



Thank you for attending this presentation about making a Smart Choice for Health Insurance. It is a part of a multi-state Cooperative Extension effort to help you better understand your health insurance choices and make the best decisions for you and your family.

This presentation includes information about the two ways that the Affordable Care Act (ACA) affects farm families: 1) As individual consumers of health insurance just like other Americans and 2) As employers of farm workers. Key provisions of the ACA law are described along with examples of how they affect farm families.

Basic Webinar Instructions

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Cultivating Accessible Agriculture

- **AgrAbility: USDA-sponsored program that assists farmers, ranchers, and other agricultural workers with disabilities.**
 - Partners land grant universities with disability services organizations
 - Currently 20 projects covering 22 states
 - National AgrAbility Project: Led by Purdue's Breaking New Ground Resource Center. Partners include:
 - × Goodwill of the Finger Lakes
 - × The Arthritis Foundation, Heartland Region
 - × The University of Illinois at Urbana-Champaign
 - × Colorado State University
 - More information available at www.agrability.org

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Pre Assessment Questions for Farmers as Consumers


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Pre Assessment Questions for Farmers as Employers

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Farm Families and Health Care

Two Affordable Care Act impacts on farm families:

- As consumers who will be making health care decisions for their families
- As employers of farm workers
 - Migrant workers (travel frequently between job sites)
 - Seasonal farm workers (local temporary labor force)
 - Year-round farm workers




Farm families are affected by regulations contained within the Affordable Care Act (ACA) in two ways. First, like everyone else in America, they are **consumers who will be making health care decisions for their families**. Second, some farm families **employ farm workers** on a temporary (seasonal) or permanent basis and may be affected by the ACA employer mandate provisions.

Notes: According to USDA, hired farm workers make up a third of all those working on farms; the other two-thirds are self-employed farm operators and their family members. The majority of hired farm workers work on the nation's largest farms with sales over \$500,000 per year. Employment is highly seasonal.




For more information about the U.S. farm labor force, see <http://www.ers.usda.gov/topics/farm-economy/farm-labor/background.aspx>.

It is important to note that some farm operators are also employees at off-farm jobs and may have access to health insurance via their employers. In addition, their family members may be employed, either on the farm or at off-farm occupations.



ACA: Comprehensive Changes to Health Care Insurance and Delivery Systems

- Changes rules and funding for health insurance, trying to decrease number of uninsured
- Includes incentives for preventive and wellness programs
- Provides money to improve access to providers
- Expects to lower health care costs
- Affects all population groups and communities
- Leaves current private insurance marketplace in place




The health care reform law, The Affordable Care Act (ACA), makes comprehensive changes to America's health care insurance and delivery systems. As mentioned, these changes will affect farmers as they do all other consumers.




This presentation will focus on changing rules and funding for health insurance but also know that the ACA law:

- includes incentives for preventive and wellness programs
- provides money to improve access to health care providers
- expects to lower health care costs
- affects all population groups and communities
- leaves the current private insurance marketplace in place

Farm Families and Health Care



- Farmers/ranchers are more likely than the U.S. population as a whole to have health insurance
- Farm work is hazardous; many occupational injuries
 - Have insurance to “protect the farm”
- Many rely on individual policies (36% vs. 5% of all Americans)
 - Few group options previously
 - May use a high-deductible policy paired with a HSA
- The Marketplaces (Exchanges) will offer new insurance options with likely lower premiums because it will no longer be legal to charge anyone (including farmers) for any pre-existing condition or risks associated with a higher risk occupation (such as farming)

Before implementation of the Affordable Care Act (ACA), **farmers and ranchers have been big purchasers of health insurance. On the whole they are more likely to be insured than the U.S. population.** This is not surprising given that farm work is hazardous with many potential occupational injuries. The purchase of health insurance- and disability insurance- are viewed by many farmers as essential elements in **protecting their family farms**. Health insurance is essentially “bankruptcy insurance.” If farm operators can’t work due to an illness or injury, their farms may become unprofitable and cease to exist.

Unless farmers join cooperatives to pool risks and purchase insurance together, **many have turned to the individual health insurance market** to purchase insurance for themselves and their family members (we’ll cover farm workers later). **Over a third (36%) of farmers buy health insurance in the individual market versus just 5% of Americans in general.** Sources of individual health insurance include the range of national and state insurance policies represented and offered by insurance brokers, health insurance co-ops, and agriculture-related organizations such as Farm Bureau.


Because premiums have been high in these plans **some farm families can only afford high deductible policies to provide coverage for catastrophic conditions.** Along with a high-deductible policy, some farm families have funded a health savings account (HSA) to save money in a tax-exempt savings account for qualified out-of-pocket expenses (see <http://njaes.rutgers.edu/healthfinance/health-savings-accounts.asp>). However, given the risks of farming, it is important to note that high-deductible plans can be an expensive proposition if farm families incur large medical expenses every year.


Because premiums in the individual health insurance market are rated based on the individual’s own risks, they have been exceptionally high for this high risk occupation (farming). It is therefore **likely that farm families will be attracted to policies offered in the new ACA developed government-run Exchanges, “The Marketplaces.”** As premiums in the Exchanges have become public, we are seeing that premiums for farmers will be much less than what they have traditionally been paying in the private market. And, unless a farmer continues with an old plan that has been “grandfathered” in without having to meet new requirements (more about this later), all plans, new ones in the private market and new ones in the state-based Marketplaces, will cover at least the same 10 major essential benefits.


All in all, farm families will have more options for coverage than they have had in the past. For more information, refer to: <http://kunc.org/post/health-insurance-unknowns-loom-farmers-affordable-care-act-approaches>


ACA Goal: Decreasing the Number of Uninsured Americans

- Requiring insurance companies to take all seeking insurance
 - No more exclusions for consumers who have pre-existing conditions (already in place for children under 19, for all ages starting Jan 1, 2014)
 - No more cancellation of policies for someone being too sick (already in effect)
 - No more lifetime maximums on the amount paid for care for essential benefits (already in effect)
 - No more annual maximums on the amount paid for care for essential benefits (starting Jan 1, 2014)









A major goal of the Affordable Care Act (ACA), and certainly the one we hear talked about the most because it directly affects so many people, is its attempt to decrease the number of uninsured Americans. It does this by requiring insurance companies to take all people seeking to purchase insurance. The ACA also includes the following provisions:

- No more exclusions for consumers who have pre-existing conditions (already in place for children under 19; for all ages starting Jan 1, 2014)
- No more cancellation of policies for someone being too sick (already in effect)
- No more lifetime maximums on the amount paid for care (already in effect)
- No more annual maximums on the amount paid for care (starting Jan 1, 2014)

Many information sources refer to these as “**The Consumer Protections**” and they are standard across all health plans except for those that are grandfathered in. These strong consumer protections mean that:

1. Families are more secure in not being one major illness away from being uninsured or uninsurable.
 2. Workers can work where they want and for whom they want, even if it means starting their own businesses.
- Disengaging health insurance from the need to work for an employer that offers that benefit, without fear of losing it if one changes jobs, may foster new entrepreneurial opportunities.


Notes: Protections about no annual limits do not apply to plans that have been “grandfathered” in.

<https://www.healthcare.gov/how-does-the-health-care-law-protect-me/#part=9>

Grandfathered plans are an “interesting” exception. For more information about them, refer to:

<https://www.healthcare.gov/what-if-i-have-a-grandfathered-health-plan/>




Basically, “grandfathering” refers to a plan that has not changed its major elements since before the ACA went into effect March 23, 2010. There are about 20% of plans that qualify, with decreasing numbers expected each year (**Reason:** it is hard for plans to stay static; if they make any changes, including increases in premiums, they lose this status). Grandfathered plans DO have to comply with no lifetime maximums.



