State of Vermont
Green Mountain Care Board
89 Main Street
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Report to the Legislature

REPORT REGARDING THE COSTS OF HEALTH SERVICES PROVIDED TO UNDOCUMENTED IMMIGRANTS

In accordance with Act 48 of 2011, Section 4c(b)

Submitted to
the General Assembly

Submitted by the
Green Mountain Care Board

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EXECUTIVE SUMMARY

Act 48 of 2011 charged the Green Mountain Care Board (Board) with explaining (1) the potential costs of health care services provided to undocumented immigrants if they are not covered through Green Mountain Care and (2) the potential costs of providing coverage under Green Mountain Care.[1] To address those questions, the Board has surveyed the research and data concerning the size and demographics of Vermont's undocumented immigrant population and has met with and obtained information from providers, researchers, and advocates. The Board also researched the federal and state legal parameters governing coverage for undocumented immigrants.

The Board's research points to some important conclusions bearing on the potential costs associated with Vermont's undocumented immigrant population. Beginning with the legal analysis, federal law generally precludes using federal funds to pay for the health care costs of undocumented immigrants, with some limited exceptions. However, under federal law, states may make undocumented immigrants eligible for state or locally funded public benefits by enacting a law affirmatively providing such eligibility.

Next, the available data and research suggest a number of conclusions about the size and demographics of this population and their health care costs. First, the data indicate that Vermont's undocumented immigrant population likely ranges from approximately 1500 to 3000 people. Second, Latino dairy workers form the majority of this population. Third, this demographic is largely young, male, and relatively healthy compared to the rest of Vermont's population. Fourth, serious barriers exist that impede undocumented immigrants' access to care, including fear of immigration enforcement, lack of transportation, and language. Finally, this population generally does not access health care services in Vermont frequently and consumes a low volume of services, likely a result of the demographic profile combined with the access barriers.

[1] Act No. 48 (2011), § 4c(b).

Although we cannot calculate numerical estimates of the two cost scenarios laid out in Act 48 at this time, because the cost of Green Mountain Care is not yet known, the factors mentioned above suggest that the cost of health care services consumed by Vermont's undocumented immigrants is likely to be low compared to that of Vermont's overall population. Further, it is clear that much of the burden of paying for the services undocumented immigrants do receive falls to the providers who serve them and to the Vermont business owners—mostly farmers—who employ them.

Finally, we note that throughout the process of developing this report, advocates requested that we conclude in this report that Vermont should extend Green Mountain Care coverage to undocumented immigrants. As we have advised in response to those requests, drawing a conclusion on that ultimate question would go beyond the scope of this report, as defined by the General Assembly in Act 48. We do note, however, that Act 48 appears to extend Green Mountain Care to all Vermont residents, without distinguishing based on immigration status.[2]

I. Statutory Charge

No. 48 of the acts of 2011 (Act 48) creates Green Mountain Care, a public-private universal health care program for Vermont residents. Act 48 requires the Green Mountain Care Board (Board) to report to the general assembly on the costs of covering undocumented immigrants living in Vermont through Green Mountain Care. The general assembly found that 1) federal law requires certain health care providers to provide emergency treatment to all individuals regardless of immigration status, yet 2) prohibits Vermont from using federal funds to cover undocumented immigrants through Medicaid or Vermont's federally mandated health benefit exchange. The general assembly also found that 3) the federal law requiring employers to provide health insurance coverage to certain immigrants working seasonally in Vermont excludes dairy workers, who work year-round, from accessing this benefit. Finally, the general assembly found that 4) some employers of undocumented immigrants pay employment taxes for these workers, though these workers do not derive health care benefits from the government.[3] In this context, Act 48 asks the Board to explain:

> (1) [t]he potential costs of services provided to undocumented immigrants by health care professionals if these immigrants are not covered through Green Mountain Care, including any increased costs of care delayed due to the lack of coverage for primary care; and
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> (2) [t]he potential costs of providing coverage for health services to undocumented immigrants through Green Mountain Care, including any state funds necessary to fund the services.

Act No. 48, § 4c(b).[4]

[2] *See, e.g., id.*, §§ 1(a), 1a(1), (4), (5).
[3] *Id*. 48, § 4c(a).
[4] Act 48 does not ask the Board to clarify how covering undocumented immigrants through Green Mountain Care might impact Vermont's eligibility for waiver from federal health insurance exchange requirements under section 1332 of the Affordable Care Act. It delegates this task to Vermont's Secretary of Administration, along with that of

II. Legal Parameters

A. Federal restrictions on use of federal funds to pay for health care benefits for non-citizens

Federal law has always prevented undocumented immigrants[5] and temporary visitors to the United States from receiving assistance through federally-funded public benefit programs.[6] Prior to the 1996 federal welfare and immigration reforms, by contrast, lawful permanent residents in the United States were generally eligible for federal assistance in a similar manner to United States citizens.[7] Current federal law, codifying the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as subsequently amended, generally limits non-citizen federal benefit assistance–with some important exceptions–to lawful permanent residents who have had that status for five years or longer.[8]

Non-citizens in the United States are divided into two categories for federal benefit eligibility purposes. "Federal public benefits" are generally defined as:

> (A) any grant, contract, loan, professional license, or commercial license provided by an agency of the United States or by appropriated funds of the United States; and
> (B) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the United States or by appropriated funds of the United States.[9]

Medicaid, the Children's Health Insurance Program (CHIP), and Medicare are considered federal public benefit programs for immigrant eligibility purposes, even though not all services offered by these programs are considered federal public benefits.[10]

Members of the first category of non-citizens, "qualified aliens," are generally only eligible for federal means-tested benefit programs after they have had that status for five years or more.[11] Lawful permanent residents, asylees, refugees, and certain other

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coordinating with Vermont's congressional delegation to provide a mechanism for non-seasonal farm workers to achieve legal status under federal immigration law. Act No. 48, § 4c(c). Vermont's Secretary of Administration has raised this issue with the state's congressional delegation.

[5] For the purposes of this report, "undocumented immigrants" includes both immigrants who have entered the U.S. illegally and immigrants who entered legally but have overstayed their visas. Those immigrants legally residing in the United States are not included in this report.

[6] Overview of Immigrant Eligibility for Federal Programs, National Immigration Law Center (October 2011), *available at* http://www.nilc.org/table_ovrw_fedprogs.html (hereinafter "NILC Overview").

[7] NILC Overview.

[8] 8 U.S.C. §1613.

[9] 8 U.S.C. § 1611(c) .

[10] U.S. Dept. of Health and Human Services, PRWORA, "Interpretation of 'Federal Public Benefit,'" 63 FR 41658-61 (Aug. 4, 1998).

[11] 8 U.S.C. § 1613.

lawfully-residing aliens are considered qualified aliens.[12] However, federal law exempts most "humanitarian" immigrants–asylees, refugees, victims of battery and trafficking, and immigrants from specified countries–and "qualified" active military members, veterans, and their families from the five-year bar.[13] States may additionally opt to provide federally funded Medicaid and CHIP to lawfully-residing pregnant women and children regardless of when they entered the United States. States must verify citizenship or qualified alien status as a condition of individual receipt of federally-funded benefits.[14]

By contrast, "non-qualified aliens"–the second category of non-citizens which includes all undocumented immigrants–are generally ineligible for any federal public benefit programs,[15] with a few important exceptions. For example, non-citizens regardless of immigration status may receive federally funded emergency Medicaid[16] if they would be eligible for state Medicaid but for immigration status; federally funded immunizations and treatment for communicable disease symptoms; and other in-kind non-means-tested federally funded services that the Attorney General determines necessary to protect life or safety.[17] Table 1 below shows these categories:

Table 1.

