and simplify the Medicaid system (which was implemented in each of the fifty states according to each state's own eligibility requirements), by making the ACA Medicaid expansion voluntary, the national standardization process is unable to truly standardize and simplify the program as intended.

Even if states sign on to the ACA and extend Medicaid coverage as planned by the ACA, it is unclear (but probably unlikely) that it would make a significant difference for migrant farmworkers. While uniformity of Medicaid programs throughout the fifty states would simplify the Medicaid system for everyone including migrant farmworkers, the expansion only extends coverage to include non-disabled, childless adults below an established income level. Migrant farmworkers would still face numerous other access barriers to Medicaid. For example, migrant farmworkers would still be required to show proof-of-citizenship, wait five years after obtaining an eligible immigrant status, complete the application process, and meet state residency requirements. Thus, while under the ACA Medicaid expansion it would be possible for single, non-disabled, childless men to be covered under Medicaid, it is nevertheless not guaranteed, and there are still significant barriers to actual coverage for migrant farmworkers.

It is important to note, especially given the rhetoric surrounding both the national immigration and public health care debates,<sup>91</sup> that the ACA does not cover the estimated eleven million undocumented immigrants living in the United States.<sup>92</sup> And approximately half of all migrant and seasonal farmworkers are undocumented.<sup>93</sup> It also does not extend Medicaid coverage to documented immigrants who have been in the United States for less than five years.<sup>94</sup> To qualify for Medicaid under the ACA, an individual is still required to be a U.S. citizen, a long-term permanent resident, or a member of a very narrow category of special immigrants like refugees and asylees.<sup>95</sup>

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91. See generally Patrick Glen, *Health Care and the Illegal Immigrant*, 23 HEALTH MATRIX 197, 230 (2013).

92. Arturo Vargas Bustamante & Philip J. Van der Wees, *State of the Art and Science: Integrating Immigrants into the U.S. Health System*, 14 AM. MED. ASS'N J. ETHICS 318, 318 (2012).

93. *Who Are Farmworkers?*, *supra* note 33.

94. *The Affordable Care Act: Coverage Implications and Issues for Immigrant Families*, U.S. DEP'T HEALTH & HUMAN SERV. (Apr. 2012), <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.shtml#targeted>; see also Bustamante & Van der Wees, *supra* note 92, at 318.

95. Patient Protection and Affordable Care Act, 45 C.F.R § 152.14 (2013).



## III. ACCESS BARRIERS FOR MIGRANTS

*The union is very important for poor people. We didn't know where [to] go to ask for help and I barely spoke Spanish.*

Pedro, California Farmworker<sup>96</sup>

Migrant and seasonal farmworkers are a very diverse group. Not only are migrant farmworkers by definition distinct from seasonal farmworkers, but there are also significant variances in each of those groups. For example, immigration status varies widely, and even whether one is a naturalized U.S. citizen or a U.S. citizen by birth is an important distinction for Medicaid purposes. Both of these factors are largely overlooked in both the national discourse and the statistical analyses of the health needs of this population.<sup>97</sup>

Because of the great range in language skills, educational background, immigration status, country of origin, and other factors, it is difficult to define the exact barriers facing migrant farmworkers in accessing Medicaid. However, generally, these barriers can be grouped in three major sections: language, knowledge, and cultural understandings; federal- and state-based eligibility criteria; and group mobility.<sup>98</sup>

A. *Language, Knowledge and Cultural Understandings*

Medicaid is a massive program that in fiscal year 2014 alone requested over \$284 billion.<sup>99</sup> On average, a state spends 15 percent of its budget on Medicaid benefits.<sup>100</sup> Besides its enormous budget, and the complicated and varying federal and state eligibility criteria, Medicaid and the ACA struggle to maintain functional websites.<sup>101</sup>

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96. David Bacon, *Stories from the Field: The Story of Pedro*, FARMWORKER JUSTICE, <http://www.farmworkerjustice.org/stories/pedro.html> (last visited Apr. 3, 2015).

97. See U.S. Dep't of Health & Human Serv., *Barriers to Immigrants' Access to Health and Human Services Programs* (May 2012).

98. *Id.*

99. DEP'T HEALTH & HUMAN SERVS., CENTERS FOR MEDICARE & MEDICAID SERVICES: JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, FISCAL YEAR 2014, at 4 (2013), <http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2014-CJ-Final.pdf>.

100. *Police Basics: Where Do Our State Tax Dollars Go?*, CTR. ON BUDGET & POLICY PRIORITIES (Apr. 12, 2013), <http://www.cbpp.org/cms/?fa=view&id=2783>.

101. While there has been significant controversy surrounding the ability of the ACA website to handle the onslaught of users and crashing as a result of the high volume, those crashes are not the issue in this context.

For example, Medicaid.gov does not have an option to switch the website's language.<sup>102</sup> Healthcare.gov, the so-called "ObamaCare" site, does have a Spanish equivalent, CuidadoDeSalud.gov.<sup>103</sup> However, even this Spanish language site does not solve all language issues for Spanish speakers; the website merely provides instructions in Spanish while the forms provided are in English.<sup>104</sup> These are just a few examples of the multiple factors that determine the ease of accessibility of Medicaid, particularly its online forum. It should not be surprising that familiarity with the system (or lack thereof as is the case of many migrants) plays a significant role in access.<sup>105</sup> The statistical information that has been gathered about migrant and seasonal farmworkers—their low educational levels and lack of English language skills—means that "coverage does not automatically translate into access."<sup>106</sup> Medicaid applicants all face certain problems, including complex forms, language difficulties, and the details of Medicaid coverage.<sup>107</sup> But since only 30 percent of migrant

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Such crashes obviously make use of the website difficult, although not necessarily any more difficult for migrant farmworkers than for the rest of the website's users.

102. MEDICAID.GOV, <http://www.medicaid.gov> (last accessed Apr. 10, 2015) (lacking an option or button to convert website into Spanish, the most common non-English language used in the United States); *id.* (having an obvious option to link to the Spanish equivalent of the website).
103. This Note uses Spanish in its examples because Spanish is the most common non-English language in the United States, even in non-Hispanics households. *See generally* Ana Gonzalez-Barrera & Mark Hugo Lopez, *Spanish is the Most Spoken non-English Language in U.S. Homes, Even Among Non-Hispanics*, PEW RESEARCH CTR. (Aug. 13, 2013), <http://www.pewresearch.org/fact-tank/2013/08/13/spanish-is-the-most-spoken-non-english-language-in-u-s-homes-even-among-non-hispanics/>; CUIDADODESALUD.GOV, <https://www.cuidadodesalud.gov/es/> (last accessed Apr. 3, 2015).
104. Kelli Kennedy & Russell Contreras, *Obamacare's New Website Isn't in Spanish. It's in Spanglish.*, DENVER POST, Jan. 13, 2014, [http://www.denverpost.com/obamacare/ci\\_24900400/obamacares-new-website-isnt-spanish-its-spanglish](http://www.denverpost.com/obamacare/ci_24900400/obamacares-new-website-isnt-spanish-its-spanglish).
105. Bustamente & Van der Wees, *supra* note 92, at 319.
106. *Id.*
107. HANSEN & DONOHOE, *supra* note 26, at 160; MEDI-CALI, <http://www.medi-cal.ca.gov> (last accessed Apr. 3, 2015). Information pertaining to Medicaid coverage and eligibility for new residents like migrant farmworkers on California's Medicaid website was very inaccessible. If in the course of academic research, information on the state's official website is difficult to locate, it would presumably be even more difficult for a migrant farmworker, with a typically low level of education and language barriers, to access the information. *See also* Katie Coburn et al., *The Texas Migrant Care Network: Police Context*

farmworkers say they speak English well, and just 27 percent have made it past a ninth grade education level, migrant farmworkers struggle even more than the average Medicaid applicant.<sup>108</sup> Based purely on language, education level, and familiarity with Medicaid, migrant farmworkers face an additional huge hurdle to accessing Medicaid.<sup>109</sup>

Furthermore, the application process itself may be intimidating for many migrant farmworkers. There is evidence that many migrants—immigrant and U.S. citizen alike—do not apply for Medicaid and other public health benefits for which they are eligible for fear of jeopardizing their own immigrant status or that of family or community members.<sup>110</sup> This fear is typically a result of living in what is known as a “mixed status family,” although the rationale behind this fear is not limited to an individual’s biological family and can expand to the community in general.<sup>111</sup> “A mixed status family is one where some members of the family have different immigration statuses from other members of the family.”<sup>112</sup> A simple and common example of a mixed status family is one where one or more children are native born U.S. citizens, while one or both parents are undocumented immigrants.<sup>113</sup> Although an individual is eligible for Medicaid based only on his or her own circumstances (including citizenship or immigration status, state residency, and income), many migrant farmworkers have a justifiable fear that they will draw unwanted attention to members of their family or community who do not have legal status within the United States.<sup>114</sup>

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*and Program Implementation*, TEXAS ASS’N OF CMTY. HEALTH CTR. (Sept. 19, 2009), [https://www.tachc.org/content/TMCN\\_Policy\\_Context\\_and\\_Program\\_Implementation.pdf](https://www.tachc.org/content/TMCN_Policy_Context_and_Program_Implementation.pdf).

108. *Demographics*, *supra* note 37, at 2-3.

109. *See* HANSEN & DONOHOE, *supra* note 26, at 160.

110. LEONARD D. CUELLO, PA HEALTH LAW PROJECT, HEALTH CARE FOR IMMIGRANTS: A MANUAL FOR ADVOCATES 26 (Oct. 2011).

111. It is hard to know how many families are of “mixed status” although estimates show that there are approximately 16 million U.S. born children living in mixed status families. Tim Gaynor, *For Mixed-Status Families, U.S. Immigration Reform Would End Anxiety*, REUTERS, Aug. 10, 2013, <http://www.reuters.com/article/2013/08/10/us-usa-immigration-mixedstatus-idUSBRE97903H20130810>.