Essential Health Benefits

Qualified Health Plans in the Marketplace must cover:

Ambulatory patient services	Maternity and newborn care
Emergency services	Prescription drugs
Mental health and substance use disorder services	Laboratory services
Rehabilitative and habilitative services and devices	Chronic disease management
Preventive and wellness services	Pediatric services, including oral and vision care

These are the Essential Health Benefits that all health insurance plans must cover, i.e., those provided in Marketplace, those offered by employers, or those purchased in the private market.

Note that “coverage” does not mean first dollar coverage (definition: full coverage for the entire value of a loss without a deductible, co-insurance, or other out-of-pocket expenses), nor complete coverage. In other words, insured individuals can expect to pay part of their health care costs.

Background Information


The definition of habilitative was also not clearly defined. Several states have passed legislation to define it more fully (see <http://www.aahd.us/wp-content/uploads/2013/02/HabilitSrvcsStDefintionsAOTAFeb2013.pdf>) but it may not be consistent throughout the states. As an example, California legislation reads:

“Habilitation services” means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual’s environment. Examples of health care services that are **not habilitative** services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.”


<http://blogs.kqed.org/stateofhealth/2013/02/11/just-what-are-habilitative-services-hint-think-health-insurance-and-chronically-ill-kids/>


For more information about habilitative services, refer to <http://www.aahd.us/wp-content/uploads/2013/02/HabilitSrvcsStDefintionsAOTAFeb2013.pdf> and https://www.aapmr.org/advocacy/federal-reform/Documents/Essential_Benefits_Position_Paper.pdf.


ACA Goal: Decreasing the Number of Uninsured Americans (Continued)



- Consumers are mandated to purchase insurance
- Creates Marketplaces (Exchanges) where consumers can choose among affordable plans, offering tax credits to some
- Builds on current employer-employee fringe benefit insurance arrangement and mandates large employers to offer adequate and affordable plans
- Intended to expand states' Medicaid programs to include all individuals and families under 138% FPL (\$15,856 for individual, \$32,499 for family of four)








Insurance companies can take on all of these previously-uninsured people, many of whom might be sick and need lots of care costing significant amounts of money, **ONLY** if there are also healthy people in the risk pool to balance out the amount of dollars spent on care. The intent of the individual mandate, and the penalty associated with it, is to broaden the pool of people with health insurance, especially young adults, in an effort to spread costs and risks across a larger pool of people, hopefully lowering premium costs. **This is the reason that consumers are mandated to purchase insurance.** Without the individual mandate, we might expect that healthy people would delay the purchase of insurance until they needed it.

Note: This is similar, although not entirely, to the Medicare insurance regulations where there is a surcharge on the premiums every year someone chooses not to enroll in Medicare. The difference is that, when someone finally chooses to become a Medicare beneficiary, that surcharge on the premiums follows them into the future. With the ACA, there is a set fine (tax) imposed every year but it is not cumulative. During the development of the ACA, insurance companies argued that they would be willing to take on many more policy holders (called “covered lives”) only as long as there was a level playing field and all insurers were required to assume the same level of risk.




To make insurance more affordable and more likely that consumers can pay for coverage, **the ACA creates Marketplaces (Exchanges) where consumers can choose among affordable plans offering tax credits to some.** The ACA also **builds on the current employer-employee fringe benefit insurance arrangement** and mandates that large employers offer adequate and affordable health care plans. There will be more information presented about the employer mandate later.

Finally, the ACA also **intended to put all individuals and families under age 65 and under 138% of the Federal Poverty Level (FPL) into states' Medicaid programs.** (see <http://www.shadac.org/blog/aca-note-when-133-equals-138-fpl-calculations-in-affordable-care-act>). The method ACA used to accomplish this goal was considered overly coercive by the Supreme Court of the United States so this particular provision has become less secure. Only about half of the states are choosing to go along with Medicaid expansion. Not expanding Medicaid and not having affordable alternatives for low-income individuals and families means that a large percentage of the uninsured population that ACA was originally crafted to help will remain uninsured due to what will be for them, especially without tax credits, unaffordable private health insurance premiums even in the new Marketplaces. Some of those remaining uninsured will be farm families and farm workers. This map shows state decisions regarding Medicaid expansion: <http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap>.



ACA “Pay or Play” Rules

- **Individual Mandate:** “Everyone must have health insurance.....or pay a federal government penalty” (certain exceptions apply)
- **Employer Mandate:** “Employers (including farms) must offer their workers adequate and affordable insurance if they have 50 or more employees, including seasonal ones, working 30 hours a week for more than 120 days.....or pay a federal government penalty”

A key feature of the Affordable Care Act is the so-called “Pay or Play” rules. What this means is that those who fail to “play”; i.e., buy coverage for themselves or their employees (if required) will “pay”; i.e. owe a penalty that is payable to the federal government via their income tax return. The **individual mandate** requires Americans to have health insurance. Those who don’t will pay a penalty. The **employer mandate** requires large employers (i.e., those with 50 or more full-time employees or full-time equivalents) to offer their employees health insurance that is adequate, affordable and covers a list of essential health benefits (see Slide #6). It does NOT require employers to offer coverage to an employee’s spouse in order to comply with the employer mandate.

Notes:

Exceptions: Uninsured people won't have to pay a fee (tax) if they:


- are uninsured for less than 3 months of the year
- are determined to have a very low income and coverage is considered unaffordable
- are not required to file a tax return because their income is too low
- would qualify under new income limits for Medicaid, but their state has chosen not to expand Medicaid eligibility
- are a member of a [federally recognized Indian tribe](#)
- participate in a health care sharing ministry
- are a member of a recognized religious sect with religious objections to health insurance

If you don't qualify for these situations, you can apply for an exemption asking not to pay a fee. You do this in the Marketplace. <https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014/>

A full-time employee is defined as someone who works, on average, 30 hours per week or 130 hours per month. Full-time equivalents are determined by dividing the total hours worked by part-time employees by 120 (see the online calculator <http://www.paychex.com/health-reform/resources/esr-calculator.aspx>)


Example: 1,800 hours ÷ 120 = 15 full-time equivalents (FTEs)


There are many issues that an individual, family, and/or farm operator will have to consider to make best use of what the ACA has to offer. Some may choose to purchase a health insurance plan. Some may choose to pay a penalty. There are advantages and disadvantages to either course of action.





Insurance Affordability

Insurance is deemed affordable if the annual premium for a self-only plan (not a family plan) costs less than 9.5% of a person's annual household gross income.










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Notes:

Since employers could not possibly know employees' total annual household incomes, a "safe harbor" (exception) provision was put into place so that the issue of affordability is determined by comparing the cost of an employee's premium for the lowest cost self-only coverage against 9.5% of the employee's income from the employer who sponsors the coverage. Note that there is still an expectation that businesses will begin to offer coverage, just that there will be a delay in fines to ensure that this happens.




Why a self-only plan? While many businesses offer family plans, the ACA considers this unnecessary, especially as there are now expected to be affordable options in the Marketplaces (Exchanges). This rule also highlights the fact that, for some families, purchasing a family plan, even through an employer, may NOT be the most cost effective way for a family to choose to insure all of its members.

It is possible that the Marketplace will offer a single person plan that, combined with the single plan offered by an employer, is actually less expensive than employer-provided coverage for the family unit as a whole. This may be particularly true if there are only two members in the family (e.g., single mom and adult child), where the adult child might select a catastrophic plan through the Marketplace. Only adults under 30 and those who really cannot afford to pay more for insurance (note: there are standards for this) will be eligible for catastrophic plans.



Insurance Adequacy

Insurance is deemed adequate if it is a 60/40 plan. That is no more than 40% of the total health care costs in a year would be expected to be paid by the average person insured in this type of plan. Many current employer-provided plans are 50/50 or even less.



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Notes: Insurance adequacy is an actuarial term. It refers to the cost of all of the health care that an insured person may receive in a given year (not including premiums). It takes into account out-of-pocket expenses such as copays and deductibles. What is important to understand is that this is yet another way in which the insurance plans are being required to be more substantial so that Americans are no longer at risk for being severely under-insured.

