Health IN THE BALANCE

- Blurred line between family and farm
- Who’s in charge of healthcare?
- No shirt, no shoes, no insurance
- Health policy diagnosis
- Prescribed rural recovery
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COVER STORY

At What Cost?
Healthcare today exposes one of the risks of full-time farming — self-employment means pricey and often inadequate insurance. Review some of the options now available.

Ripping the Band-Aid Off the Farmer Healthcare Conversation
As healthcare premiums continue to rise, more families may take someone out of a productive, full-time role on the farm to work elsewhere for insurance. Producers weigh in on the discussion.

Shaky Prognosis
The state's rural healthcare system is ailing. Nearly half of rural hospitals operate on slim to negative profit margins with older, poorer and often uninsured patients. What's the answer?

Blurred Lines
Health issues when you are self-employed and farm full-time illustrate the tight relationship between health, family and business and the need to protect what can be protected.

How Did we Get Here?
Industrialization and wars have driven health insurance and agricultural progress, although the roads are unique. View the similarities and differences that have shaped the last 200 years.

DIFFERENCE MAKERS

Shoshanah Inwood
Inwood is project director for HIREDnAg, the first program to understand farmer health insurance navigation and develop tools to help support a healthy agricultural sector.
Health is All-Hands-on-Deck Issue

According to a USDA-funded 2017 national health survey, three out of four farmers and ranchers report health insurance as an important or very important risk management strategy. Almost half of farmers and ranchers are concerned they will have to sell farm assets to address health-related costs, 64 percent have pre-existing health conditions, and half say they are not confident they could pay costs of a major illness without going into debt.

In addition, the Centers for Disease Control and Prevention (CDC) reports people working in farming, fishing and forestry have the highest suicide rates in the U.S., at 84.5 suicides per 100,000 people. These rates are highest in rural areas. Suicide is the tenth leading cause of death.

Clearly, quality healthcare and accessible health insurance are literally critical to our well-being.

All Illinois farmers need access to affordable health insurance. Many of us rely on family members with off-farm jobs that provide medical plans. Others simply can’t go back to farm because they must work for insurance. The Illinois Soybean Association (ISA) recognizes these concerns. ISA has set up a task force to be forward-looking and to help lead the discussion about health-related challenges. We want to find solutions and educate soybean producers about them.

This issue of Illinois Field & Bean is largely devoted to health-focused topics. We provide information about health care and health insurance options for Illinois soybean producers. We also have stories that show the broader scope of health-related challenges. We touch on the impact for young, beginning farmers, as well as those reaching retirement. We highlight some of the solutions being tested in the marketplace, and we look at how policy might affect the future of healthcare and insurance and rural development in our local communities.

Health-related care, cost and insurance issues affect all of us. As our task force explores this topic, I invite you to share your situations, problems and solutions. Health is an all-hands-on-deck matter that requires we look out for each other and for the future of our industry.
Rural Americans Need Affordable Health Care

> BY JESSICA SEIGEL, NRHA Government Affairs Communications Coordinator

Rural Americans need affordable insurance plans and access to providers in their communities, but far too many residents struggle to receive critical care because of costly insurance and a dearth of care options.

The laudable goals of the Affordable Care Act (ACA) were not fully achieved in rural areas. We’ve seen a growing crisis in rural America that includes a lack of plan competition in rural markets; exorbitant premiums, deductibles and co-pays; co-op collapses; devastating Medicare cuts; and nonexistent Medicaid expansion.

As cuts have forced more and more rural hospitals to close, even those who can afford care through their insurance are losing access to options in their communities.

A recent TransUnion study found a significant increase in the number of patients unable to pay their hospital bills. The study revealed 68 percent of patients with bills of $500 or less did not pay off the full balance during 2016 – up from 53 percent in 2015 and 49 percent in 2014. The author explained the issue’s predominant culprit: higher deductibles. Unaffordable plans mean more unpaid bills, known as bad debt for providers. Rural hospital bad debt has increased by 50 percent since 2010, an increase not seen by urban providers.

The ACA included cuts to programs that help hospitals with unpaid bills and charity care, since Medicaid expansion and increased insurance coverage would reduce this burden. However, many rural states have not expanded Medicaid. Medicare bad debt cuts now equate to more than $1 billion in lost revenue for rural hospitals – a small number for federal budgets, but losses that push rural hospitals from vulnerability to closure. Reversing these cuts costs the government little and keeps care in rural communities.