112. Cuello, *supra* note 110, at 25.

113. *Id.*

114. Mark Hugo Lopez & Ana Gonzalez-Barrera, *High Rate of Deportations Continue Under Obama Despite Latino Disapproval*, PEW RESEARCH CTR. (Sept. 19, 2013), <http://www.pewresearch.org/fact-tank/2013/09/19/high-rate-of-deportations-continue-under-obama->

Additionally, cultural norms can be an impediment to accessing Medicaid for some migrant farmworkers.<sup>115</sup> These cultural norms can be specific to the migrant farmworker and his or her ethnic heritage, or more general to migrant farmworkers as a class.<sup>116</sup> For example, migrant farmworkers tend to “value hard work, family support, and self-reliance, and therefore fe[el] ashamed to use public benefits.”<sup>117</sup> Because of these generalized cultural norms of migrant farmworkers as a whole, coupled with a fear of exposing family or friends to negative immigration consequences like removal from the United States, many migrant farmworkers are opposed to applying for Medicaid.

### B. Federal and State Based Eligibility Criteria

The federal government imposes few structural restrictions on migrant farmworkers’ access to Medicaid. The two major limitations are the proof-of-citizenship requirement and a five-year ban. Essentially, the proof-of-citizenship requirement mandates that anyone who applies for Medicaid prove that he or she is a U.S. citizen, or an otherwise qualified immigrant. A 2006 law, tucked into the Deficit Reduction Act, made this requirement more formal and no longer allowed citizens to simply sign a statement attesting to their citizenship.<sup>118</sup> Prior to its enactment, immigrants legally residing in the U.S. already were required to show proper documents, and

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despite-latino-disapproval/; Elizabeth Llorente, *Deporter-In-Chief? President Obama’s Base Turning Against Him Over Inaction On Immigration*, FOXNEWS LATINO (Mar. 7, 2014), <http://latino.foxnews.com/latino/politics/2014/03/07/deporter-in-chief-president-obama-base-turning-against-him-over-inaction-on/>. During Obama’s presidency, more immigrants have been deported, or removed, each year than were deported annually during Bush’s presidency.

115. U.S. DEP’T OF HEALTH & HUMAN SERV., *supra* note 97, at 10.
116. Rachel Becker, *Support and Barriers to Help Seeking in Latina/o Migrant Workers*, OPEN ACCESS DISSERTATIONS, UNIV. OF MIAMI, at 44 (2013) (explaining that many migrant workers rely on traditional medicines as a first resort for treating their medical needs. For example, in Latino culture, the norm is to treat mental health problems as a religious issue, not a medical issue. Mental health problems are traditionally seen as a result of “bad spirits”).
117. U.S. DEP’T OF HEALTH & HUMAN SERV., *supra* note 97, at 10.
118. *New Requirements to Document Citizenship & Identity Become Effective September 1, 2006 for Medicaid*, N.C. HEALTH START FOUND. (July 2006), <http://www.nchealthystart.org/outreach/prognews/citizenship.html>; Robert Pear, *Medicaid Rules Toughened on Proof of Citizenship*, N.Y. TIMES June 5, 2006, [http://www.nytimes.com/2006/06/05/washington/05medicaid.html?\\_r=0](http://www.nytimes.com/2006/06/05/washington/05medicaid.html?_r=0).

undocumented immigrants were already disqualified from receiving Medicaid benefits.<sup>119</sup>

Allegedly, the Deficit Reduction Act was enacted to combat widespread citizenship fraud within Medicaid, although a July 2005 report by the Health and Human Services Office found that such fraud did not exist and that “virtually no ineligible immigrants [were] applying for or receiving Medicaid.”<sup>120</sup> Additionally, “most ‘qualified aliens’ entering the country . . . are banned from receiving ‘federal means-tested public benefits’ [like Medicaid] for a period of five years beginning on the date of the alien’s entry with a qualified alien status.”<sup>121</sup>

Medicaid eligibility criteria established by an individual state are more common than the federally established criteria. And despite the fact that each state can set its own requirements, there are two broad criteria that states agree upon. First, each state has an income/asset-based assessment. For the vast majority of Americans under the age

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119. Valarie Blake, *Health Law: Citizenship Requirements for Medicaid Coverage* 14 AM. MED. ASS’N J. ETHICS 324, 325 (2012).

120. *Id.* See also *New Citizenship Documentation Option for Medicaid and Chip is Up and Running*, CTR. ON BUDGET & POL’Y PRIORITIES (Apr. 20, 2010), <http://www.cbpp.org/cms/?fa=view&id=3159>; *Self-Declaration of U.S. Citizenship for Medicaid*, DEP’T OF HEALTH & HUMAN SERV., OFFICE OF INSPECTOR GENERAL (July 2005), available at <http://oig.hhs.gov/oei/reports/oei-02-03-00190.pdf>.

121. *Summary of Immigrant Eligibility Restricts Under Current Law*, *supra* note 71. Certain immigrants are exempted from the five-year ban on federal means-tested public benefits like Medicaid. “States have the option to provide Medicaid [exempt from the five-year ban on public benefits] . . . to children and pregnant women who are lawfully residing in the United States without a 5-year delay . . . [;] refugees, asylees, aliens whose deportation is being withheld, Amerasians, and Cuban/Haitian entrants and victims of a severe form of trafficking[; and] veterans, members of the military on active duty, and their spouses and unmarried dependent children.” *Id.* Non-immigrants or temporary residents, undocumented immigrants, and individuals given temporary administrative statuses (for example, they are given a stay of deportation or are granted voluntary departure to return to their home country) are not eligible for federal public benefits. *Id.* See also NAT’L IMMIGRATION LAW CTR, FEDERAL GUIDANCE ON PUBLIC CHARGE: WHEN IS IT SAFE TO USE PUBLIC BENEFITS? 1-2 (2014), available at <http://www.nilc.org/document.html?id=164> (last accessed Apr. 2, 2015). Once an immigrant becomes a U.S. citizen, he no longer has to worry about becoming a public charge and losing citizenship; it is only a concern for immigrants entering or re-entering the United States or for those immigrants who apply to become a lawful permanent resident (LPR). The government applies the public charge doctrine, and can deny entry, re-entry or LPR status based on a finding that an immigrant is likely to become a public charge in the future.

of sixty-five, the ACA establishes that the national Medicaid minimum eligibility for income must be set at 133 percent of the federal poverty level.<sup>122</sup> Second, each state has a state residency requirement. Basically, each state may require that an individual establish residency within that state first, before the individual may apply for Medicaid within that state. After establishing residency and then applying for Medicaid, the state typically allows itself a certain number of days to review the application before granting Medicaid benefits to a qualified applicant. It is this last requirement that causes significant problems for the migrant farmworker population.

### C. *Mobility of Group*

A migrant farmworker is defined by the Department of Labor as an agricultural worker who, because of the nature of his work, is required to be away from his permanent place of residence.<sup>123</sup> The Supreme Court has defined domicile, or permanent place of residence, as that place where an individual in fact resides, combined with the intent to continue residing in that place.<sup>124</sup> By definition then, a migrant farmworker is away from his permanent residence and cannot meet the state residency requirement in any other state.<sup>125</sup> For states concerned with the expansion of Medicaid benefits to non-residents, the fact that migrant farmworkers are away from their permanent place of residence translates to migrant farmworkers needing medical attention in their state of temporary residency. Obviously, this possibility would use public resources that a state understandably would like to reserve for its own residents.

While a migrant farmworker would have residence in fact, because he is physically present and living in the state, he typically will lack

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122. *Eligibility*, MEDICAID.GOV, <http://www.medicaid.gov/affordablecareact/provisions/eligibility.html> (last accessed Mar. 17, 2014) (explaining that the national eligibility level is 133% of the federal poverty level). Prior to the ACA, states could use their own state poverty levels as guidelines or eligibility criteria for income or means-tested requirements.
123. *Who Are Farmworkers?*, *supra* note 33; ROSENBAUM & SHIN, *supra* note 26, at 6; 29 C.F.R. §§ 500.20 (2014).
124. *Texas v. Florida*, 306 U.S. 398, 424-425 (1938). This case is a tax case; most case law explaining permanent place of residence comes from estate, tax and probate law. However, the definitions that the Court arrives at are applicable in other contexts, like establishing state residency for public benefits purposes. The Court applied the physical presence plus intent to remain formula to public education, a public benefit, in *Martinez v. Bynum*, 461 U.S. 321 (1983).
125. MEDICAID AND MIGRANT, *supra* note 28 (defining residency as “a person living in the state with the intention to remain there permanently or for an indefinite period.”).

the intent to remain, which is an integral part of establishing domicile. While an individual's stated intent to reside permanently or indefinitely is a factor that the state may consider when evaluating the validity of a claim to residency, the state may also look to the pattern or "course of conduct," which are controlling factors for determining residency.<sup>126</sup> Should a migrant farmworker attempt to claim residency in the state where he is working for a given period of time, a state may reasonably conclude, that based on that individual's pattern of repeated movement following agricultural cycles, that his stated intent to reside permanently does not match his course of conduct, and thus that state may invalidate his claim to residency for Medicaid purposes. Thus, due exclusively to their transient work situation, migrant farmworkers can be excluded from receiving Medicaid in the state in which they work, despite being otherwise qualified, simply because they fail to meet the state residency requirement.<sup>127</sup>

Typically, the particular means of establishing state residency are worded broadly and are a source of significant confusion.<sup>128</sup> Most states have some sort of frequently asked question (FAQ) section on their department of health website. For example, Florida's website<sup>129</sup>

126. *Texas v. Florida*, 306 U.S. at 425.

127. Many people do not meet Medicaid requirements for reasons besides failure to meet the state residency requirement. However, migrant farmworkers, by definition only temporarily within a state's border, are excludable from Medicaid coverage within that state based solely on the state residency requirement.

128. *Overview of Final Medicaid Eligibility Regulation*, STATE HEALTH REFORM ASSISTANCE NETWORK (Apr. 2012) (policy brief), available at [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf\\_72572](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf_72572); CMS Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa, 42 C.F.R. § 435.403 (2006) (defining "state residence"). The definition, or the means by which residency is established, can be categorized as broad and confusing because "intent" is hard to define. Despite 42 C.F.R. 435.403, which defines residency, states can and do still provide little guidance on their websites. The typical migrant farmworker might find the phrase "intent to reside" particularly confusing, especially given the other factors that they are facing at the same time: little guidance with complicated forms, language and cultural difference, a widespread distrust of government systems and a fear of deportation, and lack of familiarity with Medicaid. Arguably, an average American, without the complications and access barriers that the migrant farmworkers face, would also find this to be confusing.