Qualified Aliens with 5-year bar	Qualified Aliens exempt from 5-year bar	Non-qualified Aliens
• lawful permanent residents • asylees • refugees	• humanitarian immigrants • qualified active military memebrs • veterans and families	• undocumented immigrants

[12] 8 U.S.C. § 1641.
[13] 8 U.S.C. § 1612.
[14] 8 U.S.C. § 1642. Non-profit charitable organizations providing any federal, state, or local public benefits are not required to verify citizenship or immigration status. § 1642(d).
[15] 8 U.S.C. § 1611.
[16] 8 U.S.C. §1611. Emergency Medicaid covers treatment of "a medical condition . . . manifesting itself by acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in: (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part." 42 U.S.C. §1396b(v).
[17] 8. U.S.C. § 1611. The Attorney General has specified that medical, mental health, public health, disability, and substance abuse services may meet this criterion. U.S. Dept. of Justice, "Final Specification of Community Programs Necessary for Protection of Life or Safety under Welfare Reform Legislation," A.G. Order No. 2353-2001, 66 FR 36713-16 (Jan. 16. 2001).

The Patient Protection and Affordable Care Act of 2010 (ACA) does not alter the lawful permanent resident five-year wait period for federal benefit assistance or the overall restriction on use of federal funds to assist undocumented immigrants, although it does contain additional parameters for non-citizen access to health care benefits. Lawfully present immigrants are generally subject to the individual mandate and tax penalty, may purchase insurance from state insurance exchanges, and may be found eligible for premium tax credits and cost-sharing reductions without any waiting period.[18] These benefits are subject to verification of citizenship or immigration requirements.[19] Undocumented immigrants are not permitted to participate in state health insurance exchanges and are not eligible for exchange-related federal payments, credits, or cost-sharing reductions.[20]

B. Federal restrictions on use of <u>state</u> funds to pay for health care benefits for non-citizens

States generally have authority under federal law to limit the eligibility of qualified aliens for state and locally funded public benefit programs based on their immigration status.[21] A "state or local public benefit" is defined as:

> (A) any grant, contract, loan, professional license, or commercial license provided by an agency of a State or local government or by appropriated funds of a State or local government; and
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> (B) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of a State or local government or by appropriated funds of a State or local government.[22]

A state must offer benefits to certain specified groups of qualified aliens, such as humanitarian immigrants and certain veterans, on par with its citizen population.[23] A state may require applicants for state and local public benefits to provide proof of immigration status to verify eligibility.[24]

By default, non-qualified aliens, including all undocumented immigrants, are ineligible for any state or local public benefits, subject to similar exceptions that apply to federal benefit programs (emergency medical assistance, immunizations, treatment for communicable disease symptoms, and certain in-kind services deemed necessary for life or safety).[25] Under federal

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[18] How Are Immigrants Included in Health Care Reform, NILC (April 2010), *available at* http://www.nilc.org/immigrantshcr.html.
[19] ACA § 1411(a), (b)(2).
[20] ACA §§ 1312(f)(3), 1412(d).
[21] 8 U.S.C. § 1622.
[22] 8 U.S.C. § 1621(c).
[23] 8 U.S.C. § 1622.
[24] 8 U.S.C. § 1625.
[25] 8 U.S.C. § 1621.

law, a state may make "illegal aliens" eligible for state and local public benefits, but only if the state enacts a law affirmatively providing such eligibility.[26] As noted above, the ACA prohibits undocumented immigrants from any participation in state health insurance exchanges.[27]

C. Potential state law limitations on restricting health care benefits for certain non-citizens

About half of the states have used state funds to offer assistance to at least some of their immigrant residents who are not eligible for federally funded public benefits.[28] Many of these programs, however, have been reduced or eliminated due to state budget concerns, and sometimes proposed cuts—most often cuts to health care benefits to *legally residing* non-citizens—have been successfully challenged in court.[29] For example, the Supreme Court of Massachusetts recently held that its state constitution forbids tying eligibility for state subsidies for health insurance to eligibility for federally funded programs by discriminating against lawfully residing non-citizens who have been in the U.S. for less than five years.[30] Other court challenges involving immigrant eligibility for health care benefits have occurred in Connecticut, Hawaii, Maryland, New Jersey, New York, and Washington.[31] This suggests that the question of whether the Vermont constitution—for example, the Common Benefits Clause—or other existing Vermont law might preclude excluding non-citizens from Green Mountain Care may bear further exploration.[32]

D. Implications for individual immigration status

The general assembly may wish to consider immigration status implications, whether real or perceived, for any non-citizens included in Green Mountain Care. Specifically, two areas of concern may arise. First, with significant limitations (and dependent on factors such as humanitarian status and time in the country with lawful status), immigration laws allow officials to refuse to admit, deport, or otherwise deny lawful permanent residence to individuals who are or are likely to become a "public charge," i.e. primarily dependent on the government for assistance.[33] Agency guidance clarifies that non-cash benefits like Medicaid, other health

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[26] "State authority to provide for eligibility of illegal aliens for State and local public benefits — A State may provide that an alien who is not lawfully present in the United States is eligible for any State or local public benefit for which such alien would otherwise be ineligible under subsection (a) of this section only through the enactment of a State law after August 22, 1996, which affirmatively provides for such eligibility." 8 U.S.C. 1621(d).
[27] ACA § 1312(f)(3).
[28] NILC Overview.
[29] *Id*.
[30] *Finch v. Commonwealth Health Ins. Connector Auth.*, 461 Mass. 232 (2012). The court applied strict scrutiny to the legislative appropriation denying state subsidies to these non-citizens and held that fiscal concerns alone cannot justify discrimination based on alien and national origin protected by the state constitution's equal protection clause. *Id*.
[31] NILC Overview.
[32] The Common Benefits Clause states "[t]hat government is, or ought to be, instituted for the common benefit, protection, and security of the people, nation, or community, and not for the particular emolument or advantage of any single person, family, or set of persons, who are a part only of that community. . . ." Vt. Const. ch. I, art. 7.
[33] *See e.g.* 8 U.S.C. § 1212(a)(4); 8 U.S.C. §1237(a)(5); Overview, Oct. 2011 (citing DOJ guidance). Case law concerning deportation on public charge grounds has been limited to the relatively rare cases where a public assistance program has imposed on the non-citizen an obligation to repay an agency, and the agency has not been repaid. See Matter of B --, 3 I & N Dec. 323 (BIA 1948). Public charge concerns are more significant in the

insurance and health services (except for long-term care Medicaid and services), and certain special-purpose cash benefits are not subject to public charge considerations.[34] Second, federal law forbids state or local governments from prohibiting or restricting communications to and from the federal government regarding the immigration status of any individual.[35] Federal law does not, however, generally require states to provide immigration violation information to the federal government that is collected in the administration of state-funded public benefit programs.[36] Both real and perceived immigration status may affect and ultimately impact costs attached to covering undocumented and other immigrants under Green Mountain Care.

III. Vermont's Undocumented Immigrant Population: Estimated Size, Demographics, Health Status, and Barriers to Accessing Health Care

A. Estimated numbers of undocumented immigrants in Vermont

Accurately estimating the total number of undocumented immigrants living in Vermont is not a simple task. While undocumented immigrants live in every state, they are highly concentrated in just a few states,[37] and the Department of Homeland Security[38] keeps little data specific to states with comparatively small immigrant populations. Data collected locally focuses on migrant farmworkers and thus do not provide detail on workers in other fields or those without employment.[39]

Further, the data is limited by certain characteristics of Vermont's undocumented immigrant population. For example, undocumented immigrants, vulnerable to both discrimination and immigration enforcement, are motivated to avoid detection. Providers of services to the immigrant population generally do not track the immigration status of their clients. Finally, Vermont's undocumented immigrant population tends to be transient, with relatively short tenures at a given workplace and within the state overall.[40]

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inadmissibility context, as the administering officials have broad discretion to disqualify applicants who have not been formally admitted from obtaining visas or adjusting status to that of legal permanent resident. Protections do exist, however, for asylees, refugees, and others seeking admission on humanitarian grounds.

[34] DOJ, "Field Guidance on Deportability and Inadmissibility on Public Charge Grounds," 64 FR 28689-93 (May 26, 1999).

[35] 8 U.S.C. § 1644.

[36] NILC Overview. Federal reporting requirements do attach to agencies administering federally-funded SSI, public housing, and TANF programs. *Id.*

[37] Jeffrey Passel & D'Vera Cohn, Unauthorized Immigrant Population: National and State Trends, 2010 at p.3 (Pew Hispanic Center (February 1, 2011)), *available at* http://www.pewhispanic.org/files/reports/133.pdf (hereinafter "Pew Study").

