Farm Operations and Health Care Insurance Options

Do you agree? You, your family and the people who work with you are all important to the success of your farm. Their health can be an asset or a risk to the farm operations.

And do you agree all farmers are risk managers? A critical area for risk management is the health and well-being of the owner operator, the family and employees of the farm operation. Health insurance enables access to preventive health care, chronic disease, pain management and catastrophic coverage for those important human farm resources. It is a key tool to keep each farmer, farm family and worker healthy, able to perform their duties, and the farm operations running smoothly.

Health insurance is a significant expense for farmers — both for their families and workers. It also both costs and benefits a farm family's financial well-being. To stretch your finances, you'll need to do comparison shopping among the many options that may be available to you. You'll want to compare not only the cost of the premium and other out-of-pocket costs but also the services covered by the plan. This factsheet outlines available health insurance options that farm operators can consider and provides some tools you can use to compare plans.

Many factors contribute to your decision as to which health insurance plans to choose and how to pay for them, including:

- The state in which you live
- Available health insurance policies and plans
- Your income
- Number of family members or employees, and
- Business entity organization (sole proprietor, LLC. or S Corp.

You may need to consider multiple streams of insurance coverage to ensure the lowest price and the best coverage. It may feel like you are putting pieces of a health insurance puzzle together, but doing so will ensure that you, your family and employees are covered for the long term success of the farm operation and everyone's health.

Note to Reader: Throughout this document, you'll see words that are in bold. They are considered **Important Words to Know** and their definitions are listed at the end of this document.

Health Insurance Options for Farm Operators & Family Members

There are several options for acquiring health insurance coverage for farm individuals and their families.

1. Off Farm Employer Based Health Insurance - Off-farm employment is often used to acquire health insurance and other benefits for members of the farm family. When a member of your family works off-farm, employers of the off-farm employee may provide insurance for employees and provide options for other members of the farm family. This option may be open to on-farm spouses and children who are under the age of 26. The tradeoff with this strategy is that working off-farm reduces time, know-how and energy, called human capital, available for the farm operation. If the employer plan offers family coverage, compare the cost and coverage for the family members with other sources of insurance for them to see which plan offers the best cost and coverage. If your employer offers a health care plan for you, you are not eligible for insurance from the **Health Insurance Marketplace**.
2. State-based **Health Insurance Marketplace** – Medical and dental insurance for those under age 65 can be found through each state's Marketplace. Qualified health insurance providers offer a variety of plans that meet federal and state guidelines, present a variety coverage options and are at a variety of price points. When you purchase through the Marketplace, you may qualify for **tax credits or premium subsidies** that can help reduce your **premium** costs. To be eligible for any **tax credit/subsidy**, you must purchase health insurance through the Marketplace and be at or under the eligible income. States have online, in-person and over-the-phone assistance in enrolling in these programs. They can help you better understand what your premium (and tax credit) might be. Find out more and get help at www.healthcare.gov.
3. Health Insurance Provider (Company) – Many health insurance providers will sell directly to you. Plan options are available that cover just you and/or your family members. Check with your state's Insurance Commission to see which health insurance providers are licensed to sell in your state.
4. Agent/Broker – Independent insurance agents/brokers can help you identify a plan that works best for your situation. An agent usually represents one company while a broker may represent several. Depending on which health insurance providers they represent, the broker may be able to help determine an insurance plan that fits your needs. The more insurance companies the broker represents, the more comparison-shopping can occur across plans. Be sure you understand the process by which the agent or broker gets paid and compare the difference between purchasing through their business and through other health insurance options. Some

agent/brokers have been certified to offer Marketplace plans. You can find out which agents are certified in your area by going to www. healthcare.gov.