129. Examples were drawn from Florida because it has a very significant population of migrant farmworkers, but does not have a special program providing them with Medicaid benefits. While Florida is similar to Wisconsin and Texas in this demographic division, it differs in the provision of Medicaid benefits to the population.

provides the following question and then gives the state's vaguely-worded answer:

Do I have to live in Florida a certain amount time of before I can apply?

It is not necessary to have lived in Florida for a certain length of time, but you need to be a resident of Florida. If you just moved to Florida and were covered by Medicaid in another state, you will still need to apply for Medicaid in Florida.<sup>130</sup>

Additional questions on Florida's website are common and serve as useful examples for the types of questions Medicaid applicants, including migrant farmworkers, ask. Florida's responses are likewise typical of state websites.<sup>131</sup> Two particularly applicable questions include: "How long will it take to decide my Medicaid eligibility?" and "When does my Medicaid coverage begin and end?"<sup>132</sup> Florida, like many other states, indicates that applications must be decided within forty-five days, and that there is a process for appealing that decision.<sup>133</sup> Finally, an applicant can request retroactive coverage, and

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130. *Florida Medicaid*, FLORIDA AGENCY FOR HEALTH CARE ADMIN., <http://www.floridahealthfinder.gov/reports-guides/medicaid-reference.aspx> (last accessed Jan. 21, 2014).

131. *Medicaid FAQs*, GEORGIA DEP'T OF CMTY. HEALTH, <http://dch.georgia.gov/medicaid-faqs> (last accessed Mar. 17, 2014). Georgia, another state with a significant migrant farmworker population, has a FAQ section on its state Medicaid site. The website states, under the "Citizenship and Residency" section, that one must be a Georgia resident to qualify for Medicaid. However, the only clarifying questions have to do with U.S. citizenship. This provides little to no guidance to someone trying to determine if they qualify as a Georgia resident or not. *See also Medicaid Expansion 2014 Frequently Asked Questions*, WASH. ST. HEALTH CARE AUTH., <http://www.hca.wa.gov/hcr/me/Pages/faq.aspx#new17> (last accessed Mar. 21, 2014). Likewise, the Washington Medicaid FAQ website only references "residency" when it explains that the five-year ban will still apply under the "new" Medicaid (presumably referencing the ACA Medicaid expansion, as Washington has decided to expand and standardize Medicaid under the ACA). *Applying for Health Coverage*, OREGON HEALTH PLAN, <http://www.oregon.gov/oha/healthplan/pages/apply.aspx> (last accessed Mar. 17, 2014). Oregon's Medicaid FAQ page only explains that residency is one of the qualifications to receive Medicaid in that state.

132. *Id.*

133. 42 C.F.R. § 435.911 (2010). Medicaid applications must be decided within 45 days, unless the application is based on disability, in which case the application must be decided within 90 days. However, because of limited resources and understaffing, these applications are not always decided within the time frame established by the Medicaid statute.



if granted, Florida (like many states) *may* extend Medicaid back three months, as long as the applicant would have been eligible during that time period.<sup>134</sup>

Some state statutes explicitly address residency requirements for migrant farmworkers. Wisconsin, for example, maintains a very user-friendly website where one can access the definition of “state resident,” both generally and specifically for migrant farm workers.<sup>135</sup> This is helpful for migrant farmworkers because it removes the guesswork of determining eligibility.<sup>136</sup>

#### IV. UNIQUE STATE MODELS

*Given the high needs of migrant and seasonal farmworker families, health providers and governments must search for innovative ways to provide them access to health coverage programs to which they are entitled.*<sup>137</sup>

Each state’s ability to manipulate its requirements for Medicaid, which can cause serious confusion and impede access, also allows each state to flexibly and creatively solve problems of access. A few states have created workable solutions to health care and access issues that its populations face. Specifically, Texas and Wisconsin have targeted Medicaid access issues for migrant workers, focusing specifically on access issues arising out of the mobility of this demographic group.

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Medicaid applications must be decided within 45 days, unless the application is based on disability, in which case the application must be decided within 90 days. However, because of limited resources and understaffing, these applications are not always decided within the time frame established by the Medicaid statute. *See* Arielle Levin Becker, *DSS Trial: Are Medicaid Application Delays Breaking The Law?*, CT MIRROR (May 14, 2013), <http://ctmirror.org/dss-trial-are-medicaid-application-delays-breaking-law/>.

134. *Id.* Medicaid coverage usually ends at the end of the month in which the applicant no longer qualifies, which could be for a number of reasons, including moving outside of the state or earning an income higher than the means-test permits. When Medicaid coverage begins is slightly more complicated, and it can depend on factors like retroactive coverage and prior coverage, which in Wisconsin, can mean continuous coverage.
135. *Medicaid Eligibility Handbook*, WISC. DEPT. OF HEALTH SERVS. § 6.1 Residency Eligibility (Aug. 28, 2013), *available at* <http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm>.
136. In contrast to Florida’s Frequently Asked Questions Section, *see supra* note 130, which still leaves open the question of what duration of residency is sufficient to meet Medicaid requirements, the Wisconsin handbook provides a clear stated four-part test. *See supra* note 135.
137. Coburn et al., *supra* note 107, at 7.

## A. Texas

Recognizing the incredible need and vulnerability of migrant farmworkers and the size of this population residing within its borders, Texas established the Migrant Care Network (TMCN).<sup>138</sup> Texas has between 200,000 to 300,000 migrant and seasonal farmworkers, and at least 100,000 additional migrant children.<sup>139</sup> TMCN cites migrant farmworkers' "high mobility . . . [and] language and cultural barriers, inaccessibility to health care services, low socioeconomic status and lack of health insurance coverage [as] a few [of the] obstacles faced by [migrant farmworkers] when accessing care."<sup>140</sup> Because of these barriers, only 13 percent of eligible farmworkers use needs-based public benefits like Medicaid, despite the fact that the overwhelming majority of migrant farmworkers qualify based on their low level of income.<sup>141</sup> This program expands coverage for migrant farmworker children and families.<sup>142</sup> TMCN allows Texas migrants to travel and work out-of-state for a period of up to six months, and continue with their Texas Medicaid coverage.<sup>143</sup> To use TMCN Texas "portable" Medicaid, a migrant farmworker need only to be enrolled in Texas Medicaid and use an out-of-state provider who is enrolled in the TMCN network.<sup>144</sup> This "portable" Medicaid covers both emergency and regular medical services,<sup>145</sup> and it includes "most primary and preventative services, as well as dental, pharmacy and behavioral health services."<sup>146</sup> The program began in 2008 and "has successfully paid almost 500 claims to different providers in Illinois,

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138. *Program*, TEX. ASS'N OF CMTY. HEALTH CTRS., <http://www.tachc.org/programs-services/texas-migrant-care-network/program> (last visited Mar. 25, 2014).

139. *Id.* As always, these numbers are estimates. TMNC also groups migrant and seasonal farmworkers together in its population estimates and policy analysis.

140. *Id.*

141. *See id.* (referencing Dep't of Labor estimates).

142. *Id.*

143. *Id.* California also has reciprocal agreements for its migrant farmworkers who travel outside of the state; its network is limited to reciprocity between California, Oregon and Washington.

144. *What is the Texas Migrant Care Network?*, TEX. ASS'N OF CMTY. HEALTH CTRS., [https://www.tachc.org/content/Fact\\_Sheet\\_for\\_Outreach\\_&\\_Eligibility\\_Staff\\_05-09\\_\(1\).pdf](https://www.tachc.org/content/Fact_Sheet_for_Outreach_&_Eligibility_Staff_05-09_(1).pdf) (last visited Mar. 25, 2014).

145. ROSENBAUM & SHIN, *supra* note 26, at 22.

146. *What is the Texas Migrant Care Network?*, *supra* note 144.

Minnesota, Ohio, and Washington.”<sup>147</sup> Texas’s TMNC Medicaid program, which targets migrant farmworkers, does not expand or extend Texas Medicaid; it just makes it more functional for Texas migrant farmworkers who are temporarily out of the state.<sup>148</sup> Like the Wisconsin program, Texas Medicaid helps prevent coverage gaps, by allowing migrant farmworkers to keep their Medicaid while temporarily out of state.<sup>149</sup>

TMCN is not without its drawbacks. It does not extend coverage to the majority of migrant farmworkers who are male and without children.<sup>150</sup> It also requires that migrant farmworkers go to an enrolled out-of-state TMCN provider; there are providers in only ten states, aside from Texas.<sup>151</sup> TMCN recognizes the fact that “relatively few” out-of-state providers are enrolled in the TMCN network, and “many migrant families do not know how to locate those primary care physicians in other states who will accept Texas Medicaid.”<sup>152</sup> Provider availability and the payment of claims have proven to be two of the program’s biggest challenges.<sup>153</sup> While information is

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147. *Program, supra* note 138.

148. *Program, supra* note 138.

149. *What is the Texas Migrant Care Network?, supra* note 144.

150. *Id.* This issue is not necessarily unique to migrant farmworker men without children. When Medicaid was initially implemented, it was assumed that single men without children did not need government assistance or support; see Suzy Khimm, *How the Safety Net Leaves Out Poor, Unmarried Men*, MSNBC (Mar. 10, 2014), <http://www.msnbc.com/msnbc/left-out-the-safety-net>. This social safety net was designed primarily for women and children, who were seen as potentially needing additional support from the government, whereas men were not seen as needing this support. This distinction is attributable to the societal attitudes towards work and gender roles that were prevalent at the time Medicaid was signed into law, on July 30, 1965. See HISTORY, CTRS. FOR MEDICARE & MEDICAID SERV., <http://www.cms.gov/About-CMS/Agency-Information/History/index.html?redirect=/history> (last modified June 13, 2013).

151. *Texas Migrant Care Network- Enrolled Providers* TEX. ASS’N OF CMTY. HEALTH CTRS., <http://www.tachc.org/programs-services/texas-migrant-care-network/program> (last accessed Apr. 10, 2015) Of the eight states with the highest concentration of migrant farmworkers, only Michigan and Washington accept Texas’s portable migrant Medicaid. This suggests that although Texas has a unique solution to Texan migrant farmworkers’ access to Medicaid while they are traveling out-of-state for a longer period of time, the solution might not be very functional in practice.

152. *Program, supra* note 138.