[38] The Immigration and Naturalization Service is part of the Department of Homeland Security.

[39] Other Vermont industries that are becoming increasingly dependent on migrant labor include food services, hospitality, janitorial, and other forms of agriculture. Final Report: Assessing the Health Status, Health Care Needs, and Barriers to Care for Migrant Farm Labor in Franklin, Addison, and Grand Isle Counties at 6, Vermont Dep't of Health (Feb. 2007), *available at* http://healthvermont.gov/rural/documents/MigrantWorkerReport.pdf (hereinafter "VDH Report").

[40] David Chappelle, M.Sc. & Daniel Baker, Ph.D., Final Report: Migrant Farm Worker Health Needs Assessment at 13, Prepared for Bi-State Primary Care Ass'n (University of Vermont, Aug. 15, 2010), *available at* http://www.uvm.edu/extension/agriculture/faccp/files/health/vtfarmhealthassess.pdf (hereinafter "Baker Report") (reviewing survey results showing that 81% of respondents reported less than two years at current employment).

With these limitations in mind, there is nonetheless rough convergence among the recent estimates of Vermont's migrant farmworker population pointing to an estimated population of that group of approximately 1500-3000[41]:

- The Vermont Agency of Agriculture, Food, and Markets has estimated the size of the population as between 2000 and 3000 people.[42] The Agency reached that estimate by calculating the total number of workers needed to milk the state's 137,000 cows (as of Spring 2010) and multiplying that number by 30%, the Vermont Farm Bureau's estimate of the percentage of migrant workers.[43]

- The Vermont Migrant Education Program (MEP)[44] estimates a total population of approximately 1500 migrant workers in Vermont.[45] This estimate is an extrapolation from a subset of the total state migrant worker population served by the MEP, and is lower than other estimates, perhaps due to methodological differences and data availability.[46]

- A 2007 report by the Vermont Department of Health (VDH) estimated the overall population of migrant workers in Addison, Franklin, and Grand Isle counties at 1200.[47] Citing the then-Department of Agriculture, the VDH report estimated a statewide population of 2500.[48]

These estimates of Vermont's migrant worker population likely include citizens, non-citizens working with legal immigration status, and undocumented immigrants. Non-citizens with legal status include legal permanent residents; refugees, asylees, and other non-citizens here with legal immigration status based on humanitarian grounds; and non-citizens here temporarily on work or student visas. According to 2009 United States census data, an estimated 1.4% of Vermonters are not citizens (8803 residents).[49] Therefore, not all migrant workers are undocumented workers.

For example, seasonal farmworkers hired temporarily via the federal H-2A guest worker visa program have been coming to Vermont since the 1980s.[50] Unlike undocumented workers, workers with H-2A visas have access to certain benefits and protections as part of their work visa

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[41] *Id.* at 7-8 (collecting and reporting results of other estimates).
[42] *Id.* at 8.
[43] *Id.*
[44] The MEP is a federally funded program that "provides educational support services to eligible children of families that relocate in order to obtain seasonal or temporary employment in agriculture and to eligible out-of-school youth that have moved to obtain seasonal or temporary agricultural employment." Vermont Migrant Education Program homepage, http://education.vermont.gov/new/html/pgm_migrant.html.
[45] Baker Report at 8 (describing estimate from Erin S. Shea, Are Apples More Important than Milk? Migrant Labor Turnover among Dairy Farm Workers: Insights from the Vermont Migrant Education Program (University of Vermont, Dec. 2009)).
[46] *Id.* at 2.
[47] VDH Report.
[48] *Id.* at 1.

[50] Needs Assessment excerpt from Bridges to Health grant application, Office of Rural Health Policy Outreach (hereinafter "Bridges to Health app."); *see also* Baker Report at 7.

agreements.[51] H-2A workers can freely travel to and from their home countries, and they have access to free legal services, workers compensation, and health insurance (a high deductible plan offered through the foreign consulate).[52] Vermont farms employ about 400 H-2A workers each year, historically Jamaican nationals who average about 16 months in the States.[53]

Driven by the dairy farm labor shortage, however, Vermont's overall migrant farmworker population has changed significantly in the past decade as Latino workers, primarily from Mexico, have come to work on Vermont's 995 dairy farms.[54] The Vermont Agency of Agriculture indicated in 2010 that more than 50% of the milk produced in Vermont was harvested by Latino migrant farmworkers.[55] Latino dairy workers now make up the bulk of migrant workers in Vermont.[56] Dairy farmers are not able to take advantage of the H-2A visa program because dairy work is year-round rather than temporary or seasonal,[57] and a 2007 Vermont Department of Health survey estimated that 90% of Vermont's Latino dairy workers are undocumented.[58] Table 2 below summarizes the population estimates:

Table 2.

Migrant population - Estimates	
National estimates-Pew	*3,144*
Vermont Department of Agriculture	*2,000-3,000*
MEP	*1,500*
Vermont Department of Health	*2,500*
H-2A Visas	*400*

Finally, a recent national study indicates that Vermont's total population of undocumented immigrants is about 3,000. In a 2011 study, the Pew Research Center estimates that in 2010, undocumented immigrants accounted for less than 0.5% of Vermont's total population.[59] Given

[51] Baker Report at 7.
[52] *Id.*
[53] *Id.*; Bridges to Health app.
[54] *Id*. According to the US Census Bureau, Vermont's Latino population has increased 24% faster than its total population from 2000-2010, with the two largest agricultural counties seeing 73% and 111% increases. Vermont remains, however, one of the "whitest" states in the nation with 95% of its people identifying as Caucasian (98.5% non-Latino). Daniel Baker, Ph.D. & David Chappelle, M.Sc., Health Status & Needs of Latino Dairy Farmworkers in Vermont, Journal of Agromedicine, 17:3, 277-287 (June 25, 2012) at p. 278 (hereinafter "Baker Article").
[55] Bridges to Health app.
[56] See Bridges to Health app (1500) and Baker report p. 7(implies this # is low).
[57] Bridges to Health app.
[58] VDH Report, Bridges to Health app.
[59] Pew Study at p.24, Table A4.

Vermont's current total population of approximately 628,780,[60] the Pew estimate translates to less than 3144 people.

Synthesizing the above, it is reasonable to conclude that the range of migrant worker population estimates generated by the MEP, the Agency of Agriculture, and the Department of Health, along with the Pew estimate of Vermont's overall undocumented population, is a rough but reasonable proxy for Vermont's overall undocumented immigrant population. On the one hand, these estimates probably include migrant workers, such as the 400 seasonal workers with H-2A visas, who are not undocumented immigrants. On the other hand, the three Vermont-specific estimates include only migrant workers and not spouses or children, although, as discussed below, survey data suggest that these workers do not typically reside with other family members here in Vermont.

B. Latino dairy worker demographics

As discussed above, the majority of Vermont's undocumented immigrants are Latino dairy workers. The Board's research and interactions with stakeholders revealed survey data on the demographics of this sub-population but found no demographic information on Vermont's other undocumented immigrant sub-groups. Nonetheless, given that Latino dairy workers dominate Vermont's undocumented immigrant population, it is worthwhile to consider the survey data reflecting that group's demographics.[61]

Vermont's Latino dairy workers are young, with a median age of 28, and primarily male (93%).[62] While 57% are married, only 13% live with their spouses here in Vermont.[63] Three-quarters of these workers have children, with a median number of two each, but 96% of the workers who are parents are separated from their children while working in Vermont.[64] Most Latino dairy workers in Vermont are from southern Mexico, with a small percentage from northern Mexico and Guatemala.[65] Eighty-nine percent speak primarily Spanish, and 11% primarily speak an indigenous language but are fluent in Spanish.[66] Eight-nine percent report low levels of English language ability,[67] with only 4% reporting they speak English well,[68] and approximately half have had less than a 9th grade level of education.[69]

[60] Email from Devon Green, Health Care Policy Analyst at the Agency of Administration, October 20, 2012. This figure is trended from 2011 at a 2009-2011 rate.
[61] The demographic data discussed in this section is derived from the Chappelle & Baker Report and related journal article. That study was a survey of 70 workers on 26 farms spread around Vermont. The survey methodology was determined to be optimal to provide a cross-section of the population, but the sample size was not large enough to be statistically representative of the population. Baker Report at 9.
[62] Baker Article, p. 280. This study excluded individuals under the age of 18, although anecdotal evidence suggests there are immigrant youth under 18 working on Vermont dairy farms.
[63] Baker Report p. 11.
[64] Baker Report p.11.
[65] Baker Article p. 280
[66] Baker Report p.10.
[67] Melissa's Bistate health stories
[68] Baker Article, 282
[69] Baker Article 280.