In 2017, 40 percent of rural hospitals operated at a financial loss. This year that number rose to 44 percent. It has risen every year since the ACA went into effect. Eighty-seven rural hospitals have closed since 2010, and another closure has already been announced. As more rural hospitals close, local, affordable care for patients disappears.

As hospitals close their doors, options for insurance also vanish. Rural Americans are on average older, sicker and poorer than urban populations, making the individual market more challenging for insurers. Today, 41 percent of rural marketplace enrollees have a single option for insurance, representing 70 percent of counties with only one option.

Insurance companies can cherry pick profitable markets for participation and are not obliged to provide service to markets with less advantageous risk pools. The demographic realities of rural populations mean rural Americans have greater health care needs, making the market less profitable and thus less desirable for an insurance company with no incentive to assume the risk.

Fixing this is simple. In the same way financial service institutions are required to provide services to underserved neighborhoods, profitable insurance companies could be required to provide services in underserved communities.

While the situation remains difficult for rural patients and providers, these communities have shown resilience in the face of adversity. With action, easy reforms exist at the state and national levels that can remedy these policies and ensure a strong, healthy future for all rural Americans.
Farming. Producers say it’s in their blood. They put their hearts into it. They thrive on being their own bosses. They count it a privilege to work closely with family.

But healthcare today exposes some risks of full-time farming. For much of the full-time working population of the U.S., the boss pays for health insurance, with options for the whole family. For farmers, if that blood exerts high pressure, or that heart fights a clogging artery, or the family grows with a pregnancy, or a serious accident happens…the whole picture changes. The farmer as boss provides the health insurance for family and employees, and it can be pricey.

As the American Health Care Act (AHCA) begins in 2019, replacing the Affordable Care Act (ACA) implemented in 2014, uncertainty further clouds the murky health insurance picture.

**CHANGING COVERAGE**

Many Illinois producers fit the non-group plan market supported by the ACA. But those with incomes more than 400 percent above poverty are ineligible for premium tax credits through the Healthcare.gov Marketplace. This group wants alternatives (see related story on page 9).

“A recent rule allows for more loosely-regulated health insurance plans outside of the ACA,” says Karen Pollitz, a senior fellow with the Henry J. Kaiser Family Foundation (KFF) who focuses on health reform and private insurance.

Pollitz co-authored a KFF issue brief in April, “Proposals for Insurance Options That Don’t Comply with ACA Rules: Trade-offs in Cost and Regulation,” summarizing the situation and alternatives. The study reports most Marketplace insurers underpriced ACA plans and lost money between 2014 and 2016. They compensated with higher prices in 2017 and 2018. Subsidies protected 85 percent of Marketplace participants from those increases.

But the nearly seven million ineligible for subsidies experienced major premium increases. Alternative health plans reduce premiums for this group by relaxing rules for required benefits rules, coverage of pre-existing conditions and community rating, according to the KFF brief.

“With health insurance plans, it’s very hard to compare apples to apples,” says Pollitz. “But cheaper plans typically offer less protection. That means they are less likely to take care of you when and after you get sick.”

She says ACA plans cover defined essential health benefits with limits on deductibles, while charging the same rate based on universal factors like age. Pre-existing conditions don’t impact individual costs.

Alternative plans can be more selective of participants. “Under ACA alternatives, insurance companies have more options, like medical underwriting, that allow them to decide who and what services they will cover,” Pollitz says. “This creates a less risky pool of participants, so they can charge less.”

The alternatives appeal to those in good health.

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The alternatives appeal to those in good health.

“The drawback is that the ‘choices’ don’t apply to those with pre-existing conditions,” she says. “Because they are a greater risk, they likely won’t qualify for alternatives. That leaves them in the Marketplace, but if lower-risk people opt out, overall ACA premiums could increase.”

AHCA removes the mandate for health insurance and associated tax penalties, which also may impact the risk pool and ACA premiums.

**EXPLORING OPTIONS**

Pollitz notes that public attitudes about health insurance have shifted during ACA and AHCA discussions, and research shows people want health insurance protection when needed. “After ACA was implemented, our polls showed support split roughly in half, with constant shifts between more favorable and unfavorable perceptions,” she says. “Since AHCA passed, opinions favoring ACA increased slightly and have held steady for several months.”
Future Innovations

The health insurance landscape could change dramatically as technology giants like Amazon and Google invest in healthcare. Reports from Forbes, CNBC and others speculate on their goals for healthcare and health insurance delivery. Data capabilities of these companies could allow them to effectively compete in the current health insurance market.