153. ROSENBAUM & SHIN, *supra* note 26, at 23.

available, it is not well-understood by either out-of-state medical providers or the migrant farmworkers for whom the program was designed.<sup>154</sup>

### B. Wisconsin

Beginning in 1996, Wisconsin began its “unilateral” Medicaid program, which was developed with an eye towards facilitating access for vulnerable social groups like migrant farmworkers.<sup>155</sup> Medicaid coverage is automatically extended to anyone with an out-of-state Medicaid enrollment card.<sup>156</sup> The “reciprocal rapid enrollment system” allows migrant farmworkers who already have Medicaid coverage in another state to move to Wisconsin and be continually covered, with no gap in coverage while they are in transit and reapplying.<sup>157</sup> Additionally, Wisconsin determines income eligibility using annual income, rather than monthly income, thus more accurately reflecting migrant farmworkers’ income, which is subject to monthly fluctuation based on farm work availability.<sup>158</sup>

Wisconsin’s rapid enrollment program has two major drawbacks. First, because the program only works for those who already have Medicaid from another state, any new Medicaid applicant must go through the standard procedure. Although there is no “gap” in this scenario, migrant farmworkers might be at a higher risk for coming to Wisconsin without existing Medicaid coverage because of the access barriers they face in other states. Because migrant farmworkers face substantial barriers<sup>159</sup> in applying for Medicaid in any state, they are more likely than other demographic groups to enter Wisconsin and not have received Medicaid in their prior state of residence or work. This is problematic for Wisconsin’s creative solution to a gap issue, which relies on the assumption that an individual, newly arrived to Wisconsin and applying for Medicaid in that state, had previously received Medicaid benefits; this is not generally as true for migrant farmworkers as it might be for other populations. Second, while those who are covered by Medicaid from another state do not face the risk of a gap, they may face the risk that they will be ineligible for

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154. *Program, supra* note 138.

155. Jennifer Eldridge, *Health Care Access for Immigrants in Texas*, at 13 (Policy Research Project on Expanding Health Care Coverage for the Uninsured, Working Paper, May 2012).

156. MEDICAID AND MIGRANT, *supra* note 28.

157. *Id.*

158. *Id.*

159. These barriers can be both federal and state barriers, and are sometimes structural and sometimes cultural, as explained above in Part III on Access Barriers for Migrants.

Medicaid based on Wisconsin's criteria.<sup>160</sup> For example, Wisconsin's eligibility standard for parents to receive Medicaid benefits is 95 percent of the federal poverty limit while Wyoming's standard is 57 percent.<sup>161</sup> Thus, an adult coming from Wyoming would be ineligible for Wisconsin's Medicaid because of the higher threshold in Wisconsin.

## V. A LARGER SOLUTION

*Medical personnel came to the trailer park to perform examinations . . . . We farmworkers only seek medical attention when it's already too late. There are many of us with diseases like cancer. We live next to fields where they constantly fertilize. In time health issues arise due to the pesticides.*

Marisol, California Farmworker<sup>162</sup>

Individual states such as Wisconsin and Texas have implemented programs that address the needs of migrant farmworkers within their borders.<sup>163</sup> These programs demonstrate that there is a need and that there are workable solutions. However, before a nation-wide solution can even be considered, an understanding of how recent case law applies health care coverage to the states is required. Not only is the ACA Medicaid expansion voluntary, but an Equal Protection challenge under the Fourteenth Amendment would fail, making a nation-wide mandated solution impossible. Although the fundamental right to travel for newly arrived residents would be infringed, the state residency requirement and the forty-five days period for review

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160. ROSENBAUM & SHIN, *supra* note 26, at 23.

161. *State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014*, CTR. FOR MEDICAID & CHIP SERV.

162. David Bacon, *Stories from the Field: The Story of Marisol, FARMWORKER JUSTICE*, <http://www.farmworkerjustice.org/stories/marisol.html> (last visited Apr. 3, 2015).

163. Some states, like California, have experienced additional complications in providing Medicaid for the migrant farmworkers within its borders because of the particular residency requirements that California required. Within the state of California, migrant farmworkers move internally a great deal; one would assume that they would have had no problems maintaining their Medicaid benefits in such a situation. However, county governments were involved in the Medicaid application process and required re-application and re-qualification of a migrant farmworker each time he or she changed *counties*. In 2002, the state declared this to be an impermissible Medicaid coverage practice. For more information, see ROSENBAUM & SHIN, *supra* note 26, at 21-22.

of a Medicaid application would survive strict scrutiny. In satisfying its compelling state interest of fraud prevention, the requirement of state residency and the provision of a forty-five day review period are properly limited to the “least restrictive means” to accomplish the state’s compelling interest.

Given the widespread resistance to federally-mandated health care programs, it is appropriate to conduct a policy analysis for Medicaid expansion for migrant farmworkers, so that states might consider the rationales behind expanding, or limiting, Medicaid coverage to migrant farmworkers.

#### A. *What Does the Law Say?*

The Fourteenth Amendment of the U.S. Constitution reads:

All persons born or naturalized in the United States . . . are citizens of the United States and of the State wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States . . . nor deny to any person within its jurisdiction the equal protection of the laws.<sup>164</sup>

The Equal Protection Clause prohibits a state from depriving someone within its territory the equal protection of the law. When the Equal Protection Clause is allegedly violated, the Court will scrutinize the offending state law to determine if it unconstitutionally applies to a suspect class or infringes on fundamental rights.<sup>165</sup> The law will pass through a three-step analysis that asks three questions: First, what is the classification the law draws? Second, what is the appropriate level of scrutiny? And third, does the government action meet the level of scrutiny? When heightened scrutiny is applied, a state should seek the least restrictive measure possible to accomplish its purpose.<sup>166</sup>

Classification, or the demographic group to whom the law will be applied, is determined by looking at the face of the law and both the impact and purpose of the law.<sup>167</sup> Classifications based on race or national origin are always suspect and require strict scrutiny.<sup>168</sup> Some rights, like the right to travel, are considered so fundamental that any

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164. U.S. CONST. amend. XIV, § 1.

165. *Shapiro v. Thompson*, 394 U.S. 618, 639 (1969).

166. *See, e.g., Aliessa v. Novello*, 96 N.Y.2d 418, 432 (2001).

167. *See, e.g., Village of Arlington Heights v. Metropolitan Hous. Dev. Corp.*, 429 U.S. 252 (1977).

168. For a summary of classifications and fundamental rights, *see generally* Robert F. Wall, *Equal Protection: Analyzing the Dimensions of a Fundamental Right- The Right to Vote*, 17 SANTA CLARA L. REV. 163, 185 (1977).

law burdening these rights requires strict scrutiny.<sup>169</sup> Either a suspect class or a fundamental right infringement is sufficient for a Fourteenth Amendment Equal Protection Clause challenge.<sup>170</sup>

A challenged law can be subject to three levels of scrutiny.<sup>171</sup> Rational basis scrutiny is the lowest threshold and requires a reasonable relationship between the law and a legitimate governmental interest.<sup>172</sup> The second level of scrutiny is intermediate scrutiny, which requires a substantial relationship to an important government interest.<sup>173</sup> The third and most difficult level of scrutiny is strict scrutiny, which requires a compelling state interest and narrow tailoring of the law to ensure that it does not unnecessarily infringe upon an individual's rights.<sup>174</sup>

Medicaid's state residency requirement discriminates based on the classification of newly arrived residents, as opposed to longtime residents.<sup>175</sup> In *Saenz v. Roe*, the U.S. Supreme Court addressed the classification of "newly arrived residents" and the fundamental right to travel from one state to another, without suffering discrimination.<sup>176</sup> In 1992, in an effort to reduce the state welfare budget, California passed a law limiting welfare benefits for newly arrived residents, defined as those residents who had lived in the state for less than a year.<sup>177</sup> In 1996, while Saenz was challenging this residency requirement, then-President William Clinton passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which replaced California's existing benefits program with Temporary Assistance for Needy Families (TANF) and expressly allowed states to limit welfare benefits for state residents who had lived in-state for less than a year.<sup>178</sup> Saenz challenged the California law and PRWORA, both of which provided for a one-year residency requirement before a state resident could receive welfare benefits.<sup>179</sup> The U.S. Supreme Court ruled in Saenz's favor and held that the laws impermissibly discriminated between new state residents and longtime

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169. *See id.* at 163.

170. *Washington v. Davis*, 426 U.S. 229, 247 (1976).

171. *See generally* Wall, *supra* note 168.

172. *Id.*

173. *Id.*

174. *Id.*

175. MEDICAID AND MIGRANT, *supra* note 28.

176. *Saenz v. Roe*, 526 U.S. 489, 504 (1999).

177. *Id.* at 489.

178. *Id.* at 495.

179. *Id.* at 496.

state residents.<sup>180</sup> While the state had a legitimate interest in conserving its budget, duration of residence was not a sufficient justification for discriminating between otherwise equally eligible and needy state residents.<sup>181</sup> The state failed to show that it had a compelling governmental interest that required it to restrict the fundamental right of travel, as guaranteed by the Fourteenth Amendment Equal Protection Clause.<sup>182</sup>

In *Saenz*, the Court applied strict scrutiny to California's law and held that the state had violated the fundamental right to travel.<sup>183</sup> This right is implicated when an individual, newly arrived to a state, is treated differently than those individuals who have resided in that state for a longer period of time. In other words, one aspect of the right to travel is the right to be treated equally in one's new state of residence.

While *Saenz* addressed the right to travel for native born U.S. citizens, other cases have dealt more directly with the right to travel of persons who were eligible for welfare health benefits but were denied these benefits on account of their alienage or national origin.<sup>184</sup> In *Graham v. Richardson*, the U.S. Supreme Court struck down laws in both Arizona and Pennsylvania that denied aliens welfare benefits based purely on state residency requirements and held the laws to be in violation of the Fourteenth Amendment's Equal Protection Clause. The Court held that state laws utilizing "classifications based on alienage, like those based on nationality or race, are inherently suspect and subject to close [strict] judicial scrutiny."<sup>185</sup>

180. *Id.* at 506.

181. *Id.*

182. *Id.* at 499. Restrictions warranting and passing strict scrutiny are limited to those that serve a compelling state interest. Additionally, these state-level restrictions must be the least restrictive means practically available.

183. *Id.*

184. *See, e.g.*, *Graham v. Richardson*, 403 U.S. 365, 370 (1971); *see Mathews v. Diaz* 426 U.S. 67 (1976).