These workers have relatively little experience with agricultural work: only about one-quarter have worked on farms for more than three years, and 23% have done agricultural work for less than one year.[70] Although dairy work is available year-round, and indeed dairy farmers prefer workers to remain long-term, these farmworkers are mobile and generally have worked on a number of farms in the short time they have been in Vermont.[71] Nearly all Latino dairyworkers are hired to work in the barns, milking and feeding cattle, cleaning the barns, and caring for young stock.[72] Workers interviewed by the Bridges to Health program reported averaging about 68 hours each week, ranging from 42 to 90 hours weekly, with seventy percent reporting that they do not have a full day off in any given week.[73] Workers earn a median hourly wage of $7.75; all receive on-farm housing, typically including utilities, as part of their compensation.[74]

C. Latino dairy worker health status

The survey respondents self-reported as healthy. Half described their health as "excellent" (17%) or "very good" (33%) and another 34% said they were in "good" health. The remaining 16% described their health as "neither good nor bad." No respondents described their health as "poor" or "very poor."[75] Eighty-seven percent said that they felt healthy every day over the past 30 days.[76] Fifty-seven percent reported feeling about as healthy in Vermont as they did at home, with 23% reporting feeling healthier in Vermont and 19% reporting that they felt healthier at home.[77]

As shown by the survey data as well as the worker testimonials and stories provided by Migrant Justice, Bi-State, and the UVM Bridges to Health program (see Appendix), however, these workers face health problems as a result of their work. Farming is one of the most dangerous occupations in the United States.[78] The use of heavy equipment and working in proximity to large livestock exposes dairy workers to increased risk of injury.[79] Indeed, 90% of those surveyed in the Baker study reported that milking was part of their job responsibilities. The risks are exacerbated by the fact that most Latino dairy workers have limited or no English language skills, making it difficult to train on potentially dangerous tasks or to communicate about risks.[80] Further, in a survey by the UVM Extension program, employers and employees reported that less than 50% of farms provide safety training to employees.[81]

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[70] Baker Article 280
[71] Baker Report p. 280-81. More than half of farmworkers surveyed had worked on their current farm one year or less, and only 8.3% for more than three years. Id.
[72] Baker Report 281
[73] Information provided by Naomi Wolcott-MacCausland, Migrant Health Coordinator, UVM Extension Bridges to Health program. *See* Appendix to this report.
[74] Baker Article p 281
[75] Baker Report at 14-15, 55.
[76] *Id.* at 16.
[77] *Id.*
[78] Bridges to Health app. at 4, Baker Article at 278.
[79] Baker Article at 278-79.
[80] Bridges to Health app. at 4.
[81] Bridges to Health app. at 4.

Other factors contribute to the health risks faced by migrant farm workers. For example, worker housing is typically within the farm itself (all of Baker's survey respondents received on-farm housing as part of their compensation[82]). As a result, the air quality of the living quarters is often poor due to exposure to animals, cleaning agents, and machinery, and vermin and overall cleanliness are further concerns.[83] Workers also suffer as a result of being unprepared for Vermont's cold climate.[84]

The most frequent health problems reported by Baker's respondents were back or neck pain, toothaches, allergies, flu, skin problems or rashes, and gastrointestinal problems. This is consistent with the Vermont Department of Health's and Bi-State's findings[85]

Migrant farm workers also face risks of mental health issues. Fear of deportation is very strong in the undocumented migrant worker population, with nearly all respondents in the Baker survey reporting that they worried about leaving their house or their farm for fear of encountering immigration or law enforcement officials.[86] Moreover, this population is very isolated—many of Baker's respondents reported feeling sadness about being far from home.[87] Further, workers have virtually no access to their own means of transportation,[88] and as a result they seldom leave their farms—on average, Baker's respondents left only about once per month.[89] This lack of mobility increases the sense of isolation, "creat[ing] a recipe for potential mental health problems within the migrant community."[90]

D. Barriers to Accessing Health Care

The surveys and studies discussed above consistently identify the same barriers to care for Vermont's undocumented farmworkers, and those themes are echoed in the testimonials and stories in the Appendix. In particular, Baker, VDH, and Bi-State all found that the following acted as barriers to care:

- **Language:** As noted above, almost 90% of Baker's survey respondents reported low English language abilities, and none spoke English as their primary language. Fifty-three percent reported language as a barrier to receiving health care, with 16% identifying it as the greatest barrier.[91] VDH and Bi-State both found that language barriers make it difficult for this population to set up appointments and communicate about symptoms.[92]

- **Transportation:** Migrant workers largely depend on their employers for transportation since "[i]t is almost unheard of for an undocumented worker to have access to a car."[93]

[82] Baker Article at 281.
[83] Bridges to Health app. at 4.
[84] Baker Report at 27-28.
[85] VDH Report at 2; Bridges to Health app. at 3-4.
[86] VDH Report at 4; Baker Report at 28; Bridges to Health app. at 9.
[87] Baker Report at 28.
[88] VDH Report at 3.
[89] Baker Article at 283; Bridges to Health app. at 10.
[90] Baker Report at 28.
[91] Baker Report at 25.
[92] VDH Report at 3; Bridges to Health app. at 9.
[93] VDH Report at 3.

Thirty-seven percent of Baker's respondents said lack of transportation was a barrier to receiving health care.[94]

- **Fear of encountering law enforcement:** Fifty-nine percent of Baker's respondents pointed to this as the greatest barrier to care, with 70% naming it as a barrier.[95]

- **Lack of insurance/Cost of care:** As explained above, undocumented workers are not eligible for Medicaid, VHAP, Catamount, or Exchange products and subsidies. While 80% and 74% of Baker's respondents said lack of insurance and cost of care, respectively, were barriers to care, only 9% identified lack of insurance or cost of care as the greatest barrier.[96]

- **Knowledge of where to go for care:** In the VDH study, for at least half of those interviewed, the first information they received came from the interviewer.[97] Many migrant workers lack sufficient geographic understanding of Vermont and often do not understand where they are in relation to their closest health care provider.[98] Indeed, 76% of Baker's respondents did not know how far they were from health care.[99]

- **Other:** Both VDH and Baker reported that a sense of machismo—that seeking health care was "unmanly"—may prevent workers from seeking care.[100]

The impact of these factors is reflected in survey results showing relatively low use of health care services. Baker found that 64% of respondents reported that they had never been to a doctor in the United States, with only 24% reporting having seen a doctor once per year and 9% saying they had a doctor or clinic they visited regularly.[101] Similarly, a survey by the UVM Extension program's Farming Across Cultures Communication Project found that 79% of workers surveyed in Franklin County had not been to a doctor in the past year.[102] Finally, the testimonials provided by Migrant Justice support the impact of these factors as barriers to care.

IV. Costs to VT of providing Green Mountain Care coverage to undocumented immigrants

Given that the nature and cost of Green Mountain Care (GMC) is not known, it is impossible to estimate the costs of providing GMC coverage to Vermont's undocumented immigrants at this time. Below, we explain potential methods for estimating the costs associated with providing GMC coverage to this population once the necessary information is available, and offer some qualitative conclusions about the extent of these costs based on the information discussed above.

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[94] Baker Report at 25.
[95] *Id.*
[96] *Id.*
[97] VDH Report at 5.
[98] Baker Report at 27.
[99] *Id.* at 19.
[100] *Id.*; VDH Report at 4.
[101] Baker Report at 19.
[102] Bridges to Health app. at 4.

A. Potential costs of providing coverage through GMC

Act 48 asked the Board to explain "[t]he potential costs of providing coverage for health services to undocumented immigrants through Green Mountain Care, including any state funds necessary to fund the services."[103] These costs can be estimated by multiplying the per-person cost of GMC by the estimated number of undocumented immigrants in the state and deducting from that any costs borne by that population.