5. Armed Forces Health Insurance – As an active or retired member of the armed forces you may be eligible to use health insurance offered through the armed forces. Tri-Care is an example.
6. Association Membership – Some business associations like the Farm Bureau, local Chambers of Commerce, and others work with health insurance providers to provide health insurance plan options that reflect the needs of their members. As a member of an association, you become part of the buying power of the association as they negotiate plan options for their members. Depending on the association size, the health insurance plans available may provide some lower cost options.
7. Medicaid - Based on income, and family-size, and eligibility guidelines, you and your family members may be eligible for Medicaid health insurance coverage. Each state has a variety of programs and state-specific eligibility requirements. For example, for access to medical care that is not long-term care, there is a program that allows you to keep your home (and the farm) and still be eligible. Applying through the www.healthcare.gov website, working with a health care **Navigator** or going to the Department of Social Services location that manages the Medicaid program will help you enroll. The www.healthcare.gov website can help you to determine if you are eligible by answering a few questions about your income and age of family members. The website will also provide you contact information for the office closest to you. The Medicaid Long Term Care program is for those who need continuous nursing home or assisted living care. It has different eligibility requirements that does include value of assets as one of the criteria.
8. Children's Health Insurance Program (CHIP) - This program is for low-income families with children generally under the age of 18. It helps to cover medical and dental care costs of the children and, in some states, the program will also cover pregnant women. The income and family size eligibility may be different than the Medicaid program eligibility. For more information go to: https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/.
9. Medicare, Medicare Advantage and Medicare Supplemental (Medigap) Insurance – Available to those 65 and older, Medicare provides health insurance coverage for hospitalization, doctors and medical services, equipment, and prescription drugs. When you pay Social Security and Medicare taxes, you have contributed to Medicare throughout your working lifetime. If you were born before 1929 and you worked 40 quarters (or 10 years), you can receive the benefit of a reduced **premium**. You must sign up for Medicare during the seven month period around your 65th birth

month (three months prior to your birth month to three months after). Even if your Social Security eligibility age is higher than 65, you need to register for Medicare during this seven month window. If you have insurance from a different source, Medicare can be your secondary source.

Medicare Part A covers hospitalization. Part B covers doctors, medical services, equipment, preventive screenings, and other services such as nursing home care. Part D covers prescription drugs. Depending on your work history, there is no premium for Part A, but there is a monthly **premium** for Part B and an extra **premium** for Part D. There is a life time penalty for not enrolling in Part D when you first turn 65, so consider enrolling at that time. The Part B part of the plan covers about 80% of the costs and there is a deductible for Part A, B, and D (depending on the plan you choose).

Medicare doesn't cover all medical needs. Many individuals also purchase Medicare Supplemental or Medigap insurance. This insurance wraps around the Medicare plans to help offset the costs of care not covered by Medicare. Go to the Medicare website (www.medicare.gov). It will help you better understand the plans and assist you in identifying Medicare Supplement insurance plan options in your location. Some employers offer health care plans to their retirees that may serve as the Medicare Supplemental insurance; check with the Human Resources Department. You will find informative videos to help you through the enrollment process.

Medicare Advantage Plans are Medicare's version of an HMO – it usually provides medical, dental and vision coverage. It is not available in all areas. When you go to Medicare.gov you will be able to see what is available in your location when you put in your zip code.

10. Christian Healthcare Plans or Health Care Sharing Ministries - Christian Sharing Ministries are comprised of thousands of members who come together and agree to share the cost of all members' medical bills. The Sharing Ministries do not offer insurance which is a legally binding contract. They are independent organizations that facilitate the process of collecting the monthly share (similar to a premium) and distribute reimbursement to members. There is a personal responsibility amount per incident (similar to deductibles). The plans enable members to select their own providers and negotiate rates with those providers. Medical bill payments are paid by the member, the member then submits their medical bills to the Sharing Ministry organization, and the Ministry then reimburses the member. Eligibility of membership requires members to be a Christian who doesn't use tobacco or illegal drugs, uses alcohol and prescription drugs in

moderation, and pursues a healthy lifestyle. Often prescription drugs and some procedures that are controversial to the beliefs of the group may be disallowed. Be sure to read coverage information carefully to be sure this type of coverage will meet your health care needs.