This new standard is the reason why premiums may be going up for many people, especially in the private market. Until now, many people have been purchasing “bare bones” policies. Except for a few, mostly young adults under 30, catastrophic plans will no longer be available. For more information, refer to http://101.communitycatalyst.org/aca_provisions/coverage_tiers.

Remember, in the past, underinsured people have affected all of us much as uninsured people. That is, we all end up paying when the uninsured or underinsured need health care. Further, those individuals and families were at significant risk of going medically bankrupt (the primary cause of bankruptcy). Medical bankruptcies affect all consumers indirectly through increased health care and credit card costs resulting from unpaid medical bills.

Note: An ongoing issue that will need to be monitored is whether some employers will be allowed to “sneak through” and offer “bare bones” policies with skimpy coverage.

ACA Provisions for Consumers: Individual Mandate

- Starting January 1, 2014, Americans must be enrolled in a health insurance plan
- With few exceptions, if you are not insured, and your income is over 138% of the FPL (\$15,856 for an individual; \$32,499 for family of four) you will be required to pay a penalty (tax).
 - Penalty for no coverage will rise from \$95 for adults or 1% of income, whichever is greater (2014) to \$695...(2016)

<http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>

Logos: SMART CHOICE HEALTH INSURANCE, K-STATE Research and Extension, RUTGERS New Jersey Agricultural Experiment Station Cooperative Extension of Middlesex County, UNIVERSITY OF MARYLAND EXTENSION Solutions in your community

Here are some specific details on the individual mandate.

Starting January 1, 2014, Americans must be enrolled in a health insurance plan unless, as noted earlier, they meet exemption criteria. **If you are not insured in any number of ways** (e.g., Medicare, Medicaid, TRICARE for service members and military retirees, veteran's health program, CHIP insurance for children, employer plan, spouse/partner's employer plan, qualified individual (private) insurance at least at the Bronze level), **and if your income is over 138% of the Federal Poverty Level (FPL ; \$15,856 for an individual; \$32,499 for family of four), a penalty tax will be charged.**


The penalty for no coverage will rise from \$95 for adults or 1% of income, whichever is greater (2014), to \$695 or 1% of income, whichever is greater (2016). See <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>

The penalties make it more likely that the costs of being uninsured, yet still having to pay the tax, will result in more people deciding to eventually purchase insurance. The penalties are rising to encourage more healthy people to enter the health insurance pool.


See the infographic from Kaiser that fully explains the requirement to buy health care coverage: <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>.


Notes: Federal poverty level (FPL) guidelines are based on family size, household income, and geographic location and can be found at <http://aspe.hhs.gov/poverty/13poverty.cfm>. As an example, in 2013, the 100% FPL in the 48 contiguous states and the District of Columbia is \$15,510 for a family of two persons and \$27,570 for a family of five. Higher FPL income levels apply in Alaska and Hawaii.


ACA Provisions for Consumers: Individual Mandate (Continued)



- Children are also required to be insured. May be through
 - Public insurance (e.g. state's Children's Health Insurance Program) or CHIP or
 - Parents' obligations (employer or through private purchase) Fines for uninsured children are half that of the adults up to a family maximum of \$285 for 2014.
- The tax will be assessed on federal income tax return
 - May need to adjust estimated payments and/or W-4







Children are also required to be insured (if their parent's income falls within mandated guidelines) but it is expected that this responsibility will continue to be split between the parents and the state. Many children of low-income families will already be insured through their states' Children's Health Insurance Programs or CHIP (a federal-state partnership that began in 1997) or other public health insurance programs.


For children who are not in public programs, their parents are required to insure them or also face a fine for each uninsured child. The fine is half that of an adult fine, up to the family maximum of \$285 in fines for a family in 2014. Or the penalty could be 1% of family income, if that results in a larger fine. "Income" is defined as total income above the tax filing threshold for a family according to their tax filing status (e.g., single or married filing jointly).

By 2016, the flat fees grow to \$695 per adult and \$347.50 per child or 2.5% of family income, whichever is greater. For more information, refer to:


<http://money.cnn.com/2013/08/13/news/economy/obamacare-penalty/index.html>.


The ACA individual mandate penalty has **tax planning implications**. Those who expect to pay a penalty for not purchasing health insurance may need to adjust their quarterly estimated tax payments and/or W-4 form tax withholding (e.g., on income from off-farm employment).


More ACA Consumer Provisions



- Lowest income (< 138% of FPL) will be enrolled in Medicaid (legal residents only) in expansion states
- Higher income workers can get coverage through
 - Medicare (age 65+)
 - Large employers (farm or off-farm)
 - State health insurance marketplaces (“Exchanges”)
 - Private market (e.g., insurance brokers, health co-ops)







As noted earlier, **Americans at the lowest income level of less than 138% of the federal poverty level (FPL) will be enrolled in Medicaid** as a result of the Affordable Care Act (ACA) Medicaid expansion, **IF their states opt to expand Medicaid eligibility criteria**. The Supreme Court ruling regarding the ACA allowed state governors and/or legislatures to opt out of the law’s Medicaid expansion and about half are in and half are not in for 2014 but states could choose to enter this federal-state partnership expansion in later years. It is important to remember that **Medicaid eligibility is limited to legal U.S. residents only**; i.e., citizens or those who can provide proof of legal immigration status. One needs a Social Security number.

Higher income workers above 138% of FPL will need to secure health insurance in a variety of ways, including through: a government program such as **Medicare**, **employers** (self or spouse), a health insurance **Exchange**, or in the **private insurance market**. For a complete list of health insurance sources, see <http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/>. Note that the Exchanges are marketplaces of multiple private insurance plans that the government (federal and state) is setting up. The government is responsible for vetting which plans are eligible to be offered in the Marketplaces but plans themselves will be offered by private insurance companies. There will be no public plans.

Notes: Even with implementation of the ACA, the Congressional Budget Office (CBO) estimates that about 23 million U.S. residents will remain uninsured. About a third of this group will be undocumented immigrants. It is estimated that more than 50% of farm workers are undocumented. They are not required to buy health insurance under the individual mandate but are also not eligible for Medicaid or to participate in state Exchanges.

Undocumented farm workers may benefit from the ACA, however, through increased funding for community health centers. That is, they may not be insured, but there will be better support of safety net health care providers that they use for care. For more information about the impact of the ACA on farm workers, see <http://farmworkerjustice.org/sites/default/files/documents/Health%20Reform%20and%20Farmworkers.pdf>.

Without getting into any political debate, it is important to note that the ACA and U.S. immigration laws are strongly intertwined, especially for farm operators. This is because many farms employ undocumented workers.

More Affordable Health Care

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In many cases, you can get preventive services for free:

- ☐ Cancer screenings such as mammograms and colonoscopies
- ☒ Vaccinations such as flu, mumps & measles
- ☒ Blood pressure screening
- ☒ Cholesterol screening
- ☒ Tobacco cessation counseling and interventions
- ☒ Birth control
- ☒ Depression screening
- ☒ And more...

Visit www.healthcare.gov/prevention for a full list

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The ACA will make **some health care more affordable**.

That starts with preventive care. We know that getting preventive care like cancer screenings and vaccines is one of the best ways to stay healthy. But in the past, too many Americans went without this care because their insurers didn't cover it or required expensive co-pays. For example, when the choice was \$50 for a mammogram or \$50 for groceries, many women had to take their chances.

Now, they don't have to take that risk. Under the Affordable Care Act (ACA) law, a wide range of recommended preventive services are available for free in all new plans.

Notes:

Birth control is one of the controversial covered benefits. Employer plans don't have to cover every type of birth control approved by the Food and Drug Administration — but they have to cover some. They can often charge a co-pay for some brands or products as long as they offer others for free. A woman may not know precisely which category her specific prescription falls into until the pharmacy rings it up.