There are at least two ways to estimate the per-person cost of GMC. First, that cost could be calculated as an annual premium for an insurance-like product for each of the GMC enrollees (as Massachusetts does with its Commonwealth Care program). Second, it could be based on actual costs of health care services as reflected in claims paid. Until more is known about the scope of the benefits that will be provided under GMC, it is not possible to select the best method for determining costs, or calculate or estimate those costs. Further, it is not possible at this stage to determine the share of those costs that undocumented immigrants would pay.

As discussed above, the data and research available do shed light on the size of Vermont's undocumented immigrant population as well as the population's health status and health care use patterns. In particular, the available data suggest that the population is small: 1500-3000 appears to be a reasonable estimated range of the number of undocumented immigrants in Vermont. Further, Vermont's undocumented immigrant population appears to be largely young, male, and relatively healthy. Moreover, this population currently consumes a low level of health care services, in part because it is a relatively healthy population and in part because it faces unique barriers to accessing care due to language, immigration status, lack of transportation, and other factors. Significantly, these barriers are unlikely to be affected by the availability of coverage through GMC.

A 2010 study published in Health Affairs corroborates the notion that Vermont's undocumented population is a relatively low-cost population with respect to health care. The study determined that in 2006, per capita health care spending across the United States was about $3700 for citizens and about $1900 for noncitizens.[104] In the northeast, the per capita spend was about $1200 for citizens and $780 for noncitizens.[105] Dr. Julie Arel of the Open Door Clinic in Addison County estimates that the Clinic incurs costs of $55,000 per year for health care services provided to 200 unduplicated immigrants,[106] a per capita expenditure of $275.

In sum, the health care costs associated with Vermont's undocumented immigrant population are likely to be relatively small due to the size of the population and its low use of health care services. Because federal law prohibits the use of federal funds to cover most health care services provided to undocumented immigrants, the bulk of the costs would have to be covered with state funds.

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[103] Act No. 48, § 4c(b)(2).
[104] Jim P. Stimpson, Fernando A. Wilson & Karl Eschbach, Trends in Health Care Spending for Immigrants in the United States, Health Affairs, vol. 29, no. 3 (Feb. 11, 2010): 544-550, at 547.
[105] *Id.* at 548.
[106] E-mail correspondence from Dr. Julie Arel (Jan. 11, 2103). The Open Door Clinic does not inquire as to immigration status, and thus cannot break out undocumented immigrants from the immigrant population it serves.

B. Potential costs if not covered through GMC

Act 48 also directed the Board to explain "[t]he potential costs of services provided to undocumented immigrants by health care professionals if these immigrants are not covered through Green Mountain Care, including any increased costs of care delayed due to the lack of coverage for primary care."[107] For the reasons discussed in the previous section—small size of the population, access barriers, low use of health care services, and relatively low per-capita costs of the services consumed, the potential costs of services provided to undocumented immigrants if not covered by GMC are also likely to be relatively low. However, because undocumented workers are paid low wages and tend to send much of their earnings home, much of the cost for the services now provided is borne by providers and employers. Providing coverage through GMC would eliminate this "cost-shift" burden for those providers and employers.

Finally, the costs associated with providing health care to this population must be considered in the broader context of Vermont's economy. Put simply, Vermont's agricultural industries depend on the labor provided by the great majority of the state's undocumented immigrants. Further, to the extent our farmers bear the costs of providing the care needed to keep their employees healthy, lack of coverage through GMC would, in effect, represent an added cost of doing business for Vermont farmers. Finally, our agriculture and food production systems cannot function at optimal levels if a sizable segment of the workforce becomes unhealthy due to lack of access to services. Unhealthy workers in our food production systems also represent a potential public health risk.

V. Conclusion

While the data on Vermont's undocumented immigrant population is limited, and the costs associated with Green Mountain Care are not yet known, the information discussed above does provide valuable insight about the extent of the costs of health care services provided to undocumented immigrants in Vermont. First, the work done by the Agency of Agriculture, the Department of Health, and the Migrant Education Program indicates that 1500-3000 is a reasonable range for estimating the size of Vermont's undocumented immigrant population. That range is corroborated by the Pew Research Center's national study, estimating Vermont's undocumented population at less than 0.5% of our total population.

Next, the surveys and research by UVM's Dan Baker and David Chappelle, the Department of Health, Bi-State, and the Bridges to Health program provide helpful insight into the demographics, health status, and health care use patterns of this population. Vermont's undocumented immigrant population appears to be largely young, male, and relatively healthy. This population also faces considerable barriers to obtaining health care, including fear of deportation, lack of transportation, and difficulty paying for services. As a result, this population consumes fewer health care services and incurs lower costs than the overall population. These conclusions are corroborated by the testimonials received from workers.

[107] Act No. 48, § 4c(b)(1).

Finally, while the costs of providing coverage for health services and the costs of services if coverage is not provided cannot be calculated, it appears from the available data that both cost categories would be relatively low, given the size of the population and its demographics, health status, and patterns of use. Further, it is also clear that, without coverage, undocumented immigrants' health care costs will continue to fall heavily on the providers who serve them and on the Vermonters—mainly farmers—who employ them.

SOURCE LIST

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APPENDIX

1. December 21, 2012 Letter from Migrant Justice containing testimonials from Vermont migrant farmworkers.

2. Health Stories from Bi-State Primary Care Association, from reports provided by local free clinics, FQHCs, and the UVM Migrant Education program

3. Document from Naomi Wolcott-MacCausland, Migrant Health Coordinator, UVM Extension Bridges to Health Program

Migrant Justice/Justicia Migrante
294 N. Winooski Ave, Ste. 130
Burlington VT 05401

December 21, 2012

Dear Members of the Green Mountain Care Board,

We are writing in order to submit testimonies from Vermont's migrant farmworkers in response to a request made by the Green Mountain Care Board on December 11th when Migrant Justice presented first hand experiences of various challenges migrant farmworkers face, in terms of accessing health care in Vermont. More specifically, the testimonies and supporting evidence indicated that:

- Accessing health care for the average migrant worker is extremely difficult and costly, and thus many migrant workers are not able to seek medical care or preventative care at early stages of injuries, sickness, or disease.
- When migrant workers do not have access to healthcare, relatively preventable injuries and illnesses that go undetected or untreated develop into more severe health problems
- In general, migrant workers are young and relatively healthier than average populations. In general, national studies have shown that immigrant workers utilize health care far less than the broader population.
- Having healthy food-system workers is important for the health and security of the entire food system, and the number of undocumented migrant workers is relatively small in Vermont (recent studies by UVM Extension suggest 1500 in total).

Additionally, in a survey of 100 migrant workers from 5 different counties conducted by Migrant Justice in 2011-2012, farmworkers were asked to rank what would be the most important thing to improve life here in Vermont. The number one response was "Knowing if you are injured or sick you have access to affordable healthcare/workman's compensation."

As the Green Mountain Care Board is charged with reporting to the legislature on January 15, 2013 the results from Act 48, we want to advocate again that Vermont can (legally and procedurally), and should find the way, to include our state's undocumented workers, who put the milk and cheese on the table for so many Vermonters. The Green Mountain Care system will only be truly universal if it includes all of our state's residents.

We ask you to please share these findings and attached testimonies with the legislature on January 15, 2013 as part of your report on Act 48.

Sincerely,

Migrant Justice/Justicia Migrante

Danilo Lopez, Over Lopez, Javier Franco Duran, José Norman, Erik Diaz, David Santiago, Arnulfo Ramirez, Natalia Fajardo, Brendan O'Neill, Monica Collins, Martha Caswell

The following testimonies by Vermont migrant farmworkers were collected by Migrant Justice in December 2012 for the Green Mountain Care Board's work on Act 48

For more information: info@migrantjustice.net, Brendan O'Neill or Natalia Fajardo at 802-658-6770

Javier Franco
Underhill, VT
Dairy Farmworker
from Mexico City

My name is Javier. I work in Chittenden. A few years ago I had to work outside in the middle of winter for many days in a row, then I got sick with what I thought to be a common cough. Since I do not have health insurance or any health benefit I ignored the cough. When I finally could not take it anymore, I went to the hospital. Unfortunately the cough evolved into a chronic pulmonary illness: farmer's lung. And now I am paying hundreds of dollars per month out of pocket from the diagnostic visits to the hospital. I am not currently seeking treatment because the medical costs are too high and I cannot afford them. That is the problem I face for not being recognized as a member of Vermont, even though I live and work in Vermont, and I pay taxes like everyone else, but I don't receive any benefits.