11. Short term insurance plans – "Term Health Insurance" is sometimes used interchangeably with "short-term health insurance." Both phrases refer to limited duration medical plans, that offer coverage for 180 days or less and after which an enrollee must apply for new coverage. With these plans, there are lifetime claims maximums, pre-existing conditions are excluded and you have to be approved for coverage. These plans are good for short term situations when you have lost coverage and need insurance coverage until the next enrollment period. Comparison shop to be sure it offers the types of services you may need.

    The Consolidated Omnibus Budget Reconciliation Act (COBRA) is law that requires employers and their group health plans to provide temporary continuation of group health coverage that otherwise might be terminated when an employee leaves that employer. It provides 180 days of coverage and the employee is usually required to pay the full **premium** rate (there is no employer contribution to help pay for the premium.) To access this benefit, talk with the Human Resources department at your place of employment. You usually have 30 days after termination to inform the health care plan of your intent to keep your health insurance.

Health Insurance Options for Employers Who Want to Help Cover their Employees

1. The Small Business Health Options Program (SHOP) –SHOP is for small employers who want to provide health and/or dental insurance to their employees. These options are available through the **Health Insurance Marketplace** in each state. To purchase SHOP insurance, your farm business must have 1 to 50 employees. You may be eligible for **tax credits** that will help offset the cost of providing insurance. SHOP insurance gives choice and flexibility because you can offer your employees one plan, or let them choose from multiple; offer only health coverage, only dental coverage, or both; choose how much you pay toward your employees' premiums and whether to offer coverage to their dependents; and decide how long new employees must wait before enrolling. Find out more at healthcare.gov
2. Agent/Broker – Independent insurance agents/brokers can help you identify a plan that works best for your situation and the number of employees you would like to cover.
3. **Health Reimbursement Accounts (HRA**) – This type of account is used as an employee benefit by encouraging employees to purchase health insurance individually. It is an IRS approved, tax advantaged, health benefit plan that reimburses employees for **out-of-pocket** medical expenses and individual health insurance **premiums**. The HRA is 100 percent funded

by the employer. The terms of these arrangements can provide funds to pay for medical expenses until the funds are exhausted. The contribution amount per employee is set by the employer and can be used for **premiums**, **deductibles**, **copayments**, **coinsurance** and other IRS **qualified medical expens**es. Contributions are tax deductible by the employers but is not considered taxable income for employees. There are IRS rules about who can be covered by an HRA. For more information look to IRS Publication 969; https://www.irs.gov/forms-pubs/about-publication-969.

For sole proprietors, you would set up a HRA for yourself and your family. For those businesses that have up to 49 employees there is the ability to set up a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) for all the employees in your operation. Again, the operation sets an allowance, and employees submit their medical expenses for reimbursement. To get the income tax advantages offered by the QSEHRA, employees must have access to insurance plans that meet the minimum essential coverage (MEC) as set forth by the Affordable Care Act.

4. Additional Income – While not a direct health insurance option, one strategy to help employees purchase health insurance is for employers to pay a higher salary to help employees pay for independent health insurance coverage. The major downside to this option is an employer can't require employees to purchase insurance with this additional income.

Comparing Plans - Tools You Can Use

No matter where you get your health care coverage, comparing plans will help you choose a plan that meets your health care needs and better understand the costs. You should consider the types of care needed – medical, dental, vision, prescription drug, and/or long-term care and for whom you need coverage – family, dependents, employees and self. As you review the costs, consider the fixed costs of the **premium**, **deductible**, and **out-of-pocket maximum** as well as the more flexible **copayment** and **coinsurance** costs. Understanding what the plans offer and using a tool to compare will help you make the best choice. Here are two tools to help you:

Summary of Benefits and Coverage - Comparing plans can be a little tricky but each health insurance plan offered by a health insurance company is required to offer a **Summary of Benefits and Coverage** document. This document provides some of the basic information in a standardized format so you can easily compare plans. Information like the **deductible**, **out-of- pocket maximum**, **copayment** and **coinsurance** amounts are included as well as descriptions of the types of health insurance services that will be covered. Lastly, at the end of the summary, there are two standardized scenarios so that you can compare across plans what your out-of-pocket costs would

be (excluding **premium**). Using this document helps you compare the plans and better understand the costs and coverage. Be sure the Summary of Benefits and Coverage you are reading represents that plan you are comparing. Because of the way plans are titled, it can be confusing. Contact the insurance company that provides the plan to access this information; it is probably on their website.