Read more: <http://www.politico.com/story/2013/07/aca-birth-control-rule-creates-confusion-94573.html#ixzz2cLjXVJwV>

Also note that some exams can be classified as "diagnostic" as opposed to "preventive." That is, problems already identified when a health care provider is looking for more information for, say, some intestinal issues may be considered a diagnostic rather than a preventive colonoscopy (though all of us might consider it an early detection method). Some insurance companies are apparently using this as a distinction to require certain co-pays.

Also note that here the term **"free" means that, at point of service, there is no "barrier"** to making a decision to receive a particular type of preventive screen or service. However, we should all understand that "free" is a relative term since insurance companies are certainly adjusting their premiums and overall cost-sharing methodologies based on their anticipated costs for covering all of these additional services.

Young Adult Coverage

Young adults under the age of 26 can now stay on their parents' health plans.

"I honestly don't know what we would have done.... There was no way we could have afforded it. I might not be here right now."

--Kylie L., 23, in Illinois, who credits the health care law for enabling a life-saving heart transplant

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A key provision of the Affordable Care Act is the provision for **young adults under the age of 26 to remain on their parents' health insurance policies.**

If a parent's employer's plan covers children, they can be added or kept on the health insurance policy until they turn 26 years old. Children can join or remain on a parent's plan even if they are:

- married
- not living with their parents
- attending (or not attending) school
- not financially dependent on their parents
- eligible to enroll in their employer's plan

For more information about adult child coverage, refer to <https://www.healthcare.gov/can-i-keep-my-child-on-my-insurance-until-age-26/> and <http://www.dol.gov/ebsa/faqs/faq-dependentcoverage.html>.

Note: In some instances, family insurance through an employer may be more expensive than paying for a combination of employer-based single plan coverage for the parent and a different policy for the adult child through the Marketplace. This latter combination of health insurance plans may actually be quite useful when the employer's plan's network is restrictive to a particular region and adult children live in a different area. The adult child's coverage in his/her own plan would reflect the availability of health care providers wherever he/she lives, not where his/her parents live.

The Marketplace



- Marketplaces are managed either by the state or federal government
- Will be housed at www.healthcare.gov
- Started October 1, 2013, people can apply:
 - Online, over the phone, with a paper application, in-person
- A 24-hour call center has been established by the federal government: 1-800-318-2596
- If applying online, there is a chat feature to help someone walk through the application
- Open enrollment is guaranteed in Oct. – Dec. of each year (dates TBA) with extension to March 31, 2014 for first enrollment period
- Qualifying events are reasons for enrolling out of usual schedule





The Marketplaces will be the new shopping environment for choosing among many health insurance plans. The **Marketplaces are managed either by the state or federal government**. Though this was a big political issue, it really matters little which level of government is administering the plans. Effective October 1, 2013, there will be insurance options offered and ways for consumers to enroll in state, state-federal partnership, or full federal government Marketplaces.

www.healthcare.gov is the “go to” federal government Web site for information about health insurance terminology and implementation of the Affordable Care Act (ACA). It will also be where people will apply for health care coverage through Marketplaces that are managed by the state or federal government (depending on their states of residence). If the state is sponsoring its own Marketplace, the state will have a separate website that is linked to the healthcare.gov Web site.


Starting October 1, 2013, people can apply for coverage: online, over the phone, with a paper application, and in-person. A 24-hour call center has been established by the federal government and is now open: 1-800-318-2596. If applying online, there is a chat feature to help someone walk through the application.

Open enrollment is guaranteed to be in October through December of each year (exact dates to be announced), with an extension to March 31, 2014 for the first enrollment period, and possibilities for insurers to offer additional open enrollment periods. <https://www.healthcare.gov/what-key-dates-do-i-need-to-know/#part=3>

Qualifying events (e.g., change in family structure or citizenship status) are reasons for enrolling out of the usual schedule. <https://www.healthcare.gov/glossary/qualifying-life-event/>




Notes: Application submission dates and guaranteed effective dates of coverage are as follows:
 October 1 through December 15, 2013 (January 1, 2014); December 16 through January 15, 2014 (February 1, 2014);
 January 16 through February 15, 2014 (March 1, 2014); February 16 through March 15, 2014 (April 1, 2014);
 March 15 through March 31, 2014 (May 1, 2014)

As noted earlier, the Web page to find health insurance providers for each state is www.healthcare.gov/what-is-the-marketplace-in-my-state/.



Different Levels of Plans

- 4 Levels of Coverage – Bronze, Silver, Gold, and Platinum
 - Each has a different value for level of coverage
 - Bronze: 60%. Silver: 70%. Gold: 80%. Platinum: 90% (adequacy values, how much plan vs. insured pays)
 - Any costs not covered by the plan are paid by individuals through deductibles, co-pays, co-insurance (not including monthly premium)
- Each plan level must cover the same set of minimum essential health benefits
 - What differs is amount of cost-sharing required
 - **Example:** The bronze plan will have the least generous coverage (60%) with more out-of-pocket costs
- No health plan can apply a deductible or any cost-sharing for certain preventive health services

The health care plans available under the Affordable Care Act (ACA) are sometimes referred to as “The Metals” because of the names given to the **four tiers of coverage**. As with the Olympics or different types of credit cards, where metals indicate a different level of quality, the metal tiers vary in the amount of cost-sharing between insurance companies and patients. Plan range from **Bronze to Silver to Gold to Platinum**. Each type of plan will offer essential health benefits and the provisions related to pre-existing conditions, preventive care, and lifetime limits.

The real difference between each metal tier is that each metal represents the percentage that an insurance company will have to pay versus the amount a person will have to pay out-of-pocket. For example, if a person purchases the **bronze level plan, the insurance will cover 60% of the health care costs while the consumer will cover the remaining 40%.**

Here is a description of all four levels of coverage: A **Bronze Plan** will cover **60%** of health care costs with the consumer responsible for paying 40%. For **Silver** plans, insurance companies will pay **70%** of costs and the consumer pays 30%. For **Gold** Plans, the split is **80%-20%** and, for **Platinum** plan, the split is **90%-10%**. In general, the higher percentage of expenses that an insurance company covers, the more the consumer will pay for the premiums but the smaller the out of pocket expenses are likely to be.

For more information about the levels of coverage, refer to <http://www.extension.org/pages/68612/what-is-the-difference-between-bronze-silver-gold-and-platinum-plans#.Ug1pf9rD-M8>.

Notes:

Because insurance companies will be competing for your business, some silver plans may actually provide better coverage, yet be less costly, than some bronze plans, and so on. Therefore, consumers should evaluate insurance plans carefully for determining both the best coverage for their and their families’ needs and for costs, both premiums and other expected out-of-pocket expenses.

The ACA also allows for a tax to employers if they offer “Cadillac” plans that are very low cost to the employees. Since this element of the law is not set to take effect until 2018 and, since it remains under debate, we need not worry about it quite yet. Further, it is likely that few farms offer this type of coverage to their workers.

Premium Assistance Tax Credits					SMART CHOICE [®] HEALTH INSURANCE [®]
Federal Poverty Level	% of income premium costs	Maximum income for an individual (salary), 2013 FPL	Maximum income for an individual (hourly) – [40 hour work week]	Approx. maximum annual premium (before tax subsidy)	
Up to 138% FPL	2% of income	\$15,282	\$7.35/hr.	\$306	
138 - 150% FPL	3 - 4% of income	\$17,235	\$8.28/hr.	\$690	
150 - 200% FPL	4 - 6.3% of income	\$22,980	\$11.04/hr.	\$1,448	
200 - 250% FPL	6.3 - 8.05% of income	\$28,725	\$13.81/hr.	\$2,312	
250 - 300% FPL	8.05 - 9.5% of income	\$34,470	\$16.57/hr.	\$3,274	
350 - 400% FPL	9.5% of income	\$45,960	\$22.10/hr.	\$4,366	

As indicated by its name, the goal of the Affordable Care Act (ACA) is to make health insurance available to Americans regardless of their ability to pay. Thus, the law includes federal subsidies for certain income groups and out-of-pocket limits on all purchasing done through the Marketplaces.