When the Senate considered excluding undocumented workers from the universal healthcare bill in 2011, I stood on the State House steps to say that lack of access to healthcare is in part to blame for simple illnesses becoming major health problems, and that, to me, the amendment to exclude us was discriminatory. Universal means everybody.

Alberto Madrigal
Irasburg, VT
Dairy Farmworker
from Tabasco, Mexico

Good day. Due to my work schedule I cannot be present in person to share my story about the importance of universal health.

I work on a dairy farm and I was at work when an 80 lbs. pressure-washing machine fell on my finger, smashing it.

Since I didn't have access to healthcare, I had to finish my work shift that day and the next day, fortunately my English teacher took me to the clinic the third day, where they gave me some pills and a cream to keep it clean. I only I had 2 days of rest and I had to start working again, my finger was swollen and in pain for 3 weeks and for three weeks, during the second week I went to get an x-ray and they told me that it was not broken. I was glad because otherwise I would not have been able to the pay the medical expenses.

Later on I applied for a discount at the clinic and that is why my clinical evaluation and x-ray were free of charge, because I do not think I could afford a very big bill, Hospitals here are expensive and not everyone has enough money to cover expenses.

I believe that everyone should have access to healthcare regardless of there income, nationality or immigration status, I think that the health of any human being is more important than the three criteria mentioned above.

Eva Hernandez
St. Albans
Unemployed. Her husband Works at a dairy farm.
from: Chiapas, Mexico

Fortunately I've been a very healthy person. A year ago I had a stomachache, I went to the doctor, they checked me and said it was nothing serious. I paid $10 because my friend helped me with the paperwork.

A cow kicked my husband Guillermo in the mouth about a year ago, the farmer refused to take him to the hospital right away. Eventually the farmer took him. At the hospital they took him in bur refused to treat him, I am not sure if it was because we are undocumented or because they didn't have an interpreter. Much later he was sent to the dentist, who cleaned his good teeth and pulled the loose ones. After my friend convinced the farmer to help pay, he covered $700, while Guillermo paid $200.

My daughter Carina was born in Vermont. She had Dr. Dinosaur, I paid $10 per month for it. We temporarily moved to New York, so her health insurance was cancelled. We came back to VT two months ago, another friend helped us fill out the paperwork to sign her up again for Dr. Dinosaur. Before the paperwork went through, Carina got fever and diarrhea. We took her to St. Albans hospital, where she was given IV. She was there for two hours, and now I am getting bills for $1200.

José Norman Alfonso
Vergennes, VT
Dairy Farmworker
from Chiapas, Mexico

My name is Norman and work in dairy farm. Some time ago I went to the clinic to get hives checked out, which were all over my body, but the doctors who were there did not have all the equipment required to diagnose me so they sent me to the hospital, they took me in but they would charge $100 per visit and the truth is, I do not have much money to pay this much.
I only went to the hospital twice, and they gave me some pills and an ointment, which were not working. I still have a few welts on my body, and I have not been able to go to other hospitals because they are more expensive or they do not serve undocumented people.

I think that access to healthcare is very important because it is how mankind will maintain its wellbeing, protected from disease and healthier. Government, instead of spending trillions of dollars on armament that destroys nature and makes people sick, should invest in medical centers so people would have more access to healthcare.

Eliasar Martínez
Enosburg Falls, VT
Dairy Farmworker
Chiapas México

My name is Eliasar, I share this story so that it serves as an example and to change things, due to certain policies I was undocumented in the United States, and as such I was excluded from many services, including healthcare.

I am a person who worked very hard in the U.S.A so that people can have milk with cereal in the mornings, but I feel like I am not valued. I am a human, who gets tired, sick, both at work and at home, like anyone else.

One day I went to the dentist, a at a dental clinic visited frequently by my colleagues working in dairy in Vermont, I think it is the clinic where they charge us a reasonable amount and where they do not ask immigration status, so it is easy for Border Patrol to wait outside for us to deport us, automatically we are going to "the wolf's mouth" and it is because the doors are not open for us in other clinics, or we cannot afford them.

I went to this clinic to take care of an aching tooth, I was arrested and faced a deportation order, today I am in my country, thinking how is it that the U.S.A used my hands for people not to be hungry, and when I wanted to use a service for which I paid, I was arrested. This is why I feel it is necessary for everyone to have access to hospitals, and not let people die just for being poor or from other countries.

Francisco Gonzales
Enosburg Falls, VT
Dairy Farmworker
from: San Marcos, Guatemala

My name is Francisco Gonzales. I've lived in Vermont with my wife Floridalma for four years. We have two sons, a two-year-old and a one-year-old, who were born here and have health insurance. We do not.

My first son was born at the farm where I used to work, I could not take my wife to the hospital so I had to pay private doctors, fortunately I did not have to pay them too much, maybe my former employer helped me cover the costs. My second sons 'birth was a little easier because now I know people who helped me find out which hospital supports the migrant community regardless of our immigration status and is affordable.

Last month at my work the cows slammed me against a door. My employer saw the accident. He asked me if I was ok, since it did not hurt at the time, I said I was fine, but when the pain started, I told him I needed to rest and he replied, "so who is going to work?" I endured three days of excruciating pain, working. But on the third day I could not take it anymore, so I rested for two weeks while my wife covered for me. I didn't go to the hospital because I was afraid that, even if they didn't find anything serious, I would owe expensive bills. I felt a lot pain and I could not get up, so we got some pain shots sent from Guatemala, which my wife administered. Fortunately that cured me. I don't know what I would have done if it would have worsened.

Also, Floridalma went to the dentist a year ago because of a toothache, when the Jehovah Witnesses visited they spoke with the farmer about taking Floridalma to the hospital, but the Witness ended up taking her because the farmer did not have time. The dentist pulled out her tooth. It cost us $38. The reason why we weren't afraid of the bills is that the Witness lady looked for the most affordable place

and filled out paperwork so they wouldn't charge us full price.

We know that we paid little, because a colleague who went to the dentist for the same procedure was charged $800. We feel good that we could afford to pay our part.

The kids have Dr. Dinosaur, fortunately they have never had to go to the hospital, and I feel happy to know that if they get sick I can take them and I will be able to pay their bills. However, I feel sad not having health insurance myself.

My wish is for all of us to have access to healthcare, so that we may get ahead in life. With my insurance I would feel better because you could seek preventative medicine, and I would go try to treat the insomnia I suffer from.

David Santiago
Bridport, VT
Dairy Farmworker
from: Oaxaca, México

Hello, my name is David Santiago and I want to share with you something about my health.

I was sick for a long time, at first it didn't seem to be a major issue, but gradually it worsen, getting more and more ill, because I didn't know of a health center I could access. I did some research and finally I found out about Open Door Clinic, which offers financial support and receives anyone, no matter their nationality. Unfortunately this clinic does not have specialized equipment or specialists, so I was referred to Fletcher Allen to get liver exams.
After the liver exams I got an $8000 bill, this is a very large amount and I cannot afford it. Not quite knowing what to do, I asked around, and my friend Natalia helped me to fill out a financial aid application, told me what paperwork I needed, and told me to speak to the financial aid office. So I gathered all the required paperwork, I applied, and this is why today my health is improving.

This is why I think it is important for everyone to have access to healthcare, I was lucky to find support, but what about the folks who don't? We all deserve the chance to live. Nobody should be denied health.

Health is not a business. It is unfair for some to make money on the backs of the ill.