At the same time, technology like Fitbit and smart watches have growing capabilities to monitor heart rate, sleep and other personal health data, according to online company product information. Individuals could proactively manage their health, relying on personal devices to indicate potential problems, says a technology report from Bloomberg. Such an approach could work well with ACA alternatives that offer less coverage.

Uninsured

With the ACA mandate repeal, producers can choose to forgo health insurance coverage without tax penalty, although consideration should be given to farming’s inherent risks and average age.
Marketplace insurers underpriced ACA plans and lost money between 2014 and 2016. They compensated with higher prices in 2017 and 2018. Subsidies protected 85 percent of Marketplace participants from those increases. But the nearly seven million ineligible for subsidies experienced major premium increases.

Source: KFF April 2018 Issues Brief

**TIME CLARIFIES BIG PICTURE**

“It’s too early to tell how options developed in response to the new rule will impact the overall health insurance market,” says Pollitz. Her KFF brief notes nearly one-third of individual market enrollees are self-employed, so the impact of AHPs and other options could be significant.

“We don’t know how people, the government and health insurance companies will respond. Will less regulated options be promoted to this group? How will insurance companies compete within this segment?” she asks. “This uncertainty can change the market every year.”

Affordable options will allow many to provide families and employees with health insurance. But for those with pre-existing conditions, alternatives and the absence of a mandate could push affordable health insurance further out of reach.

**Association Health Plans**

The primary alternative to lower premiums are Association Health Plans (AHPs). They allow people to organize in groups eligible for large group health insurance plans that don’t have to comply with ACA. Most provide less coverage but more flexibility in premium costs.

“Associations provide individual relief through better rates,” says Hopwood. “I believe they are a concept that will and should grow. I’m not aware of any AHPs in Illinois yet. Those in the individual market should keep an eye on them, monitor results and consider creating one.”

AHPs appear to be a good fit for agriculture. Land O’Lakes created BuyPoint Insurance Solutions to offer affordable insurance for their member-owners and cooperatives. This group offers medical, life and other options. But AHPs allowed them to go a step further.

“In 2018, members in Minnesota had the additional option for purchasing insurance through the MN Co-op Health Plan, created and sponsored by Land O’Lakes,” says Pamela Grove, president of BuyPoint Insurance Solutions. “This option grew out of a change in Minnesota law that allows for those in agriculture to form a group health plan. On Jan. 1, 2018, this plan went live with 318 farmers signing up and covering more than 700 people across the state.”

Several state Farm Bureaus have developed AHPs. Iowa passed a state law last spring allowing Iowa Farm Bureau to offer health insurance to members. Nebraska Farm Bureau followed this fall with their own AHP. Washington Farm Bureau’s plan pre-dates those in the Midwest.

These AHPs resemble the plan offered by the Tennessee Farm Bureau that has been in place since 1993. Roughly 25,000 in Tennessee purchase the plan, which saves them up to two-thirds the cost of ACA plans because it denies coverage for pre-existing conditions. They may have owed a tax penalty, but that changes in 2019 with the mandate repeal. However, confining sicker residents to ACA plans likely contributes to Tennessee’s individual market having one of the highest risk scores in the country, according to the KFF issue brief.

The map shows the average percent change in the lowest cost monthly premium for a 40-year-old male ineligible for a tax credit from 2017 to 2018. Grundy County is the only county that shows a decline — 7 percent in this case — while all other counties show an increase of up to 29 percent.

% Change in Lowest-Cost Monthly Premium, 2017-2018

The map shows the average percent change in the lowest cost monthly premium for a 40-year-old male ineligible for a tax credit from 2017 to 2018. Grundy County is the only county that shows a decline — 7 percent in this case — while all other counties show an increase of up to 29 percent.