Individuals and families who purchase health insurance through a government Exchange are eligible for **two kinds of subsidies**. They are eligible for **premium assistance tax credits** if their incomes are less than 400% of federal poverty level (FPL) and are eligible for **subsidies** if their incomes are below 250% of FPL. On this slide is a chart illustrating how the premium assistance tax credits work. The next slide describes the out-of-pocket maximums and how they also affect families under 250% of FPL. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf>

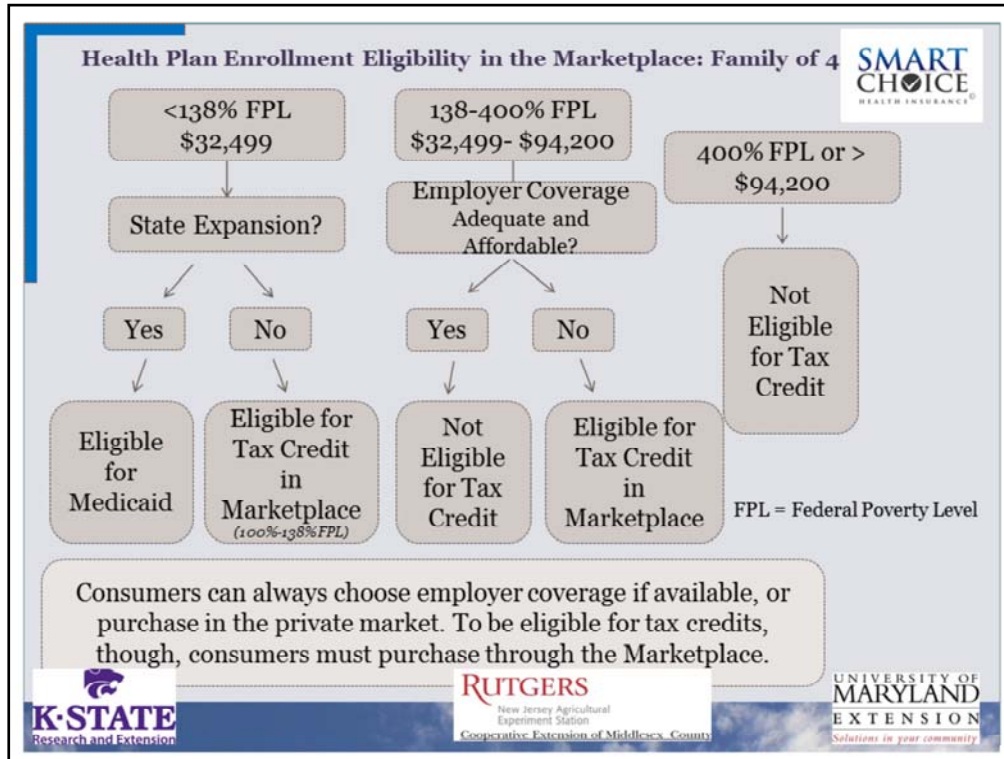
Notes: The tax credit may be taken either monthly or annually. It can only be taken monthly if one has his/her share auto-deducted from a bank account. This obviously only has relevancy for banked populations. Those without bank accounts (unfortunately, often the lowest income populations who might benefit most from a monthly split of premium payments between their share and the government's share) will have to wait until they file their taxes to receive their "tax refund" representing the share of the premium that the government will pay.

Also note that consumers should be careful not to request too much of a tax subsidy up front so as not to have to pay back some additional taxes at year-end. That is, for those with unstable incomes, it may be better to over-report their likely annual income, rather than under-report, and take the difference in a refund at tax year-end as opposed to having to pay back a large sum because their tax subsidy was over-estimated.

The maximum an individual will pay for their premium as calculated for this chart is a percentage of their income based on the expected cost of the Silver Plan (70% coverage).

For specific calculations **based on income, family size, geographic region cost factor, and age of policyholder**, see: <http://kff.org/interactive/subsidy-calculator/>. Those are the only factors that will be considered in setting premiums and will be used by individual companies offering policies in the Marketplaces. The calculator uses those features to both estimate the cost of the premium, and then to calculate the "credit" or "cost-sharing amount" for that individual or family.

Kaiser also has a good summary of how the insurance subsidies work: <http://kff.org/health-costs/issue-brief/explaining-health-care-reform-questions-about-health/>




This graphic shows the process for determining whether a family is eligible for Medicaid benefits or tax credits based on their income, whether or not their state expands their Medicaid eligibility criteria, and whether or not affordable and adequate health insurance is offered at their workplace.

When shopping for individual health insurance in the Marketplace, consumers should do a “Rule of Three” comparison by analyzing the costs and features of at least three different health insurance plans.

Helpful worksheets to do a “Rule of Three” comparison were developed by the University of Maryland:

https://www.extension.umd.edu/sites/default/files/_images/programs/insure/My%20Smart%20Choice%20Health%20Insurance%20Guide%204-3-13.pdf






Limits on Out-of-Pocket Costs

Starting in January 2014, there will be a limit on out-of-pocket costs:

- \$6,350 for an individual and \$12,700 for a family (2014 figures)
- This limit applies to co-payments and deductibles, but *not* to premiums
- People with incomes below 250% FPL will get subsidies to lower those limits, based on their income

Exception: Some plans won't be required to implement this until 2015

Source:
http://101.communitycatalyst.org/aca_provisions/subsidies




All people who buy coverage through an Exchange will have a cap on their total out-of-pocket spending, including deductibles, co-pays, and co-insurance. These limits are based on the out-of-pocket limits that apply to high-deductible plans used with Health Savings Accounts (HSAs).

People with incomes under 250% of federal poverty level (FPL) will get subsidies to lower those caps based on their incomes.




Background Information




Some insurance plans offered by employers have separate policies or benefit managers for different parts of their coverage, such as medical care and prescription drugs and dental services. Some employer plans have separate out-of-pocket caps for each of these coverage areas. Therefore, discussion is ongoing about how out-of-pocket limits will be implemented.

The reason for this implementation delay (for certain plans) has to do with how some companies split medical and prescription insurance between insurers and administrators. To determine full out-of-pocket expenses, databases have to be shared between all insurers. Since this may prove tricky, companies that have two separate administrators are going to be allowed (for another year until January 2015) to have separate, parallel, and equal out-of-pocket (OOP) maximums for medical and prescription coverage, in effect doubling the new legal OOP maximums. Still, this may be more affordable than no OOP maximum, which many people had before this rule.




What Does the ACA Mean for Farm Owners as Employers?








Now that we have covered provisions of the Affordable Care Act (ACA) that affect farmers as consumers, let's transition to talking about how the ACA affects farmers as business operators and employers of farm workers.



Sole Proprietorships

- Sole proprietors are considered “individuals” and are subject to ACA individual mandate
- Can shop for coverage for farmer/family on state Exchanges or privately
- Compare cost of current individual policy (if any) to policies available on state Exchanges
 - May have cost savings vs. policies offered in private market

Sole proprietorships are the simplest form of business ownership. Unlike a corporation, a sole proprietorship is not a legal entity unto itself. Rather, it is simply where a single person owns a business. All income earned from that business “passes through” to a sole proprietor’s individual tax return. Some farms are sole proprietorships.


Under the Affordable Care Act (ACA), the government considers sole proprietors to be individuals who are subject to the individual mandate contained within the ACA. Thus, beginning in 2014, sole proprietors (like other individuals) must purchase health insurance or pay a penalty and they are to **purchase insurance in the individual Marketplace (or privately)**. Other small businesses will be expected to purchase insurance for the owners and workers in the SHOP small business health insurance program (see Slide #24).

Anyone looking to purchase health insurance should use “The Rule of Three” and **compare at least three competing policy providers** including a current individual policy (if any). As noted in the earlier discussion about the ACA and consumers, health insurance can be purchased through the Exchanges or in the private insurance market. Thus, Exchanges are an important option for sole proprietors to compare and consider.