185. *Graham*, 403 U.S. at 371; Leonard Dinnerstein, *The Supreme Court and the Rights of Aliens*, AM. POL. SCI. ASS'N & AM. HIST. ASS'N (1985) available at <http://www.apsanet.org/imgtest/supremecourtalienright.pdf>. Other state-court based cases support this proposition; for instance, *Aliessa v. Novello* (96 N.Y.2d 418, 432 (2001)), from the Court of Appeals of New York, dealt with long-term permanent residents who were denied Medicaid benefits in New York based solely on their status as legal aliens. In that case, the plaintiffs argued that this was a violation of both the U.S. and New York Constitutions. The Court of Appeals agreed and applied strict scrutiny. The court held that the denial of



While the U.S. Supreme Court has held that *state* laws which discriminate based on alienage or length of in-state residency are in violation of the Fourteenth Amendment's Equal Protection Clause, the same does not necessarily hold true for *federal* laws.<sup>186</sup> In *Mathews v. Diaz*, the Supreme Court upheld a federal law that allowed the federal government to restrict aliens from qualifying for or receiving benefits, enjoyed by U.S. citizens and long-term permanent residents, for a period of five years.<sup>187</sup> The Court said that the Fourteenth Amendment Equal Protection Clause is about an alien's relationship with the *state*, not the federal government.<sup>188</sup> In regards to the federally imposed requirements, the federal government has plenary authority to regulate immigration and naturalization processes.<sup>189</sup> Thus, it would be exceedingly difficult to challenge the requirement of proof-of-citizenship, the five-year ban on federal means-tested benefits like Medicaid, or the limited class of non-U.S. citizens to whom Medicaid is available.<sup>190</sup>

Ultimately, a state may not discriminate in extending welfare benefits to someone based on their national origin or alienage, or how long they have resided in the state.<sup>191</sup> This limitation does not apply to the federal government, which is free to restrict benefits based on an individual's national origin or alienage, or the length of time that they have resided in the country.<sup>192</sup> Medicaid is a federal program, jointly funded by state and federal government, and overwhelmingly administered and regulated by the states. Thus, it is important whether the restriction is imposed by the federal government or by a state. The federal government has imposed the five-year ban for newly arrived immigrants. A similar federal restriction has already been held

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state Medicaid to otherwise eligible legal aliens based on, or because of, their alien status failed to pass the test and was thus impermissible.

186. 426 U.S. 67, 85.

187. *Id.* at 87.

188. *Id.* at 85. The 5th Amendment applies equal protection to the federal government.

189. *See generally* *Chy Lung v. Freeman*, 92 U.S. 275 (1876); *Plyler v. Doe*, 457 U.S. 202 (1981); *Zadvydas v. Davis*, 533 U.S. 678 (2001).

190. The Patient Protection and Affordable Care Act, 45 C.F.R § 152.14 (2013). The limited class of non-U.S. citizens who can obtain Medicaid benefits include: “refugees, asylees, aliens whose deportation is being withheld, Amerasians, and Cuban/Haitian entrants and victims of a severe form of trafficking[; and] veterans, members of the military on active duty, and their spouses and unmarried dependent children.”

191. *See generally infra* note 196.

192. *Supra* note 189.

constitutional in *Mathews v. Diaz*.<sup>193</sup> The state-imposed state residency requirements are subject to strict scrutiny and must be the least restrictive means practically possible to achieve a compelling state interest.<sup>194</sup>

States cannot, and do not, impose a specific durational requirement for newly arrived residents applying for Medicaid. However, the states can, and do, require that a newly arrived resident intend to remain and live in that state permanently or indefinitely.<sup>195</sup> The Supreme Court has been careful to maintain the rule that a durational residency requirement to receive a public benefit is unconstitutional, while a bona fide residency requirement is permissible.<sup>196</sup> By definition, a migrant farmworker is employed for a seasonal or temporary basis and is required, for work, to be away from his permanent residence.<sup>197</sup> The rationale behind the distinction is that a state has a legitimate interest in maintaining and preserving the quality of certain benefits for true residents of that state. Such benefits can include public education, voting, and public aid. The Supreme Court has said that a “bona fide residence requirement . . . furthers the substantial state interest in assuring that services provided for its residents are enjoyed only by residents . . . . A bona fide residence requirement simply requires that the person *does* establish residence before demanding the services that are restricted to residents.”<sup>198</sup>

While the distinction between durational residency and bona fide residency requirements seems logical, its weakness is demonstrated by applying it to the context of migrant farmworkers. If a migrant worker is defined as someone required to work away from his permanent residence, then almost by definition he does not qualify for

193. 426 U.S. 67, 70.

194. In this asymmetrical system, it depends on whether the federal or state government is imposing the restriction of benefits based on alienage. This is easily demonstrated by comparing *Mathews*, 426 U.S. 67 (1976) with *Saenz*, 526 U.S. 489 (1999). In *Mathews*, the federal government could constitutionally impose both a five-year continuous residency requirement and a permanent residency requirement. In contrast, in *Saenz*, the state of California could not constitutionally impose a continuous residency requirement of one-year.

195. MEDICAID AND MIGRANT, *supra* note 28.

196. *Martinez v. Bynum*, 461 U.S. 321, 325 (1983). For example, a durational residency requirement would require an individual to reside in a state for one year before being eligible to receive benefits, while a bona fide residency requirement would require an individual to demonstrate true residency, or intent to remain.

197. MEDICAID AND MIGRANT, *supra* note 28.

198. *Martinez*, 461 U.S. at 328-29.

Medicaid because he has no intent to reside in his new state permanently or indefinitely. And if he is not in fact residing in the state he came from, he cannot claim bona fide residency there either. Additionally, states typically allocate the full forty-five day period<sup>199</sup> before a ruling is required on a Medicaid application. This forty-five day period further reveals the difficulties a migrant farmworker would face in trying to prove bona fide residency to qualify for Medicaid in a given state.<sup>200</sup> Because of the high rate of mobility of the migrant farmworker community, many migrants might only expect to be in a state for ninety days; a forty-five day period cuts their time to receive Medicaid benefits in half.<sup>201</sup>

Applying the three-step framework that the Supreme Court has set forth for analyzing potential Fourteenth Amendment Equal Protection Clause violations to the state residency requirements for Medicaid, the classification is “newly arrived state residents.”<sup>202</sup> The requirements do not facially target migrant farmworkers, or non-

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199. This limit is imposed by the Medicaid statute. *See* 42 C.F.R. § 435.911 (2010).

200. *About America's Farmworkers: Population Demographics*, NAT'L CTR. FOR FARMWORKER HEALTH, INC., <http://ncfh.org/?pid=4&page=3> (last accessed Apr. 7, 2014). Even assuming that the migrant farmworker applies on his first day in state, many migrants move at least four times a year, although it is not uncommon for a migrant to move eleven or twelve times a year. Based on four moves a year, a migrant farmworker might expect to reside in one place for only 90 days. The state's self-allocated 45-day period of review thus restricts a migrant farmworker to possibly receiving Medicaid benefits for half of his time in that state. And this is assuming that the migrant farmworker applies on the very first day, and that his application is approved. Combined with language barriers and possible scheduling issues with the migrant's work schedule and the hours of the benefits office, it is not unreasonable to assume that the migrant farmworker would *not* be able to apply on his very first day in state.

201. Coburn et al., *supra* note 107, at 3. (“Frequently, migrant families move from their current state of employment before eligibility is determined and health services can be accessed.”).

202. The question of whether migrant farmworkers are bona fide residents revolves around their intent to return to some other “home state.” However, the Migrant Clinicians Network's map of routes taken by migrant farmworkers indicates that some routes are more linear, while others are cyclical. Regardless of the route, most migrants will complete the same route year after year. For that reason, it is difficult, if not impossible, to determine which of the states a migrant farmworker lives in each year is his or her bona fide residence. For a map demonstrating the routes that many migrant farmworkers take, *see Migration Patterns, MIGRANT CLINICIANS NETWORK*, <http://www.migrantclinician.org/issues/migrant-info/migration-patterns.html> (last accessed Mar. 18, 2014).

native U.S. citizens. The state residency requirements disproportionately impact newly arrived state residents, which includes all migrant farmworkers who are moving between states. Courts hold this class to be suspect, and state infringement of migrant farmworkers' fundamental right to travel between states and to be treated equally is sufficient to trigger the second step of the analysis.<sup>203</sup>

In the case of infringement of fundamental rights, as is true with state residency requirements for Medicaid, strict scrutiny is appropriate. The court requires the state to show a compelling state interest and narrow tailoring of the law to achieve that interest. Two of the most commonly cited reasons for requiring an intent to remain permanently or indefinitely and allowing a forty-five day window before a decision on a new Medicaid application is due are budgetary concerns<sup>204</sup> and concerns about catching Medicaid fraud.<sup>205</sup>

The Court in *Saenz* clearly explained that budget concerns are not a sufficiently compelling reason for discriminating against newly arrived residents in the context of a denial of a fundamental right.<sup>206</sup> If a state cannot show a reason other than budgetary concerns for discriminating based on duration of residency, then the law is invalid.

Avoiding Medicaid fraud, specifically by undocumented migrants, is another potential compelling state interest that a state might argue and indeed, the Court has held fraud prevention to be just such an interest.<sup>207</sup> In *Shapiro v. Thompson*, public benefits were denied to new residents who had not resided in the jurisdiction (state or in the District of Columbia) for at least a year before applying for public benefits.<sup>208</sup> States argued that preventing Medicaid fraud and conserving financial resources in public welfare programs were compelling state interests. While the Court agreed, it ultimately struck down the one-year ban on travel,<sup>209</sup> The Court found that the

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203. *Compare Mathews v. Diaz* 426 U.S. 67 (1976) (explaining that the federal government can distinguish between citizens, new citizens and foreigners) *with Saenz v. Roe*, 526 U.S. 489 (1999) (explaining that states cannot distinguish between new and old residents based on newness of residency).

204. 526 U.S. at 497.

205. *Shapiro v. Thompson*, 394 U.S. 618, 637 (1969) *overruled in part by Edelman v. Jordan*, 94 S. Ct. 1347 (1974).

206. 526 U.S. at 507.

207. *Shapiro*, 394 U.S. at 637.

208. *Id.* at 622.