Source: Kaiser Family Foundation analysis of premium data from Healthcare.gov and review of state rate filings.
Ripping the Band-Aid Off the Farmer Healthcare Conversation

Rising healthcare costs impact farmer profitability and it’s time to start talking about it

> BY RACHEL PEABODY

Healthcare affordability is a pressing national problem, but farmers are particularly feeling the pinch. Deanna Thomas, Manito, Ill., a farmer growing corn, soybeans and popcorn alongside husband, Braden, and their two young daughters, pays $1,200 a month for an insurance plan that still fails to adequately cover medical expenses. She understands her story is not unique and that, unfortunately, this harsh reality is status quo for producers who solely work on the farm.

“Spending $1,200 a month for healthcare is not affordable or realistic. For that kind of spend, it makes more sense for me to get a job off-farm where we could get insurance,” says Thomas.

As healthcare premiums continue to rise, more families like the Thomases will probably consider taking someone out of a productive, full-time role on the farm.

FINDING A CURE

Thomas attributes some of the strain to the Health Insurance Marketplace. Its income-based model is not intuitive for farming. From year to year, farm income can vary greatly, making it hard to project where they should land in the marketplace. Project too low and they could end up in a subsidized healthcare program. Project too high and double their monthly payment.

“The reality is that producers are less than two percent of the population, so I understand that our population is not going to be a priority in the marketplace. But there has to be a better compromise out there,” says Thomas.

Marketplace is also cumbersome to use and unpredictable, which certainly aren’t new concerns or even unique to agriculture.

“When we first signed on, we got a great family plan that was $400 a month and covered everything we needed. Six months later, we received a 30-day notice that our plan was going away and that we would need to pick another. I picked a similar plan and our premium jumped to $1,200 a month,” says Thomas.

It’s clear that Illinois producers need a more affordable healthcare option, but who will deliver, and how? Thomas believes it is time for Illinois to start talking about it.

“Recent headlines tell us other states are leaning on ag organizations to start providing healthcare options to farm families. Illinois needs a producer-focused program like that,” she says.

OFF-FARM ANSWERS

“If you want to talk about farmer profitability, healthcare is one of those items that producers are talking about when we look at budgets,” says Ross Albert, farm manager for Soy Capital in Bloomington, Ill. “It’s not uncommon for producers to tell us they pay in excess of $1,000 for their monthly premium. As the farming population ages, those costs climb.”

Albert, who’s also a farmer by night and weekend, is an example of someone pursuing an off-farm career. He states his insurance plan “is definitely a benefit.”

Albert supports a wife and three children on his healthcare plan and echoes other producers’ calls for an affordable healthcare solution.

TAKE ACTION

Can the healthcare crisis be fixed? Is it conceivable for a producer to have affordable health benefits without being a burden on the farm balance sheet?

The Illinois Soybean Association (ISA) thinks it can be done, and wants to hear from Illinois producers to keep the conversation going. Send thoughts to ilsoy@ilsoy.org.

>BY RACHEL PEABODY

Ripping the Band-Aid Off the Farmer Healthcare Conversation

“Spending $1,200 a month for healthcare is not affordable or realistic. For that kind of spend, it makes more sense for me to get a job off-farm where we could get insurance.”

DEANNA THOMAS, farmer, Manito, Ill.
Rural hospitals and clinics struggle to provide care to a generally older and poorer population where a lack of practitioners is a growing concern.

> BY CANDACE KREBS

Randall Dauby is chief executive officer of a community hospital in Pinckneyville, Ill., population 5,000, built three years ago with a USDA Rural Development loan. The on-site emergency room and adjacent health clinic have two telehealth computers with high definition TV screens, which allow specialists, such as dermatologists, to diagnose and treat conditions through video conferencing.

Pinckneyville is considered a “Critical Access Hospital” (CAH), a designation that reduces financial vulnerability of rural hospitals and improves access to healthcare by keeping essential services in rural communities.

The set-up sounds nearly ideal. But Dauby, who was named Rural Health Administrator of the Year this past summer by the Illinois Rural Health Association (IRHA), can also point to all the ways the state’s rural healthcare system is ailing.

According to a recent report by the Illinois Health and Hospital Association, nearly half of the state’s small, rural hospitals operate on slim to negative profit margins. Compared to urban settings, rural populations are older, poorer, more often uninsured and more dependent on Medicare or Medicaid.

Lack of rural practitioners is a glaring problem. Dauby has spent the past two years trying to recruit a family physician, with no luck. Working at a rural hospital usually requires doing rotations and being on call, which isn’t popular with applicants. Attracting specialists, such as psychiatrists or obstetricians, is even more difficult.