Due to greater projected economies of scale, policies purchased through Exchanges **may provide more attractive costs and features** than some of those purchased in the private insurance market. In fact, there has been speculation that many out-of-marketplace (private) plans will not be able to compete with the Exchanges if they are unable to enroll a large enough patient pool to offset the costs of providing coverage. The way that insurance policy rates are set is also changing. This is a major issue for farmers because no longer will their high-risk occupation automatically lead to higher premiums. They will be treated as everyone else applying for insurance. Smoking/ tobacco use are the only pre-existing conditions that the ACA allows insurers to discriminate against.




As noted previously in the “consumer” section of this program, a helpful tool for sole proprietors (and all business owners who are purchasing insurance) to use to make a “Rule of Three” comparison can be found on the University of Maryland Cooperative Extension Web site

https://www.extension.umd.edu/sites/default/files/_images/programs/insure/My%20Smart%20Choice%20Health%20Insurance%20Guide%204-3-13.pdf.



ACA Employer Provisions

- American Farm Bureau: “The vast majority of {farm owners} likely won’t have to offer insurance”
- Department of Health and Human Services: “96% of all businesses will be exempt from the law”
- Only 0.2% of U.S. businesses with 50+ employees do not provide health insurance to FT employees
- **Resources:**
 - <http://buffalo.ynn.com/content/653580/how-the-affordable-care-act-could-impact-farmers/>
 - <http://www.forbes.com/sites/theyec/2013/04/22/is-the-affordable-care-act-really-bad-for-business/>






The ACA provides many important benefits to farm families (e.g., expanded coverage, a greater choice of insurance providers, and tax credits for small employers). Because most farms employ less than 50 workers, the “pay or play” aspects of the Affordable Care Act (ACA) will not affect them. The American Farm Bureau says the **vast majority of farmers in the U.S. “likely won’t have to offer health insurance.”** The U.S. Department of Health and Human Services has made similar remarks related to the effect of the ACA on small businesses in general because **small businesses with under 50 workers comprise 96% of all employer firms in the United States.**




The reality is that a majority of U.S. farms fall below 50 full-time employees. Small business operations (defined as those with less than 50 employees) are not required to provide employee health benefits. Of large businesses in the U.S. with 50 or more employees, **all but a tiny percentage of them (2%) already provide health insurance to their full-time workers**, often as an employee recruitment and retention tool. Prior to the implementation of the ACA employer mandate, more than half of Americans, some 160 million people, got health insurance through an employer. For more information, refer to: <http://www.nbcnews.com/health/delay-health-insurance-law-wont-affect-many-experts-say-6C10527171>.

There may be some smaller farm businesses that are at or very close to being classified in the large business category. For operations that are close to hitting the large business threshold of 50 workers, professional advice may be helpful. Farm operators in this situation should seek professional assistance from an insurance broker, employment law attorney, CPA, financial planner, and/or other advisor who is well versed in the nuances of the Affordable Care Act.

More ACA Employer Provisions



- Small employers (< 50 FTE) are not mandated to offer health insurance to full-time employees
 - But their workers may be mandated to purchase and may likely do so with tax credits in the Marketplaces
- If employers offer insurance, it must be offered equally to everyone
- SHOP (Small Business Health Option Program) Exchange available for small employers
- If < 25 employees and provide health insurance, 35% tax credit in 2013 and 50% tax credit in 2014
- 90 day waiting periods are allowable for new employees

As noted previously, the “magic number” in terms of the employer mandate to provide health insurance under the Affordable Care Act (ACA) is “50.” Farmers and other **small employers with less than 50 full-time equivalent employees are not mandated to offer health insurance to their full-time employees.** For small farm operators that elect not to provide insurance benefits (and are not legally mandated to do so), their previously uninsured **workers can now get coverage, and may be eligible for tax credits, in the Marketplaces** (legal U.S. residents only). This is good for farm operators because they will likely have a healthier worker force if their employees can receive health care services as needed.

However, if farm operators in the “small business” category do decide to provide coverage (e.g., to retain and/or reward valued farm employees), it **must be “all or nothing.”** In other words, small employers cannot “cherry pick” certain employees by their job title, seniority, or for other reasons to offer coverage to and exclude others.

Starting in 2014, small businesses that **purchase health insurance for their employees can do so through state-operated Small Business Health Options Program (SHOP) Exchanges.** These Exchanges will expand the purchasing power of small businesses which previously faced much higher premiums than large businesses due to their small size and lack of bargaining power with insurers. Employers who never offered health insurance previously due to the cost may consider doing so in the future due to projected lower costs. See http://www.whitehouse.gov/files/documents/health_reform_for_small_businesses.pdf.


Tax credits are available to help the **smallest employers** (less than 25 employees) pay for the cost of employee health insurance. The tax credit for businesses with fewer than 25 full time equivalent (FTE) employees that pay an average wage less than \$50,000 a year and at least half the cost of worker-only health insurance premiums is **35% in 2013 and 50% in 2014.**


Another key feature of the Affordable Care Act is that it allows waiting periods of up to 90 days for employer health insurance benefits to begin. Remember, though, about qualifying events when workers can purchase health insurance outside of the usual enrollment window (e.g., change in family structure). For additional information, refer to .
<https://www.healthcare.gov/glossary/qualifying-life-event/>.


Note: There is a year’s delay (to 2015) in the ACA requirement that there be more than one health plan offered in the SHOPS.
<http://www.californiahealthline.org/articles/2013/6/3/hhs-confirms-delay-of-part-of-small-business-health-options-program>.


Tax Credit Example: Small Dairy Farm


- 10 employees
- Total of wages: \$250,000 (@\$25,000 per worker)
- Employee health care costs: \$70,000
- 2013 tax credit: \$24,500 ($\$70,000 \times .35$)
- 2014 tax credit: \$35,000 ($\$70,000 \times .50$)











This example shows how the Small Employer Health Care Tax Credit would be calculated for a small dairy farm operator with 10 employees. Note that the wages average \$25,000 per worker which is well below the \$50,000 average wage limit required by law.


The savings to small employers are substantial. In 2014, for example, the \$70,000 cost to the dairy farm business of coverage for 10 employees is essentially cut in half from \$70,000 to \$35,000 by the tax credit. A tax credit is a dollar for dollar reduction in tax liability.

Still, since there is no mandate to provide this coverage, there is a cost of \$35,000 (in the example shown on the slide) that the farm business must be able to handle. With the tax credit, however, it is certainly more affordable to offer a health insurance benefit than it was in the past (if a farm owner is so inclined) to maintain a more stable and healthy workforce.

Note, again, that the small business employer coverage must cover at least 50% of the cost of single (not family) coverage for each employee. A new tax form, Form #8941 (Credit for Small Employer Health Insurance Premiums) is used to claim the small business tax credit.




For more information and additional tax credit scenarios, refer to this IRS fact sheet:
<http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers>.

Employers with 50+ Employees: Two Potential Penalties DELAYED UNTIL JANUARY 2015



- **Penalty for not providing health care coverage**
 - \$2,000 per year for each full time employee starting at employee #31
 - Example: 60 employees: $60 - 30 = 30 \times \$2,000 = \$60,000$ per year penalty for not providing health coverage
 - Penalty will increase with rising insurance premiums
- **Penalty for not providing *affordable and adequate* health care coverage**
 - If **any employee** has to pay > 9.5% of income for employer's coverage AND/OR
 - If coverage does not pay at least 60% of covered health care expenses
 - \$3,000 per year for each full time employee receiving a tax credit up to maximum of \$2,000 per year x number of full time employees starting at employee #31
 - Penalty will increase with rising insurance premiums

Resource:
http://kaiserfamilyfoundation.files.wordpress.com/2013/04/employer_penalty_flowchart1.pdf


This slide discusses what happens to large employers with 50 or more employees that are subject to the employer mandate and do not comply with Affordable Care Act (ACA) regulations. The employer mandate is **delayed until 2015**. Note that there are two different ways that large employers can run afoul of the ACA and have to pay penalties: **not providing health care coverage, period, and not providing *affordable and adequate* health care coverage**. For detailed information about employer responsibilities, refer to <http://www.fpanet.org/journal/ANewWayofThinkingaboutEmployerSponsoredHealthCare/>.