209. *Id.* at 641-42. The Court held that the purpose and effect of the one-year ban was to deter the in-migration of poor individuals, which was an

states had not demonstrated that the one-year ban was necessary nor that it was the least restrictive means by which to achieve their compelling interests.<sup>210</sup>

In the case of migrant farmworkers, while the state would have a compelling interest in combatting Medicaid fraud, there is no evidence of widespread fraud by undocumented or otherwise ineligible migrants.<sup>211</sup> Rather, it is far more common for migrant farmworkers, especially families and pregnant women (who are in fact eligible to receive Medicaid benefits) to not apply to receive them.<sup>212</sup> Additionally, the federally mandated proof-of-citizenship requirement sufficiently demands proof that a migrant farmworker is eligible for Medicaid. This safeguards Medicaid from migrant farmworkers who might be ineligible because of either their citizenship, or the five-year statutory bar on public benefits.<sup>213</sup> Finally, the state residency

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impermissible and unconstitutional justification for infringing an individual's fundamental right to travel.

210. *Id.* at 634.

211. *See Medicaid Citizenship Documentation Requirements Deny Coverage to Citizens & Cost Taxpayers Millions*, COMM. OF GAO & STAFF FINDINGS, July 24, 2007, available at <http://oversight-archive.waxman.house.gov/documents/20070724110341.pdf>. A Committee on Oversight and Government Reform report stated that “[f]or every \$100 spent by federal taxpayers to implement the new [documentation] requirements in six states, only 14 cents in Medicaid savings can be documented.” Of the 3.65 million Medicaid enrollees in those six states (Colorado, Kansas, Louisiana, Minnesota, Washington and Wisconsin), only eight undocumented immigrants were found to be fraudulently enrolled in Medicaid. Approximately \$11,000 were saved by denying these eight individuals their fraudulently obtained benefits, while over \$8.3 million in additional federal funds were spent to implement the program.

212. Migrant farmworkers who are eligible for Medicaid do not apply for these benefits for a number of reasons, such as a general misunderstanding of eligibility, a fear of endangering mixed status family members, and a lack of understanding of the public charge deportation ground.

213. The Supreme Court has addressed situations where existing measures are sufficient to deter fraud and promote a bona fide residency requirement, and additional measures such as a durational residency requirement, which do not actually help deter fraud but rather act as an impermissible barrier for newly arrived residents, are put into place by a state. In *Dunn v. Blumstein*, 405 U.S. 330, the Court found that a durational residency requirement for voting failed to contribute towards the compelling state interest in reducing voter fraud. The state already had in place an oath-swearing requirement, which the Court was sufficient to ensure that only bona fide residents voted. The Court also stated that the state failed to use the least drastic means to achieve its compelling state interest of voter fraud reduction, when it imposed the second requirement of durational residency failed. Thus, where states

requirement for migrant farmworkers who have previously been covered by Medicaid makes little sense if the objective of the requirement is to combat fraud; indeed, since the applicant has already been approved, any fraud they might have committed should have been caught in the initial application.

Compelling state interests such as preventing Medicaid fraud and conserving financial resources in public welfare programs may justify infringing on a fundamental right like the right to travel. But these compelling state interests must be achieved through the least restrictive means practicable. No state has an explicit durational requirement<sup>214</sup> for establishing state residency, although they do require intent to reside in the state. Every state allows itself some time period (often forty-five days, the maximum permitted by statute) to evaluate a Medicaid application and establish eligibility.<sup>215</sup> Migrant farmworkers, by definition, do not intend to permanently reside in the state in which they would be applying for Medicaid benefits. And a forty-five day window in which to evaluate a Medicaid application would not seem excessively restrictive, and might actually be seen as a quick evaluation, given the size and complexity of the Medicaid system. Furthermore, it is the time frame allowed by regulation.<sup>216</sup> A constitutional challenge to the intent-to-reside and forty-five day evaluation period would likely fail. The state has a compelling interest in conserving resources, and the evaluation period seems reasonable in duration and sufficiently tied to evaluating the applicant's need for public benefits. At best, a court might find that a migrant farmworker previously enrolled in another state's Medicaid program should be eligible for a rapid enrollment type program like that which Wisconsin employs.

### *B. Policy Argument for Extension*

While the federal government is prohibited from mandating a Medicaid expansion, and the courts are likely to uphold a forty-five day review period for Medicaid applications as the least restrictive means practicable of achieving a compelling state interest, states that

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are unable to show fraud in a system like Medicaid benefits, and the existing requirements like proof-of-citizenship and bona fide residence sufficiently achieve the goal of reducing fraud in system, the state cannot add an additional requirement which simply makes it more difficult for newly arrived citizens to achieve equal access to public benefits.

214. *Martinez*, 461 U.S. at 325 (holding that durational residency requirements are unconstitutional).

215. 42 C.F.R. § 435.911 (2010).

216. *Id.*

are nevertheless interested in expanding Medicaid to more effectively cover migrant farmworkers are free to do so. And there are legitimate reasons why a state might strongly consider expanding its Medicaid program.

Migrant farmworkers have access to emergency Medicaid under the Emergency Medical Treatment and Active Labor Act (EMTALA). Under EMTALA, a hospital that received Medicaid funds must admit and stabilize any patient who comes in its doors and presents with an emergency medical condition.<sup>217</sup> If migrant farmworkers do not have access to medical care before a condition escalates to an emergency situation, they are more likely to adopt a “wait and see” attitude. It is arguably more effective, and more financially efficient, to treat medical conditions early on.<sup>218</sup> Moreover, migrant farmworkers want to work. In order for them to be productive laborers, earning an income for themselves, benefiting their employers and ultimately consumers, they need to be healthy, and treating medical conditions early on would achieve this goal. If a state keeps its migrant farmworker population healthy, it can permit them to continue working, uninterrupted by medical emergencies.<sup>219</sup>

Similarly, it benefits public health and safety for migrant farmworkers to have access to medical care through Medicaid if they

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217. *Emergency Medical Treatment & Labor Act (EMTALA)*, CTRS. FOR MEDICARE & MEDICAID SERV., <http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/> (last modified Mar. 26, 2012).

218. Michael V. Maciosek et al., *Greater Use of Preventative Services in U.S. Health Care Could Save Lives at Little or No Cost*, 29 HEALTH AFF. 1656, 1660 (2010). Traditionally, it has been assumed that preventive care simply costs less than emergency care. Recent studies have shown that “preventive services [are] essentially cost-neutral, while conferring large health benefits . . . . Preventive services . . . should be judged by their effectiveness in improving health and the resources they consume to do so.” *But see* Ron Z. Goetzel, *Do Prevention or Treatment Services Save Money? The Wrong Debate*, 28 HEALTH AFF. 37, 37 (2009). Other studies suggest that whether preventive care costs less than emergency care is really the wrong question, and point to other benefits, besides the bottom line, like “population wide risk reduction and cost savings.” Ultimately, “prevention offers a good return on investment” for individuals, employers, and the country.

219. Amy Rossi, *Wellness Programs on the Rise*, 7 BIOTECH. HEALTHCARE 29 (2010). The rise in employee wellness programs in U.S. businesses indicates that employers understand that healthier employees are more productive. Not only are these employees more productive, but they also tend to need less emergency medical care, meaning that they and their employers spend less in employee health coverage. Logically, this trend should extend to all areas of business including migrant farmworkers working in agriculture.

are otherwise eligible. Not only do migrant farmworkers handle over 85 percent of produce grown in the United States, but they and their families also participate in life in American communities.<sup>220</sup> They shop in the same stores, ride the same buses, and go to the same schools. The larger U.S. community has a reason to be concerned with the treatment of the communicable and infectious diseases to which some migrant farmworkers are more susceptible.

These pragmatic concerns provide sufficient reason for a state to strongly consider voluntary expansion of Medicaid. Ultimately, most states will rely heavily on a financial analysis of voluntary expansion as the basis for their decision. States must decide if the expense they will save in preventive care and consistent labor outweighs the cost of emergency Medicaid and the aggregate value of unrealized economic earnings.

### C. Policy Argument Against Extension

A state might argue against the expansion of Medicaid to cover migrant farmworkers for several reasons. First, many states respond to the public's common misconception that migrant farmworkers are all undocumented or "illegal" immigrants seeking to abuse Medicaid. Second, states may argue that there is no true need to extend Medicaid benefits to migrant farmworkers, as they already have access to emergency Medicaid. Finally, states are concerned that the liberalization of their Medicaid requirements will lead to waves of uninsured people, including migrant farmworkers, entering the state to take advantage of those liberalized eligibility requirements.

The rhetoric that surrounds any conversation with the word "migrant" also comes into play.<sup>221</sup> Accurate or not, many states and communities have strong anti-undocumented feelings which will impact the debate on covering migrant farmworkers.<sup>222</sup> The assumption is that this population is also undocumented, or "illegal," and therefore a burden and a drain on public resources.<sup>223</sup> While by definition migrant farmworkers who would otherwise be eligible for Medicaid benefits except for the state residency requirement are not undocumented, they get grouped in that category quite frequently. Even academic literature often fails to distinguish between migrant

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220. Bokinskie, *supra* note 52, at 202.

221. See generally *Countering the Myths*, JUSTICE FOR IMMIGRANTS, <http://www.justiceforimmigrants.org/myths.shtml> (last accessed Jan. 21, 2014).

222. *Id.*

223. *Id.*



and seasonal farmworker, and documented and undocumented status.<sup>224</sup>

A second argument against expansion of Medicaid is that the population in question already has access to emergency Medicaid and therefore does not truly need an expansion. There are also over 400 federally authorized clinic sites, like migrant health centers, which are already in existence and available to meet the medical needs of migrant farmworkers and other uninsured populations.<sup>225</sup> However, despite the seemingly high number of clinic sites, they are unable to truly meet the needs of the migrant farmworker population that they are intent on serving.<sup>226</sup> For example, these “400 federally authorized clinic sites (funded under the Public Health Service Act)” only serve between 12 and 15 percent of the migrant farmworker population.<sup>227</sup> Their efficacy is limited by poor location, insufficient information and publicity, and resource scarcity, including financial and other tangible and intangible resources.<sup>228</sup>

Third, states may argue that waves of uninsured people will migrate there to take advantage of their expanded coverage. This is similar to the sentiment that those who pay into the system—state residents—should be the ones eligible to draw the benefits. However, the U.S. Supreme Court has clearly held that “the purpose of inhibiting migration by needy persons into the State is constitutionally impermissible.”<sup>229</sup> In *Shapiro*, the appellants defended a durational residency requirement on the grounds that it would “preserve the fiscal integrity of state public assistance programs” and deter “people who require welfare assistance” from moving into the state.<sup>230</sup> The state in *Shapiro* argued exactly what many states continue to argue: that “state programs to assist long-time residents [should] not be impaired by a substantial influx of indigent newcomers.”<sup>231</sup> The Court in *Shapiro* went on to point out that “[Congressional] sponsors of federal legislation to eliminate all residence requirements have been consistently opposed by . . . state and local welfare agencies who have stressed the fears . . . that elimination of the requirements would result in a heavy influx of

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224. *See generally* ROSENBAUM & SHIN, *supra* note 26.