The Association of American Medical Colleges predicts the shortage of physicians will reach 120,000 by 2030. In Illinois specifically, 25 percent of the state’s population reside in rural areas, but only 10 percent of physicians practice there, which means roughly three-quarters of the state’s rural counties are primary care deficient. The Illinois Health and Hospital Association finds rural areas have 45.5 primary care physicians for every 100,000 residents, compared to the statewide average of 80.7.

The area of care that causes Dauby the biggest headache, however, is mental, behavioral and psychiatric health. While such patients account for only 15 to 20 percent of emergency room traffic, they often create logjams due to insufficient treatment options.

“We had a patient the other day who waited six hours for a therapist to show up,” he says. “Tele-psych is something that is needed in every community, because there’s just not enough availability of those services, and that’s as big, or bigger, than the opioid crisis.”

That perspective comes as no surprise to Kim Saunders, executive director of the Center for Rural Health at Southern Illinois University Carbondale.
“Every small community hospital has to do a community needs assessment every three years, and in Illinois I can’t imagine mental health not being one of the top five priorities for most of them, right up there with diabetes,” she says.

In rural areas, there are 1.6 psychiatrists for every 100,000 people, according to the Illinois Health and Hospital Association. The statewide average is 10.5.

In almost every case, earlier intervention leads to better outcomes. Saunders says the state is starting to make progress on better integration of mental and physical health.

Margaret Vaughn, executive director of the Illinois Rural Health Association, agrees a shortage in any one area of care often has a cascading effect. Sixty-six Illinois counties are “dental shortage” areas, for example, and many dentists won’t take Medicare patients.

“Some of our rural counties have just one ambulance, and they might not have a single dentist. So, let’s say someone has a toothache that becomes so severe they end up calling the ambulance,” she explains. “That means the county’s only ambulance is tied up, and in the meantime, what if there’s an accident or someone has a heart attack? In a lot of rural areas, it might take 30 minutes just for the ambulance to get to the patient.”

Lack of transportation worries Dauby, too. As patients age, they have a harder time driving to see specialists in distant cities. “People in nursing homes or assisted living facilities can typically get transportation to our local hospital but not all the way to the urban areas where the specialized care is. Ambulance transport is just not very ideal for that. A lot of these are volunteer services, and it’s already a challenge for them to keep going,” he says.

Telemedicine looks like the obvious remedy for solving many of these challenges. Doug Wilson, the state’s USDA Rural Development director, says the most popular way for rural hospitals and clinics to use the agency’s facility assistance program is by expanding telehealth capabilities.

“We really are seeing more consultation between small and large hospitals, and telemedicine is how they connect,” he explains. “It can even involve online diagnostics that give live reviews of a patient’s condition in real time. If they are in an ambulance, for example, specialists can monitor what’s going on, and advise the paramedics so they can go straight to where they need to go.”

But telemedicine relies on broadband service, which can be a barrier in remote areas.

Wilson, who lives on a fourth-generation grain farm seven miles from town, says while most communities have baseline services, they aren’t always adequate for commercial use. “On my farm in southwest Livingston County, on a good day we get five megabytes download speed whereas in larger communities it may be 100 meg, so there’s quite a chasm between the two,” he says.

It’s not a situation unique to rural Illinois. Nationwide an estimated 39 percent of the population lives in areas where broadband is substandard, he says, though federal agencies are working to address the discrepancy.

Broadband capabilities aren’t the biggest problem holding back adoption of telemedicine at Dauby’s hospital, however. “The
federal reimbursement rate right now is so miniscule that I can’t afford to offer those services,” Dauby says. “Everybody is pushing the idea, but the payments are not matching what the IT infrastructure has the ability to do.”

That’s a sore spot with the rural health association, which is pushing government payers and private insurance companies to treat remotely accessed services as equivalent to in-person care. Outpatient services, which are becoming increasingly common in rural areas, also get reimbursed at lower rates than inpatient treatment.

Without advances in telemedicine, Dauby worries it will be impossible to keep pace with regulations. “Many of the new laws are good, but being able to comply is burdensome for a small hospital,” he says. “For example, Illinois passed a law requiring hospitals to have a trained sexual assault nurse examiner on staff. Our hospital may have only one or two cases a year, which is a good thing, but it’s impossible for any nurse to maintain certification. The law requires several hours of actual experience to satisfy the mandate.”