The calculation of the penalty (tax) for employers that will be assessed by the federal government is described on the slide. There are some nuances but a simple explanation of the penalty is that it is triggered when, in any month, a large employer does not offer an insurance plan with minimum essential coverage for at least 95% of its workforce AND then at least one full-time employee receives subsidized coverage on a government-facilitated Exchange. Taxes will be assessed monthly and collected annually. As shown on the slide, the penalty for not providing health care coverage to employees is \$2,000 per year for each full-time employee after employee #30. Thus, a business with 60 employees would pay a \$60,000 penalty. Penalties will increase annually according to increases in health insurance premiums.

Note: Some employers may consider \$2,000 per employee a “bargain” compared to expenses of insuring a worker (about \$10,000). Still, many employers won’t necessarily like having to pay such a hefty fine (tax) and getting nothing in return.


With regard to the penalty for not providing *affordable or adequate* health care coverage. There are two triggers: a large employer does not offer minimum essential coverage for at least 95% of its workforce AND at least one full-time employee receives subsidized coverage on a government Exchange because employer coverage is “unaffordable and inadequate” Remember, coverage is deemed “affordable” when employees pay less than 9.5% of their income for self-only employer coverage (affordability threshold). Coverage is considered “adequate” if employer coverage pays at least 60% of covered health care expenses (adequacy threshold). The maximum penalty cap for unaffordable coverage is the same as the penalty for not providing health insurance: \$2,000 per full-time employee minus 30. For more information, refer to: <https://www.healthcare.gov/what-is-the-employer-shared-responsibility-payment/>


Providing this level of detail may not be necessary. The take-away message is really that larger farms need to be working with professional advisors to make sure that they comply with the ACA law and fully understand what will happen if they do not.





Large Employer Options That Make “Business Sense”

- Not offer insurance at all and pay the smaller fine
- Make sure that insurance offered is both adequate and affordable to comply with ACA rules









There had been some proposals that, since employers could not possibly know employees’ annual household incomes, that the threshold should represent solely the employees’ incomes. This “safe harbor” provision has yet to be put in place. It may be one of the things that are worked out as the penalty aspect of the ACA has been delayed until January 2015. Note that there is still an expectation that large employers will offer coverage to their employees, just that there will be no fines assessed in 2014 to ensure that this happens.

There is little reason to believe that, when the employer mandate fines kick in, that employers won’t do one of two things:

1. Either not offer insurance at all and pay the smaller fine OR
2. Make sure that the insurance they offer meets the criteria of being affordable and adequate. To do otherwise would not make good business sense.

Background Information

Yes, there has been concern that employers would rather reduce the working hours of their employees (to less than 30 hours per week) to circumvent the FTE requirement. The Congressional Budget Office does not expect this to be a major issue.

Their report is cited in this *Journal of Financial Planning* article:

<http://www.fpanet.org/journal/ANewWayofThinkingaboutEmployerSponsoredHealthCare/>

This article also describes various decisions that large employers can make. They include offering coverage as is, decreasing employer contributions, switching to a less expensive plan, self-funding health insurance to avoid some requirements of the Affordable Care Act, and dropping coverage and paying the tax.

It should be noted that reducing employee work hours would be especially difficult for many farm operators to implement. When the growing season is in full swing during harvesting, they need a full-time labor force.

Even with the delay in implementation of the penalties for large businesses, this Urban Institute study concludes that the employer mandate will not make as much of a difference in ensuring enrollment in health insurance as will the individual mandate. That is, the ACA could achieve its major objectives without the employer responsibility provisions. For more information, refer to: <http://www.urban.org/UploadedPDF/412865-ACA-Employer-Mandate.pdf>



Seasonal Employee Rules

- Vast majority of farms have < 50 full time employees but many have seasonal workers
- Need to determine if you average 50 FT employees for > 120 days in prior year
- If you do, you are required to offer coverage
- **Calculators:**

<http://www.franchise.org/healthcare/calculator.aspx>

<http://www.retailmeansjobs.com/health-care-calculator>





Under the Affordable Care Act (ACA), seasonal employment rules apply to the employer mandate to address the unique staffing needs of businesses such as retailers, ski resorts, summer camping programs, landscapers, and farms that “bulk up” their workforce for a short period of time each year to meet consumer demand for their products or services. Examples include the holiday shopping season for retailers and the growing and harvest season for farmers.

While the **vast majority of farms have less than 50 full-time workers, many farms have seasonal workers** to provide the labor needed for seasonal farm sales and harvests. Under the seasonal employment rule, if an employer averages more than **50 full-time employees for 120 days or less** and the excess employee count consists solely of seasonal workers, the large employer mandate under ACA does not apply and the employer is not required to offer health care coverage to employees.

If temporary employees work more than 120 days, large employers are required to provide coverage. Needless to say, farm operations that are above or close to the 50 FTE employee benchmark that employ seasonal workers need to pay close attention to both their employee head count and the number of days that their employees work. Some type of system (e.g., a spreadsheet) should be developed to do this. Another recommended option is to seek assistance from a professional advisor (see slide #23).

Various calculators are available online to help business owners determine whether they are subject to the employer mandate. See <http://www.franchise.org/healthcare/calculator.aspx> and <http://www.retailmeansjobs.com/health-care-calculator> as just two examples.

Note: Full time FTE under the Affordable Care Act (ACA) equals 30 hours of work per week or more.



ACA Deadlines

- Employer mandate enforcement delayed until 2015
- All are still subject to ACA individual mandate in 2014
- Six-month enrollment period for Exchanges: October 1, 2013-March 31, 2014
- Subsequent enrollment dates: October to December with specific dates to be determined.
- **Resource:** to <https://www.healthcare.gov/what-key-dates-do-i-need-to-know/>





This slide describes upcoming deadlines associated with the Affordable Care Act (ACA).

The **employer mandate**, originally supposed to take effect in 2014, **has been pushed back a year to 2015**. The extra year delay will allow business owners more time to get familiar with the requirements of the ACA and to determine if and how it affects them. If farm businesses are affected by the employer mandate, they have an extra year to seek professional advice, decide whether to “pay or play,” and/or shop around for and purchase health insurance.

The **individual mandate** is still scheduled to take effect in **2014**, however. The **initial enrollment period will run for six months from October 1, 2013 to March 31, 2014**. In **future** years, the enrollment period will be shorter: from **October through December** of each year. (See Slide 16). During the open enrollment period, people will make their coverage selection for the following calendar year. The effective date of coverage will depend upon when people enroll; i.e., the first two weeks or last two weeks of the prior month.

An application submitted between the first and the fifteenth day of any month must have coverage in effect by the first day of the following month. An application submitted between the sixteenth and the last day of any month must have coverage in effect by the first day of the second following month.

Note that there are special enrollment periods for qualifying events. For more information, refer to: <https://www.healthcare.gov/glossary/qualifying-life-event/>

For more information, refer to: <https://www.healthcare.gov/what-key-dates-do-i-need-to-know/>



Farm Workers and Health Care

- 85% of seasonal farm workers and their families are uninsured:
<http://sphhs.gwu.edu/departments/healthpolicy/chpr/downloads/migrant.pdf>
- Only 20% of seasonal farm workers used health care services in prior 2 years. **Barriers:** cost, language, transportation, no sick leave
- These farmworkers may have better access at least to safety net providers, community health centers, that are being better funded through ACA
- Resource: National Center for Farmworker Health:
<http://www.ncfh.org/>






No discussion of health care for farm families would be complete without mentioning the health care challenges of farm workers. Unfortunately, unlike farm operators, **farm workers, especially seasonal workers, have high rates of uninsurance.**

Eighty-five percent of farm workers in the U.S. have no health insurance and their **use of health care services is low** due to a variety of obstacles that are listed on the slide: **cost, language barriers, lack of transportation to medical facilities, and no sick leave.**




There is some good news, however. One way that uninsured, undocumented farm workers may benefit from the Affordable Care Act (ACA) is through **increased funding available for community health centers. These centers, as well as hospital emergency rooms, are likely places where seasonal farm workers would receive health care services when needed.**

Background Information: There are an estimated 11 million people living illegally in the U.S. who are not covered by the Affordable Care Act. People must prove citizenship or legal immigration status to take part in government facilitated health care Exchanges. See http://www.nytimes.com/2012/07/27/nyregion/affordable-care-act-reduces-a-fund-for-the-uninsured.html?pagewanted=all&_r=0.