The My Smart Choice Workbook - The *My Smart Choice Health Insurance Workbook*™ was created by the University of Delaware Cooperative Extension and the University of Maryland Extension as a tool that helps you determine your health care needs. The workbook can help you estimate costs for plans you are considering based on how you use health care services. The workbook provides background information and worksheets to help assess needs and calculate costs for up to three different plans at a time. The workbook can be found at https://extension.umd.edu/insure/consumer-resources.

Summary

As a risk manager, farm operators need to consider themselves, their families and the people who work with them as important resources that support the success of your farm. Their health affects the current financial well-being and the vitality of the operation.

There are many health insurance options. You need to compare them to determine which offers the right coverage for you, your family and or your employees. There are many financial considerations, not only about how to cover the cost and which financial resource – farm or home - should be financially responsibility to pay for this important risk management tool.

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Resources:

Insuring Your Health – Available at: https://extension.umd.edu/insure. Developed by University of Maryland Extension with support from University of Delaware Cooperative Extension, this website provides information and tools to help you choose and use your insurance wisely.

www.healthcare.gov – this website provides a wealth information as well as serves as a tool to help you find local health insurance coverage through government programs and can link you to local Navigators or local certified Agents.

www.medicare.gov - this website provides information about the Medicare program and can help you determine Medicare supplemental policies are available in your location.

www.irs.gov/forms-pubs/about-publication-969 - IRS Publication 969 provides information about Health Savings Accounts and Other Tax-Favored Health Plans.

www.irs.gov/forms-pubs/about-publication-502 - IRS Publication 502 provides information about medical and dental expenses.

References:

IRS Publication 969 Health Savings Accounts and Other Tax Favored Health Plans found at: https://www.irs.gov/publications/p969

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Important Words to Know

Health insurance is confusing. It's like another language. To be a smart consumer you need to understand the language. The Important Words to Know below is a short version of a longer document that includes words from this publication. The complete Important Words to Know document can be found at: https://extension.umd.edu/insure/consumer-resources.

General	
Health Insurance Marketplace/ Exchange	Are organizations set up to facilitate the purchase of health insurance in each state in accordance with Patient Protection and Affordable Care Act. To access health insurance plans through the Marketplace/Exchange go to www.healthcare.gov and put in your zip code.
Navigator (also known as Assistors)	A person who helps you look for health coverage through the **Health Insurance Marketplace**. Also knows as Assistors in some states. Their services are free.
Summary of Benefits and Coverage	Insurance companies and job-based health plans must provide you with 1) a short, plain-language Summary of Benefits and Coverage (SBC) and 2) a uniform glossary of terms used in health coverage and medical care. This information helps you make "apples-to-apples" comparisons when you're looking at plans. The SBC also includes details, called coverage examples, which show you what the plan would cover in 2 common medical situations: diabetes care and childbirth.
Cost Terms	
Coinsurance	Your part of the costs of a covered service usually determined by a percent of the cost of the allowed amount for the service. You pay this amount once you have met your **deductible**.
Copayment	A set amount (for example, $20) you pay for a covered service. You pay this amount when you get the service. It can change based on the type of service. You may have to meet your **deductible** first.
Deductible	The amount you must pay for services before your insurance or plan starts to pay. Only services your plan covers can be used to meet the deductible.
Out-of-Pocket Costs	Your costs for services that are not paid by insurance. This includes **deductibles**, **coinsurance** and **copayments**. It also includes costs for services that are not covered by insurance.
Out-of-Pocket Maximum	The most you pay during a policy period (usually one year) before your health insurance plan pays 100% for covered services. This includes **deductibles**, **coinsurance**, **copayments**, or other charges. It also includes any other cost that is a qualified or allowed expense. This doesn't have to include **premiums**, balance billing amounts for non-network providers and other **out-of-network** costs. It also doesn't include what you pay for non-essential services.