Instead, Dauby is being forced to look at contracting expensive outside services — if he can find them.

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**YES, WE HAVE A REWARDS PROGRAM. IT’S CALLED “HARVEST.”**

![Image](https://example.com/hs.png)

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**INNOVATION**

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**Rural Counties Face Physician Shortages**

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<tr>
<th>Rural Counties</th>
<th>State Average</th>
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**Physician and Mental Health Shortages**

- 30.3% of small and rural hospitals are in areas designated as a Health Professional Shortage Area (HPSA) for primary care physicians
- 93.7% are in areas designated as a HPSA for mental health professionals

Source: Health Resources & Services Administration, Area Health Resources Files, 2017-2018

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Healthcare policy changes confuse constituents

It’s a common news headline: “New legislation introduced today attempts to lower healthcare costs and increase accessibility.”

From the Affordable Care Act of 2010 (ACA) to the Health Care Freedom Act in 2017 (HCFA), at least a dozen pieces of legislation have been drafted to attempt to mend healthcare woes – and the battle isn’t over.

The HCFA changes a few policies in the ACA law, including reduced penalties, increased health savings contributions and changes in state roles. Modifications allow small businesses to purchase insurance through Association Health Plans (AHP). These plans are formed by groups with common geographical or industry connections. While AHPs seem attractive, the jury is still out on the viability of this plan option considering it started in September (read more on page 8).

“Choosing a healthcare plan is complicated,” said Ari Beilin, a strategic account manager with Gravie, a health benefits company.

“How does the Health Care Freedom Act change the Affordable Care Act?

- The tax penalty is eliminated for having minimum essential coverage.
- Tax-free health savings account contributions are increased to equal the annual out-of-pocket limit under qualified high deductible health plans.
- There is no penalty for large employers that do not provide health benefits.
- State roles are changed, including modifications to state innovation waivers.

Most farmers have historically relied on either the individual market, small group plans or employer plans through their spouses or a second job.”

“Explore your options every year to make sure you’re in the best plan for you and your family,” Beilin said.

The bottom line is you don’t have to find a healthcare solution on your own.
A USDA-funded research study of farmers and ranchers last year, led by Shoshanah Inwood, Ph.D., Ohio State University assistant professor and HIREDnAg project director (see story page 22), confirms the farm enterprise and farm family are intertwined.

About 40% surveyed said they or a family member have had health problems affect their ability to farm.

Half noted no one could run the farm if there was major illness or injury.

In an Agricultural Resource Management Survey (ARMS) in 2015, researchers identified illness or injury as a major farm risk.

At the time, 9.1% of the U.S. population had no health insurance compared to 10.7% of farm household members.

Getting sick or injured isn’t fun. But health issues when you are self-employed and farm full-time can create more than just a day out of the office. It may permanently affect your business.

That fear is not lost on producers nationwide. Several survey and research projects confirm the tight relationship between health issues, farm families and the farm business.

The majority of farm households address health insurance through operator or spouse employment off the farm.

In the ARMS survey, farmers were slightly more likely than the general population to purchase health insurance directly from a company and less likely to receive insurance from a government program, such as Medicare or Medicaid.

According to Marc Lovell with the University of Illinois Tax School and Department of Agricultural and Consumer Economics, maximizing tax savings from health insurance premiums paid has become increasingly important and complex. To be accurate and make the most of the situation, farmers should consult tax advisers about reducing costs through tax savings and proactive planning.

Farmers who cover their own health insurance costs must address the finance and tax issues associated with them. According to Marc Lovell with the University of Illinois Tax School and Department of Agricultural and Consumer Economics, maximizing tax savings from health insurance premiums paid has become increasingly important and complex. To be accurate and make the most of the situation, farmers should consult tax advisers about reducing costs through tax savings and proactive planning.

Family living expenses are not tax deductible for a farm business, but must be budgeted to sustain farm family living expenses, according to a report from Brandy Krapf, Dwight Raab and Bradley Zwilling with the Illinois Farm Business Farm Management (FBFM) Association. Non-deductible expenses must come from the farm and can be supplemented by non-farm earnings. Family living expenses include medical expenses like out-of-pocket costs and premiums for purchased health, dental or vision insurance.

Medical expenses were higher in 2017 compared to 2016. In 2017, medical expenses averaged $12,007 in the Illinois Farm Business Farm Management report. Medical expenses include out-of-pocket costs for health insurance along with doctor and hospital expenses.