Health Stories from Bi-State Primary Care Association, from reports provided by local free clinics, FQHCs, and the UVM Migrant Education Program:

Stories from a free clinic in Addison County:

#1 L.M.C.C is a 25-year old farmworker that we initially saw in our clinic for a rash. During this time a heart murmur was detected. When questioned, he said he had been told as a child that he had a "heart problem that would need to be fixed". He was referred to a local cardiologist. After several cardiac tests he was diagnosed with a significant congenital cardiac defect. He had become symptomatic recently and the accompanying fatigue and shortness of breath were interfering with his ability to work. It was evident that surgery would be necessary to fix the defect. He was referred to a cardiac specialist at Fletcher Allen Health Care where he is preparing for open heart surgery. None of this care could have been possible without our volunteer medical interpreters and volunteer drivers who were able to transport him 3 hours roundtrip to FAHC (and wait during his consultations, often lasting three hours).

#2 T.E.R has been a patient with us since 2008. He is currently completing treatment for TB and has worked closely with health care providers during his treatment regime. During the latest visit to his farm, he participated in a health screening that included the PHQ-2, a depression screening tool. The results showed he was likely to be clinically depressed. We followed up at an office visit at clinic the following week where a more in-depth screening was provided. He tested positive for clinical depression. We were able to schedule a counseling appointment with him and follow-up visits should depression medication be necessary. Having access to the farms and our ability to bring health care providers out in the field was crucial in diagnosing this farmworker.

#3 Upon arriving in the office one weekend day, an ODC staff member noticed that there were repeated hang-up calls on the Spanish line from the same number. After some sleuthing she was able to find the number and promptly returned the call. A farm worker explained that he had been stepped on by a cow several days ago and been seen in the emergency room. After X-rays he was sent home to rest having been assured there was no break. Today, he told the ODC staff, his foot was turning black. Knowing that he would need to be seen right away, the staff member secured his address, and unable to find a volunteer driver, drove over to get him and bring him back to the hospital. He was transferred to a larger hospital, put on I.V. antibiotics and spent the next couple of weeks in the hospital. Luckily he did not lose his foot. Most of our farm worker patients would not seek emergency services without the support of the Open Door Clinic. ODC's trusted role as coordinator of care and advocate assists many patients in obtaining timely emergency care.

#4 This quarter, one of our patients delivered a beautiful baby girl. Our outreach assistant donated her time to provide ongoing support to the patient throughout her pregnancy and the birth. Since this was a high-risk pregnancy, the patient received

prenatal care through the local OB-GYN office rather than the midwifery service that typically provides care.

There was a free clinic outreach worker was present during the C-Section to provide interpretation services. Although the baby is eligible for Dr. Dynasaur, the local hospital did not provide the application or assistance with the process of enrolling the baby. It quickly became evident that the baby has a heart defect requiring specialist attention so the family was referred to FAHC. This time, an interpreter was provided by the hospital as was an application for Dr. Dynasaur but no assistance was given although the application is in English.

The patient brought the paperwork to our office and our outreach worker walked her through calling for assistance using the language line offered by the state. The first language line was not picked up after multiple calls and allowing it to ring for 25+ times. Our outreach worker tried another way to get translated services but found that the instructions were all in English making it impossible for the mom to manage on her own. After many challenges, our outreach worker and the mom were able to complete the application process.

Stories from a clinic in the Northeast Kingdom, written by a physician:

#1 We got to know one patient especially well. "Freddy" seemed like the picture of health at first glance: quite fit, with excellent blood pressure, didn't smoke or drink. He came to our health center four different times from his residence an hour away, each time for a completely separate reason. Usually it was a sore muscle complaint, but once it was "to check my lungs," in the absence of any cough, shortness of breath or other pulmonary complaints. Eventually, on the fourth visit, the doctor seeing him probed further. Although prior screening for depression had been negative, Freddy admitted to feeling very lonely and homesick. He was the sole worker at the farm where he was employed, and although he felt he was treated fairly and was glad for the work, he wasn't happy. He admitted that he felt much better each time he had a chance to come in and be checked. The doctor seeing him that day was able to coordinate some increased social outings for the patient through church volunteers with whom he was already connected. The providers who were involved in his care were also able to discuss his case and agreed that while it can be frustrating to see a patient and not be able to come to a definitive diagnosis or treatment plan, it is helpful to remember the unique context of these patients' lives and how that can influence their presentation and appropriate "treatments."

#2 Two other examples of improved care come to mind. Early in our involvement in the program, the local UVM Migrant Educator notified me (a bilingual physician) that a worker was coughing up blood. A home visit was made, and I determined that the patient was actually having blood-tinged nasal discharge in the setting of a viral upper respiratory infection, which cleared quickly with a few days of an over-the-counter nasal spray. The patient had been on the verge of flying home to Mexico to obtain medical care, an expensive prospect to say the least!

#3 On another occasion, I received a phone call that a young female worker, newly pregnant, was having pain “down there,” and perhaps should seek immediate emergency care. I was able to reach the patient by phone, triage the complaint, and determine that she probably had a routine yeast infection. I described the treatment (an antifungal cream) and how to access it, and the patient signed with relief, acknowledging that she had had similar infections previously and treated them successfully. In this case it was certainly helpful that I, as the physician, was fluent in Spanish.

#4 Certainly the most gratifying case has been witnessing the pregnant partner of a migrant farmworker gain access to high quality prenatal care, and give birth to a healthy (big!) baby boy. Many community members came together to provide support for this young family, from assisting in gathering needed supplies, to providing transportation to counseling and medical appointments, to providing home visits for mom and baby and assisting with enrollment in eligible services such as WIC.

Stories from UVM Extension, Vermont Migrant Education Program, working in Northwestern VT:

#1 Another patient told me when he called – “I was moving cows a few weeks ago and the cow pinned my leg against a gate. It didn't really hurt then but now it keeps bothering me. I'm worried something’s wrong with it. I didn't want to leave the farm but then I remembered when you came here with a doctor to do a check up and told us that there was a clinic nearby that was safe. Can you help me go to that doctor?”

#2 - An employer on a farm that we visited in February of last year called about one of his employees. He is an older man (in his 50's) who has been on the farm for many years. The employer noticed that his cheek was swollen and upon talking to his employee discovered it was a sore tooth. The employer asked if I could assist in getting him checked out. The local health center’s dental program was full and booked out at least a week but due to previous situations with swelling in the mouth I called the local health center’s medical program to investigate his being seen and perhaps prescribed antibiotic. He was already in the system and the local health center was able to fit him in. We completed a 2012 registration over the phone that was then faxed in. The employer transported and signed a documentation of income letter. The patient/employee was placed on antibiotics and pain medicine. A few days later, while talking to the employee, I realized he was unsure which medicine was the antibiotic and which was the pain medication. He also thought that, since his tooth didn't hurt any more, he didn't have to continue taking the medicine. With help of the employer who helped the employee identify which prescription was the antibiotic, the employee finished the medicine. A dental appointment was made for 6 weeks out due to scheduling issues. Two weeks later the employee was experiencing dental pain again. Working with the dental clinic he was put on the waiting list and the employer was willing to be on standby for a last minute call to get him to the clinic. The next day, a spot opened up, and between the clinic, the employer, the employee and me he got to the clinic and his tooth was successfully removed!

#3 – *Unfortunately not a success story* – On 12/13/11 a border patrol vehicle was parked in the fire department parking lot next to the local Health Center. The patrol watched a migrant farm worker enter the local Health Center. Border Patrol waited until he emerged from the building after the appointment and followed the farm worker and volunteer driver several miles before pulling them over for "suspicious activity". The farm worker was detained and later transported to NY as the deportation process began. The volunteer driver and her 7 month old child were detained for a short period of time and threatened with legal action. The FHC Project Director called the US Border Patrol station later that day and discussed this situation with the officer in charge. He denied staking out the health center and sited suspicious activity for the reason that the car was followed and stopped. The suspicious activity was later described as having Florida license plates on the car. This event has not only had an impact on the perceived safety of seeking healthcare off the farm but also affected the availability of volunteers willing to transport patients. On several other occasions the FHC Project Director has called the local Border Patrol station when unmarked Border patrol or immigration vehicles were stationed near the health center and each time they have reported this as a coincidence and state that they do not intentionally watch the local health center. During each call the local health center's mission has been explained as well as the public health risk related to creating barriers to healthcare for certain segments of our population.