225. HANSEN & DONOHOE, *supra* note 26, at 160.

226. *See id.*

227. *Id.*

228. *See id.*

229. *Shapiro v. Thompson*, 394 U.S. 618, 629 (1969).

230. *Id.* at 627-28.

231. *Id.* at 628.

individuals into State providing the most generous benefits.”<sup>232</sup> The Court’s holding in *Shapiro* was reaffirmed in *Saenz* when the Court said that it has “squarely held that it was ‘constitutionally impermissible’ for a State to enact durational residency requirements for the purpose of inhibiting the migration of needy persons into a State.”<sup>233</sup>

States opposed to expanding Medicaid to cover migrant farmworkers will go through the same cost-benefit analysis, but they will ultimately decide that expansion is not worth the cost.<sup>234</sup> Several studies have demonstrated the prevalence of the belief that the costs of preventative care outweigh the benefits.<sup>235</sup> However, a strict financial analysis of the balance sheet is the wrong way to evaluate the costs and benefits of extending Medicaid coverage to migrant farmworkers.<sup>236</sup> The benefits of the system might not be seen via a hospital bill. The benefits might be less visible, as they would be demonstrated by an absence or reduction in the use of medical services, and a reduction in the amount of time a migrant farmworker might have to take off from work due to illness. The amount of time one does not take off from work, or the number of doctor visits avoided are difficult to measure, but do contribute to the value of the benefits achieved, and the costs avoided, by extending Medicaid coverage to migrant farmworkers.

## VI. SOME RESOLUTIONS

*With regular health care providers, the way they are structured, the patient goes in with a problem . . . . With us, we are listening to their story and hearing what are their concerns. And then from there, we can identify possible problems that can be addressed before they become serious. It’s really for people that want to stay away from long-term illnesses and the expense that that brings. It’s invaluable because we go to where the patient is.*

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232. *Id.*

233. *Saenz v. Roe*, 526 U.S. 489, 499 (1999).

234. Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 *NEJM* 661, 663 (2008). Studies indicate that this attitude—that the costs outweigh the benefits when it comes to preventative care—is not necessarily inaccurate. However, as mentioned in *MEDICAID AND MIGRANT*, *supra* note 28, deciding whether or not preventative care is more efficient and beneficial than emergency care depends on more than just the straight medical bill resulting from either care option.

235. *See* Maciosek et al., *supra* note 218.

236. *Id.*

Claudia Stephens<sup>237</sup>

A state is arguably not required by the U.S. Constitution to remove the residency requirement that forms a serious structural barrier for migrant farmworkers' access to Medicaid. Yet, a state has good reasons for wanting to ensure that this population's medical needs do not go unmet. States have several options as they consider what program will best meet the needs of their migrant farmworker population and other state goals.<sup>238</sup> First, states should strongly consider accepting the ACA Medicaid expansion, and in so considering, weigh not only the immediate impact of expansion on the state's budget, but also the "peer pressure" effect and the benefit of creating a truly national standard. Failing that, a state should next consider existing models of extending Medicaid coverage to migrant farmworkers, as Texas and Wisconsin have done. These models might be implemented separately or in combination. Finally, a third option for states is to create their own unique solution to meet the needs of their migrant farmworker population, which allows each state to take into consideration its own strengths and weaknesses. Unless the federal government mandates universal coverage,<sup>239</sup> there will unfortunately always be people that fall through the cracks of whatever Medicaid system a state might implement. However, by intentionally forming a system that considers the Medicaid needs of migrant farmworkers, a state can ensure that fewer people will suffer the consequences of falling through those cracks.

*A. Accept the Federal Solution Inherent in the ACA Medicaid Expansion*

The ACA's Medicaid expansion element is optional.<sup>240</sup> The ACA Medicaid expansion extends coverage to childless, nondisabled adult

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237. David Erickson, *Farmers' Clinic: Health Center for Agricultural Workers Opens Near Lolo*, RAVALLI REPUBLIC, Feb. 16, 2014, [http://ravallirepublic.com/news/local/article\\_84cc6008-968e-11e3-b745-001a4bcf887a.html](http://ravallirepublic.com/news/local/article_84cc6008-968e-11e3-b745-001a4bcf887a.html). Claudia Stephens is a Strategic Planning Specialist at the Montana Migrant and Seasonal Farmworker Council.

238. States inevitably have to balance many competing interests and agendas. Recognizing that finances and legislative are limited resources, the range of programs, and the extent to which they are implemented can be customized to meet each state's needs, financial and political limitations, and policy objectives.

239. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (holding that the ACA mandated Medicaid expansion is unconstitutional).

240. *Id.*

males.<sup>241</sup> Most migrant farmworkers fall into this category.<sup>242</sup> By accepting the ACA Medicaid expansion, states would extend coverage to more migrant farmworkers and take a small step towards simplification of a complicated scheme of fifty different Medicaid programs. According to the federal government, it “will pay states all of the costs for newly eligible people for the first three years. It will pay no less than 90% of the costs in the future.”<sup>243</sup> As an additional incentive for states to accept the ACA Medicaid expansion, states should consider that by opting out of the expansion, they “are forgoing billions of dollars in federal funds, while residents in their states are contributing to the cost of the expansion in other states.”<sup>244</sup> In other words, a state has a great deal to gain by accepting the ACA Medicaid expansion, and only loses by opting out.

However, even if a state accepts the ACA Medicaid expansion, a number of barriers will still remain for migrant farmworkers to overcome in order to receive Medicaid coverage, including the state residency element. Nevertheless, the ACA Medicaid expansion would remove some of the structural impediments for a large segment of the migrant farmworker population to receive coverage.

As of January 2014, many states have not indicated that they will accept the ACA Medicaid expansion program.<sup>245</sup> If they still want to consider a Medicaid expansion program that will help meet the medical needs of the migrant farmworker population, the state could implement either the Wisconsin model or the Texas model, or a hybrid of the two.

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241. *Eligibility*, MEDICAID.GOV, <http://www.medicaid.gov/affordablecareact/provisions/eligibility.html> (last accessed Mar. 17, 2014).

242. *See supra* Part I.

243. *Is My State Expanding Medicaid Coverage?* HEALTHCARE.GOV, <https://www.healthcare.gov/what-if-my-state-is-not-expanding-medicaid/> (last accessed Mar. 26, 2014).

244. *New State-By-State Analysis: States Rejecting Medicaid Expansion Under The Affordable Care Act Are Costing Their Taxpayers Billions*, COMMONWEALTH FUND (Dec. 5, 2013), <http://www.commonwealthfund.org/News/News-Releases/2013/Dec/States-Rejecting-Medicaid-Expansion-Costing-Taxpayers.aspx>.

245. *Status of State Action on the Medicaid Expansion Decision, 2014*, HENRY J. KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#note-1> (last accessed Mar. 18, 2014). As of January 28, 2014, 25 states are implementing the Medicaid expansion in 2014; 19 states have indicated that they will not accept the Medicaid expansion at this time, and another six states are still debating the issue.

*B. Implement a Hybrid Wisconsin/Texas Model*

The Wisconsin model best addresses the needs of newly arrived migrants by essentially accepting another state's Medicaid card. The Texas model best addresses the needs of its citizen temporarily going to another state. Because both models have their drawbacks, another option for states would be to create a hybrid Wisconsin/Texas model. This would mean that a state would follow the Wisconsin model for migrant farmworkers *coming into* its state, and follow the Texas model for its resident migrant farmworkers *going elsewhere* for a short period of time. This hybrid Wisconsin/Texas model would provide the best coverage for migrant farmworkers, coming *or* going, by combining the coverage strengths of each program.<sup>246</sup>

The one drawback that a straight-forward “dual” approach like the hybrid Wisconsin/Texas model does not address is the limited network of medical providers which the Texas model currently has. However, as more and more states accept expanded Medicaid coverage, either through the ACA Medicaid expansion or the “peer pressure” of a network of states participating in some variation of a reciprocity program, this problem will likely dissipate.<sup>247</sup> The hybrid nature of this option is key, because either half of the program would only address the needs of half of the migrant farmworker population in question. Finally, as with any new program, extensive information in relevant languages will be needed for everyone involved, including other states, individuals who might be Medicaid-eligible, and medical providers.

*C. Create a New Innovative Solution, Tailored to Each State*

The federal government has put forth a solution in the ACA. As explained in Part II.B, the ACA would theoretically help meet the medical needs of migrant farmworkers. However, in reality the ACA will struggle in reality to do so because of the voluntary nature of its Medicaid expansion. Furthermore, the ACA Medicaid expansion fails to remove some of the significant barriers to coverage, most notably the state residency requirement. The Wisconsin and Texas models, individually or combined as a hybrid, also help meet the Medicaid needs of migrant farmworkers. These models try to avoid the state

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246. The strength of Wisconsin's program is that it covers those coming into the state, whereas the strength of Texas's program is that it covers its residents outside of the state. Combining the strengths offers more thorough coverage for migrant farmworkers.

247. The “peer pressure” concept simply reflects the idea that, as more states sign onto the ACA Medicaid expansion or join reciprocity agreements, those states continuing to opt out will grow fewer in number and will increasingly become outlier “hold out” states.

residency hurdle by either implementing a rapid enrollment program or by creating a highly portable Medicaid system.