Farm Worker Summary




- Farm workers will continue to face difficulties in securing health coverage and paying for care
- Medicaid expansion will primarily benefit documented individuals (undocs will receive emergency coverage only)
- Large employer mandate will benefit full-time workers who work for a single employer
- Marketplaces will benefit documented income-eligible individuals with subsidized premiums
- Some safety net providers will see increased income, while others may become financially unstable
- Critical to health reform is immigration reform



This slide summarizes key points about how farm workers will fare under the Affordable Care Act (ACA).




Note that many farm workers will continue to face difficulties in securing health coverage and paying for care, particularly undocumented workers and those who work for small employers. Many will continue to rely on “safety net health care providers” such as hospital emergency rooms and community clinics operated by non-profit organizations.

Because so many farm workers are undocumented, in the agricultural industry sector, especially, immigration reform is closely intertwined with health care reform.



“Sticky” Issue

- Health care law highlights problems with undocumented workers (> 50% of farm workers)
- Undocumented workers not eligible for Medicaid or state health insurance Exchanges
- Employers don’t have to count non-resident aliens hours or cover them
- But...if you pay a lot of people to work and don’t offer coverage, have you violated any laws by hiring them?



Political opinions aside, it is a fact that health care reform legislation is impacted by U.S. immigration laws. Perhaps nowhere in the U.S. economy is this more acute than in the agribusiness sector. It is estimated that more than **50% of farm workers are undocumented individuals**. Many are migrant laborers that travel vast distances across the U.S. following the growing season from farm to farm.

As noted earlier, undocumented workers are not eligible for the expansion of Medicaid under the Affordable Care Act (ACA) **nor for health insurance via government facilitated Exchanges**. Applicants for coverage through Exchanges are required to present a Social Security number.

In addition, **employers don’t have to cover or count the hours worked by non-resident aliens** (i.e., non-U.S. citizens without a green card or lacking a “substantial presence” of residing in the U.S. for more than 31 days in the current year and more than 183 days over a three-year period).

Regulations associated with the ACA compliance (e.g., counting the number of workers and their work hours) are highlighting potential problems associated with the hiring of undocumented workers to harvest crops.

Action Steps for Farm Families

- Compare your current insurance (especially individual policies) with state Exchanges
- Consult with a professional advisor if business is close to 50 FTE employees
 - Do the math: pay or play?
 - Develop a plan to optimize mandate requirements within your business model (e.g., more part-time, less full-time, limiting surges of workers to < 120 days)
- Obtain a health insurance plan if you decide to cover employees. Make sure it both:
 - Meets the 60/40 rule
 - Costs less than 9.5% of your least (lowest) paid employee's annual (household) income.









To conclude this presentation, here are some take-away action steps for farm families.

First, once government health care Exchanges become operational, **compare the cost and features of your current insurance** (especially policies purchased in the individual insurance market) **with those on the Exchanges**. Some Exchanges are administered by states, some by the federal government, and some by a state-federal partnership but it really doesn't matter. All Exchanges will have multiple plans for comparison ranked from bronze to platinum.

Do a "Rule of Three" comparison of health insurance options using worksheets developed by the University of Maryland:

https://www.extension.umd.edu/sites/default/files/_images/programs/insure/My%20Smart%20Choice%20Health%20Insurance%20Guide%204-3-13.pdf

Second, if your farm enterprise is at or close to the "large employer" definition of 50 employees, **consult with a professional advisor** to develop a plan of action. This includes deciding whether you will "pay" (the tax penalty) or "play" (purchase insurance) and possibly making adjustments to your business such as staffing changes and changes in work hours.

Finally, if you decide to purchase insurance for employees, allow adequate time to shop around and **select insurance coverage that is both affordable and adequate** and determine if any employees would pay more than 9.5% of their annual household income (*or, with the safe harbor, their W-2 form wage income*) for health insurance premiums.



A presentation slide titled "ACA Resource for Farm Families". The slide has a light blue background with a dark blue header bar. In the top right corner, there is a logo for "SMART CHOICE HEALTH INSURANCE". The title is in a large, bold, black font. Below the title, there is a bulleted list of five items. The first item is "Video: Healthcare Reform: Key Issues for Agricultural Producers". The second item is "Features attorney Sheldon Blumling". The third item is "One hour, 45 minutes long". The fourth item is "Taped at a Cornell Cooperative Extension seminar". The fifth item is a blue hyperlink: "https://www.farmcrediteast.com/Products-and-Services/Video-Insights/Healthcare-Seminar.aspx". At the bottom of the slide, there are three logos: "K-STATE Research and Extension" on the left, "RUTGERS New Jersey Agricultural Experiment Station Cooperative Extension of Middlesex County" in the center, and "UNIVERSITY OF MARYLAND EXTENSION Solutions in your community" on the right.

ACA Resource for Farm Families

- **Video:** *Healthcare Reform: Key Issues for Agricultural Producers*
- Features attorney Sheldon Blumling
- One hour, 45 minutes long
- Taped at a Cornell Cooperative Extension seminar
- <https://www.farmcrediteast.com/Products-and-Services/Video-Insights/Healthcare-Seminar.aspx>

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If you'd like to explore the impact of the Affordable Care Act (ACA) on farm families in depth, this video presentation is available on the Farm Credit East Web site. It features an attorney discussing the Affordable Care Act at a workshop for farm families sponsored by Cornell Cooperative Extension.

More Resources for Farm Families

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- Healthcare.gov Small Business:
<https://www.healthcare.gov/small-businesses/>
- ACA Employer Penalties:
<http://www.benefitscafe.com/newsletter/03-calculating-aca-tax-penalty.html> and
<http://www.fas.org/sgp/crs/misc/R41159.pdf>
- ACA and Agriculture:
<http://www.growingproduce.com/article/34123/what-will-the-affordable-care-act-mean-to-agriculture>

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This slide lists three additional resources related to the impact of the Affordable Care Act (ACA) on farm families.

Additional Affordable Care Act resources can be found on the eXtension Web site
<http://www.extension.org/pages/68424/affordable-care-act#.UgQNANrD-M8>.

Kaiser Family Foundation Video: *Health Reform Hits Main Street*



[HTTP://HEALTHREFORM.KFF.ORG/THE-ANIMATION.ASPX](http://HEALTHREFORM.KFF.ORG/THE-ANIMATION.ASPX)



This 9-minute video provides a good summary of the Affordable Care Act (ACA) in a very understandable “user-friendly” format.



If you'd like to learn more about how to make a smart choice health insurance decision for your or your family, you may want to get the new research-based, consumer-tested workbook available at: extension.umd.edu/insure.

Educators: If you are doing consumer workshops, you can promote them at this point in the presentation. You could insert another slide with specifics.

Comments? Questions? Experiences?

Thank you for attending this presentation.



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HEALTH INSURANCE

Thank you for attending this presentation. I hope this session has helped you to understand some provisions of the Affordable Care Act better so you can make smart choices for your family and your farm business.

Are there any additional comments or questions?

Please complete the program evaluation form before you leave.

Thank you.

Post Assessment Questions for Farmers as Consumers

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Post Assessment Questions for Farmers as Employers

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Educators, you can insert your contact information in this slide.