NEED data from the 'UVM Extension' Farming Across Cultures Study completed in 2010:

Despite farmworkers reporting illness and injury on the farm (38% and 47% respectively) the majority (98%) report not having a primary care physician where they are currently living. In the past year, 21% reported having been to a doctor and 9% to a dentist. 9% of workers reported having been to the Emergency Room at least once since coming to the United States. The injuries reported ranged from cuts, back pains, broken bones, and sprains. The most common injury was bruising (28% of all workers) as a result of cow kicks. Falls were the second cause of injury (13% of all workers).

While, experience in the field has demonstrated that on a whole the farmworkers are in good health (heart rate, blood pressure, blood sugar, BMI), they are working and living in conditions that raise their level of risk for illness and injury. They work long physical hours, use farm equipment, and in many cases share a small living space with multiple people. The majority of farmworkers in this study worked between 51 and 90 hours a week (89%). Many use equipment in their job that increases risk of injury (57% use a skidsteer). Housing for the farmworkers ranges from trailers, to houses, to apartments above the barn. Cleanliness is a concern of the farmers (77%) and farmworkers report flies, mice, cockroaches and bedbugs in their homes (81%, 69%, 46%, and 23% respectively).

Farmworkers reported various obstacles to accessing health care:

- 83% report language to be a barrier to health care access
- 67.9% report transportation
- 60.4% would have difficulty finding a doctor
- 47.2% would be afraid to go to the doctor

- 45.3% say they would have problems finding shift coverage
- 39.6% report money as a barrier

The dependency on the farm owner and/or manager by the Latino farmworker extends beyond work and home and into health care needs as well. 87% of workers would call their boss or farm manager if there was an accident on the current farm. 47% of workers would call their boss or farm manager if they were sick. Access to over the counter medicine is limited by the fact that the majority of workers have someone else purchase their food and other necessities for them (96%). Given that 45% report not knowing what food is available to them in the grocery store where they live, it is likely that workers are also unaware of over the counter options for health concerns. With farmworkers earning, on average just over $7 an hour and reporting low levels of English (89%), on top of transportation barriers, knowledge of community resources and fear support around available low cost health care options, filling out paperwork, and care coordination is imperative to farmworker health and wellbeing.

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My name is Naomi Wolcott-MacCausland. I currently work full time as the Migrant Health Coordinator for the project called Bridges to Health through UVM Extension. I also work part time on my parents' dairy farm in Franklin County, the county with the most dairy farms in the state and therefor some of the highest numbers of immigrant farmworkers. Over the past few years, I have been in contact with hundreds of Latino farmworkers: healthy, sick, and injured. For 2 years, I have been coordinating monthly visits to farms with a doctor to offer general wellness checks to farmworkers. In all, we've seen over 100 patients on these outreach visits. Because of these visits as well as time spent coordinating health care access and completing research that includes health care access information I feel comfortable making a few observations as well as providing some numbers.

In 2010, I interviewed 26 farm employers and 53 Latino farm workers in Franklin County. The dairy farms ranged from farms milking of 80 head to over 1200. The average number of workers per farm was 3.4. Given that we estimate that there is a total of 40-44 farms that hire immigrant workers in the county, we believe that there are between 130 and 150 immigrant workers currently in Franklin County. The population of the immigrant farmworkers tends to be young with the majority being under 30 years old. In Franklin County (though not in all counties) the immigrant farmworkers are all employed in dairy. The majority work directly with cows, moving them in and out of the parlor as well as milking them. 90% speak Spanish as their first language while 10% speak an indigenous language from Mexico or Guatemala as their first language. 90% are male. They work an average of 68 hours a week ranging from 42 to 90 hours a week. 70% do not have a full day of week off per week.

Overall, I would describe the population as healthy, perhaps partially due to their youth and physically active work. The majority has never sought out health care services in Vermont and report wellness checks on the farm or at Mexican consulate visits are the only time they have been seen by a doctor during their time in the United States. The typical farmworker on an outreach visit describes aches and pains associated with work but is generally deemed healthy by the medical provider. However, there is usually at least one individual on each outreach visit who identifies a health concern that has gone untreated for weeks, sometimes months, sometimes years. The barriers to health care access for this population are great. Contributing to health access issues are the lack of health insurance combined with the high cost of care. Overall the number of immigrant farmworkers in our state are low compared to most other states but those that end up needing care end up in costly situations, in part due to a lack of insurance coverage.

The lack of health insurance, perceived and real costs of care lend to a number of troubling situations including the following.

1) Most immigrant farmworkers do not receive preventative care. In fact, in a recent survey in Franklin County, 52 of 53 farmworkers reported not having a primary care physician.

2) Self-care is also common with farmworkers requesting medicine be sent from their home countries. Many times, this medicine would only be accessed through a prescription in the United States but is available for purchase without a prescription in their countries of origin. Sometimes, information about doses is not clear.
3) When sick or injured they tend to delay seeking out health care until symptoms have developed to a point in which accessing and receiving care from a primary care doctor may no longer be an option.

I could share a long list of examples to highlight the concerns that come with lack of preventative care, delayed access to health care and improper self-care. Important to note is the cost not only to the individual and health entity for uncompensated care, but also to the farm owner due to costs associated with having to cover an employee's shift while he or she recovers: A few examples from over the past 3 years:

1) Susan had not been to the doctor in 4 years. She was found to have diabetes after getting a glucose screening based on symptoms. She had to due daily glucose tests and inject herself with insulin for almost a year. Close work with a diabetes specialist around diabetes education and behavior modification resulted in the patient reaching a point where she no longer had to use insulin.

2) Juan spent weeks with stomach discomfort. He talked about going to the doctor a few times but due to his work schedule and perceived costs of access, he did not go. One day, he struggled to get out of bed due to the pain. He was referred to the emergency room due to the extent of his pain. After 6 hours in the emergency room he was found to have a swollen lymph node in his abdomen. He was treated with pain medicine and released.

3) Laura had been having on and off intense pain for months. She fainted at work, she reports it was because of the pain level. She was transported to the emergency room where she admitted and stayed for 10 days while they treated her for a gallbladder infection and pancreatitis. They ultimately ended up removing her gallbladder.

4) Dorita was five months pregnant when we did an outreach visit. She had yet to seek out prenatal care. She said she did not know where to access care and was concerned about the doctors bills.

5) Ema had no prenatal care because of a lack of insurance. When noticed spotting she call an outreach worker and was brought to the labor and delivery floor of hospital. The baby was born 30 minutes after arriving.

6) Zoila had ongoing stomach pain for months. By the time she reached out to a health clinic they referred her to the emergency room because she was in so much pain. She was found to have severe constipation. She spent 5.5 hours in the ER.

7) Sala had a painful tooth. He did not seek out care because he heard it was expensive. He ended up at the ER with an infected tooth. They treated him with antibiotics and released him.

8) The dentist recommended that Enbert get two root canals. Because of cost he decided to get them both pulled.

9) Perceived costs and lack of awareness about services available for family planning resulted in an unintended pregnancy.

10) Two of the men seen on outreach visits this year are 57 and 60 years old. The recommendation is that they get colonoscopies but both are reluctant due to anticipated costs.

11) On a farm health visit last week, Francisco said that he was finally feeling better after 2 weeks of not feeling well. He had not gone to the doctor because he was afraid of cost. He had medication sent from home that he said was helping. He was taking 800mg Ibuprofen a number of times a day, something that could damage his stomach and intestines. Also, he had been sent injectable vitamins that he had been giving himself daily using the same needle each time. Concerns here include the misuse of over the counter and prescription medication being sent from home without consultation with the doctor, improper use of a syringe, reuse of the needle by individual or other member of the household.

12) We visited Jose to set up a farm health outreach visit to his home for the following week (August 2012). Jose was in his early 20s and reported generally good health other than severe headaches that had been plaguing him for a number of years. He reported continued headaches and expressed desire for care but significant concern about cost. He said that as a father of two he couldn't afford to see any specialists. A few months earlier he had gone to a local FQHC and been referred for a cat scan. At that point he discontinued accessing health care because he said he had heard the exam was expensive and feared more tests and therefore more costs. Jose died 5 days later leaving behind a wife and two young children. Though the cause of death was determined to be unknown. I can't help but think about whether his death could have been prevented had the costs of health care not been prohibitive.