If a state is not satisfied with either of these options, but still wants to extend medical coverage to its farmworkers, then the state should create a new program, tailored to the particular state. After all, states have a great deal of freedom in establishing the eligibility requirements for Medicaid, and they should use that power to flexibly design programs that work.<sup>248</sup> This solution might not be Medicaid<sup>249</sup> in the strict sense, yet the goal of providing medical coverage to uninsured populations like the majority of migrant farmworkers can still be accomplished, even outside of the formalized Medicaid system.

First, states should strongly encourage employers, including agricultural employers, to provide health coverage for their workers. Brokaw Nursery provided its permanent employees with health coverage, which covered their children and included an option by which the employee could expand coverage to include their spouses. Employers could follow Brokaw Nursery's medical coverage plan, which included a co-share system.<sup>250</sup> States should encourage employer-based health insurance by incentivizing it. Tax or other financial incentives should continue to be used by state governments to encourage beneficial employer behavior such as employer-based health insurance, specifically in the context of migrant farmworkers. This would have side benefits as well. By shifting health insurance from the government-provided to employer-provided, state expenditures in health coverage would be reduced. It would also create incentives for employers to create safer and healthier work places, and thus reduce employees' exposure to toxic chemicals and dangerous machinery without appropriate safety equipment or training.

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248. Because states have a great deal of flexibility in determining the eligibility requirements for Medicaid, a state could go so far as to remove the distinctions between singles and those with dependents, other traditional distinctions, and the state residency requirement in its entirety. However, while these requirements may arguably be outdated, old fashioned, and no longer reflective of American society, it is unlikely that a state would do this. Given the intense controversy of the Affordable Care Act, and the touchy subject of immigration reform, a state's elected officials will shy away from jeopardizing their popularity with broad segments of their constituency by such radical changes in Medicaid law.

249. Because some of the suggestions are outside of Medicaid as a strict means-tested system, this solution might stray into technically non-Medicaid programs. However, if the ultimate goal is expanding coverage to migrant farmworkers in need of health coverage, the name of the program matters little compared to the impact it has on the population.

250. *See supra* INTRODUCTION.

Second, states should evaluate the sufficiency of the migrant health centers within their borders. There are 159 centers nationwide, with hundreds of service sites. However, ten states still do not have a single center.<sup>251</sup> Some of the reasons why a state might not have a migrant health center include the low number of farmworkers in the area; the length of the harvest season and the size of the agricultural business in the area; the number of medical providers willing to participate; and the capacity of willing medical providers to care for the number of migrant farmworkers.<sup>252</sup> For migrant farmworkers living in states without a migrant health center, there is currently a voucher program in place.<sup>253</sup> The major difference between the migrant health centers and the voucher program is how medical services are delivered.<sup>254</sup> The migrant health centers provide on-site medical services, whereas the voucher programs contact local private medical providers who participate in the program to provide migrant farmworkers with medical care.<sup>255</sup>

One of the major difficulties that a migrant farmworker faces when trying to use either the migrant health center or the voucher program involve the need to travel and the time it takes to access care. Because the distribution of both migrant health centers and voucher program participants depends on the distribution of migrants and willing medical providers, and the nature of the agricultural needs in the area, some migrants must travel farther than others to find a medical provider. This not only takes time, which implies taking time off of work, but it also requires access to transportation. A final difficulty is that this system currently is only capable of serving between 12 and 15 percent of the migrant farmworker population.

States that do not have a migrant health center should create one. The fifteen members of the National Advisory Council on Migrant Health (NACMH) “[are] legislatively mandated to advise, consult with, and make recommendations to the Secretary of Health

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251. *About Community and Migrant Health Centers*, NAT’L CTR. FOR FARMWORKER HEALTH, INC., <http://www.ncfh.org/?pid=6> (last visited Mar. 18, 2014). Ten states do not have a migrant health center: Alaska, Connecticut, Hawaii, Mississippi, Nevada, New Hampshire, North Dakota, Rhode Island, South Dakota, and Vermont.

252. *Migrant Health Voucher Programs*, NAT’L CTR. FOR FARMWORKER HEALTH, INC., <http://www.ncfh.org/?pid=65> (last visited Mar. 18, 2014).

253. *Id.*

254. *Id.*

255. *Id.*

and Human Services.<sup>256</sup> The Secretary appoints the Council for four-year terms. While the members are not democratically elected and thus less susceptible to public pressure, a state should address concerns about the lack or insufficiency of migrant health centers within its borders.<sup>257</sup>

To help meet the needs of migrant farmworkers, states should encourage mobile clinics, service weeks, and internship programs with medical and nursing schools.<sup>258</sup> A number of medical schools already provide this option for their students to gain hands on training, exposure to different health issues and different working conditions, and to contribute meaningfully in their field.<sup>259</sup> Many of these volunteer service programs emphasize cultural training and awareness, to help health care providers take proper notice and account of the cultural differences that often form an access barrier for migrant farmworkers.<sup>260</sup> Such sensitivity training should be an integral part of any volunteer-based medical program.

Despite their prevalence, in many of these states, the volunteer medical providers working with migrant farmworkers suggest that their work alone is insufficient.<sup>261</sup> For this reason, medical school mobile clinics, service weeks, and internships are not practical stand-

256. See *National Advisory Council on Migrant Health (NACMH)*, HEALTH RES. & SERVS. ADMIN., <http://bphc.hrsa.gov/about/nacmh/index.html> (last visited Mar. 18, 2014).

257. *Id.* Currently, the fifteen members of the NACMH are from California, Colorado, Indiana, Kentucky, Minnesota, New Jersey, New York, Ohio, South Carolina, Texas, Washington and Puerto Rico.

258. Kevin Graman, *Clinics, Volunteers Bring Medical Care to Migrant Farmworkers*, THE SPOKESMAN-REVIEW (July 25, 2010), <http://www.spokesman.com/stories/2010/jul/25/healthy-harvesters/>; Sara Belsole, *FSU Med School Students Give Free Health Screenings in Immokalee*, FOX4 (Mar. 20, 2014), <http://www.fox4now.com/features/4inyourcorner/FSU-med-school-students-give-free-health-screenings-in-Immokalee-249198371.html>; Gil Muñoz, *Oregon Health Care Reform Succeeds Despite Problems at Cover Oregon*, OREGONIAN, Mar. 7, 2014, [http://www.oregonlive.com/forest-grove/index.ssf/2014/03/oregon\\_health\\_care\\_reform\\_succ.html](http://www.oregonlive.com/forest-grove/index.ssf/2014/03/oregon_health_care_reform_succ.html).

259. Christine S. Moyer, *Migrant Farmworkers: Medical Care for an Invisible Population*, AM. MED. NEWS (June 11, 2012), <http://www.amednews.com/article/20120611/health/306119945/4/>. An excellent example of such a program is the University of Connecticut's mobile Migrant Farm Worker Clinic. This clinic operates in a state without a migrant health center, helping cover the gap in available medical care present in the state. See also *id.*

260. *Id.*

261. *Id.*



alone options for effectively providing medical coverage for migrant farmworkers. Yet these programs should be encouraged and applauded by states for their important work in extending medical coverage.

Finally, nearly every existing program extending medical coverage, Medicaid or otherwise, to migrant farmworkers notes that one of the major deficiencies in their program is the lack of information or understanding of the program.<sup>262</sup> Therefore, regardless of *how* a state chooses to better meet the needs of its migrant farmworker population, it is vital to educate both medical providers and the migrant farmworker population. A program that is not understood will be ineffective and under-utilized, no matter how well planned it is. States must take this into account and provide appropriate literature, in relevant languages and at appropriate education levels, and inform medical providers and migrant community outreach workers about the coverage programs available.

#### CONCLUSION

*We all have a responsibility to care for anyone in our midst who needs health care, regardless of their ability to pay, immigration status, ethnicity, race or sexuality.*

Dr. Jennie McLaurin, MD<sup>263</sup>

Many of the Medicaid eligibility criteria are difficult for migrant farmworkers to meet. For example, income-assets tests which are based on monthly rather than annual income do not accurately reflect the income of migrant farmworkers. And forms written in a language many migrant farmworkers find difficult to fully comprehend are a challenge, especially given the educational background of most of the population. However, the state residency requirement is not an eligibility criterion that migrant farmworkers can avoid or try harder to achieve.

States have a responsibility towards their citizens, especially at-risk and vulnerable groups, to ensure that they do not face undue discrimination because of the duration of their residency. And while the current status of the state residency requirement, which requires intent to stay and provides a forty-five day evaluation period, do not

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262. Bustamente & Van der Wees, *supra* note 92, at 319; *Program*, *supra* note 138.

263. Moyer, *supra* note 259. McLaurin is a pediatrician who treated migrant workers and families in North Carolina and now works as a child and migration health and bioethics specialist for the Texas-based Migrant Clinicians Network.

fail the test of being the least restrictive means of achieving a compelling state interest, states do have alternatives to the status quo. States can accept the ACA Medicaid expansion. States can adopt the Wisconsin or Texas model for extending coverage to migrant farmworkers coming or going. Or states can creatively combine the Texas and Wisconsin models and provide coverage for migrant farmworkers coming *and* going. If none of that appeals, then states can find innovative ways to use the resources available in that state to meet the needs in that state by creatively designing new solutions.

Ultimately, it is in the states' best interest to have a healthy population and a healthy workforce which includes healthy farmworkers. States must prioritize the health care needs of those workers within its borders that contribute to its economy and society. Beyond the economic and pragmatic arguments, many medical professionals believe that a moral and ethical duty exists that requires states to meet the health care needs of the most vulnerable segments of the population, including migrant farmworkers.

Most states currently have a gap in their Medicaid coverage into which migrant workers might fall because of their transient nature. These states should extend Medicaid coverage to migrant farmworkers moving into the state, for whatever period of time. In considering how to best do so, states should look first to the ACA Medicaid expansion. By first considering the ACA, states would help further the ACA's goal of standardization and simplification of the Medicaid system throughout the country. If a state were to decide that the ACA Medicaid expansion would not suit its needs, the state should next consider the Texas and Wisconsin models, and the proposed hybrid solution. If the state still believes that these solutions fail to meet the particular needs of the state, it should take inspiration from the creative solutions developed by Texas and Wisconsin, and develop its own answer and reform its existing policies.

Because of the voluntary nature of the ACA Medicaid expansion, states continue to have the flexibility to uniquely meet the needs of their residents, both those who have been there a long time and those who are new to the area. This flexibility allows states to choose which system works best for them to extend Medicaid benefits to migrant farmworkers.