Premium	The amount you pay for your health insurance or plan. You and/or your employer may pay it monthly, quarterly or yearly.
Qualified Medical Expense	A cost for healthcare services, equipment, or medications. There are many types of medical expenses that qualify. You can find these at: http://www.irs. gov/pub/irs-prior/p502--2013.pdf
Tax Credit or Tax Subsidy for Health Care Premiums	The **premium** tax credit is a refundable tax credit designed to help eligible individuals and families with low or moderate income afford health insurance purchased through the **Health Insurance Marketplace**. The size of your tax credit is based on a sliding scale. Those who have a lower income get a larger credit to help cover the cost of their insurance. When you enroll in Marketplace insurance, you can choose to have the Marketplace compute an estimated credit that is paid to your insurance company to lower what you pay for your monthly premiums (advance payments of the premium tax credit, or APTC). Or, you can choose to get all of the benefit of the credit when you file your tax return for the year. https://www.healthinsurance.org/ this website has a subsidy calculator to help you estimate by how much the premiums would be reduced if you purchased insurance through the Marketplace/Exchange.
Types of Health Insurance Plans	
High Deductible Health Plan (HDHP)	A plan with a higher **deductible** than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes. Each year the IRS defines a high deductible health plan as any plan with a certain level of deductible (in 2018 it was at least $1,350 for an individual or $2,700 for a family). An HDHP's total yearly **out-of-pocket** expenses (including deductibles, **copayment**s, and **coinsurance**) can't be more than a certain amount (in 2018 it is $6,650 for an individual or $13,300 for a family). This limit doesn't apply to out-of-network services.
Exclusive Provider Organization (EPO)	A managed care plan where services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency). You would be responsible for all cost is you used out-of-network services. Usually, you do not need a referral to see a specialist
Health Maintenance Organization (HMO)	A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be

	eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.
Point of Service (POS):	A type of plan where you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans require you to get a referral from your primary care doctor in order to see a specialist.
Preferred Provider Organization (PPO)	A type of health plan where you pay less if you use providers in the plan's network. You do not need a referral to see a specialist. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.
Types of Medical Savings Accounts	
Health Reimbursement Accounts	Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for **qualified medical expense**s up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements. An employer can limit their HRA by establishing a limit on the contributions they will make for employees. HRA are initiated by an employer and serviced by a third-party administrator or plan service provider. Funds contributed to an HRA by an employer are property of an employer and unused contributions cannot be taken by an employee when s/he leaves an employer.
Health Savings Account	A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance, and some other expenses, you can lower your overall health care costs. An HSA can be used only if you have a High Deductible Health Plan (HDHP) — generally any health plan (including a Marketplace plan) with a deductible of at least $1,350 for an individual or $2,700 for a family. When you view plans in the Marketplace, you can see if they're "HSA-eligible." For 2018, you can contribute up to $3,450 for self-only HDHP coverage and up to $6,900 for family HDHP coverage. HSA funds roll over year to year if you don't spend them. An HSA may earn interest, which is not taxable. Some health insurance companies offer HSAs for their high deductible plans. Check with your company. You can also open an HSA through some banks and other financial institutions.
Flexible Spending Accounts	An arrangement through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Allowed expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices. You decide how much to put in an FSA, up to a limit set by your employer. You aren't taxed on this money. If money is left at the end of the year, the employer can offer one of two options (not both): 1) You get 2.5 more months to spend the left over money or 2) You can carry over up to $500 to spend the next plan year. Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.