Size matters.

Data from a group of Illinois FBFM sole proprietor members with family living expenses records shows total family living expenses, including medical, increased from 2007 to 2016 at just over 20 percent. Net family living expense change was relatively flat for farmers in the 500- to 999-tillable operator acres group and the more than 1,000 tillable operator acre group, as they increased net non-farm income. The under 500 tillable operator acre group saw an 18 percent increase in net family living expenses.
HOW DID WE GET HERE?

Illinois Agriculture Alongside Health Insurance

John Deere invents the self-scouring, steel-bladed plow in Illinois, allowing farmers to efficiently break up sod.

Illinois farmers drain land with ditches and tile. Within 50 years of introduction of the steel plow, most of the Illinois prairie becomes farms.

One of the earliest voluntary mutual protection associations in the U.S., La Société Française de Bienfaisance Mutuelle, organizes in San Francisco and opens a hospital.

Diverse family farms in Illinois average 160 acres.

The Massachusetts Health Insurance Company of Boston becomes the first insurer to issue sickness insurance.

The industrial revolution creates steel mill jobs. Dangerous work and rise of unions lead to mutual benefit associations called "establishment funds" as protection from major financial losses for injury and illness. Employees form these associations, sometimes with employer involvement.

Germany passes the first national compulsory health insurance law.
Industrialization and wars have driven the progress of both health insurance and agriculture to today, although the roads have been very different. Agriculture played an integral role in the settling of Illinois. But farmers barely enter the picture in development of health insurance. Agricultural policy, from land grants to the farm bill, has been a U.S. legislative staple since the 1820s. In contrast, comprehensive universal health insurance was first introduced in 1915 and required more than eight attempts and just shy of 100 years to become U.S. law.

Illinois Farmers Embrace Advances
Illinois farmers produce greater yields with fewer workers to support the war effort. University of Illinois Extension and local war boards share current scientific techniques to achieve those goals. Nationally, rural America loses about 7 million workers to military and industrial jobs in cities during World War II.

Employers Provide Health Insurance
The 1942 Stabilization Act combats inflation during the war, limiting employer ability to raise wages to compete for scarce workers. Companies begin offering health insurance benefits as incentives to attract workers. These benefits are compensation, not income, so workers do not have to pay taxes on them.
Illinois farmers continue to improve productivity with advances like commercial fertilizer, while the amount of labor continues to decrease.

High interest rates, an embargo and other supply and demand changes combine to cause a farm crisis. Land values deflate and farmers struggle.

U.S. real farm income reaches a record high, setting in motion a rise in the value of farmland and farm debt.

The worst floods in Illinois history cover 500,000 acres and cause major crop damage in flood plains.

Illinois farmers lead the nation in soybean production and set a state record for corn production.

Illinois produces 16 percent of the total value of U.S. soybeans and corn.

A severe drought leads to record soybean and corn prices.

Illinois leads the U.S., producing nearly 612 million bushels of soybeans.

Employer-sponsored health insurance is exempted from federal income tax. This shifts how insurance companies and employers manage health insurance to take maximum advantage of the tax code.

As healthcare costs rise, types of health insurance plans expand to include preferred provider organizations (PPOs), and point-of-service (POS) plans.

Health maintenance organizations (HMOs) combine a broad range of care providers into a single group or network, an alternative to the existing fee-for-service medical care.

Healthcare costs continue to rise. The Clinton administration proposes the Health Security Act to provide universal health coverage, but it fades under heavy pressure.

Medicare expands to cover prescription drugs as health care costs continue to rise.

The Affordable Care Act (ACA) establishes the first universal health insurance system in the U.S., including an individual and employer mandate to have health insurance.

The ACA Marketplace opens for its first season of open enrollment, to allow people secure health insurance as required for 2014.

The American Health Care Act (AHCA) repeals some provisions of the ACA, such as tax penalties for the uninsured. (See article on page 6).

Wishing you a SAFE AND HAPPY HOLIDAY SEASON.

Agriculture isn’t just a market we serve. It’s what we’re founded on. It’s who we are. And we’re so thankful for the abundance provided by the hardworking individuals who work tirelessly to feed, clothe and fuel the world every day of the year. It’s an honor to serve you. Our team members from Illinois, Minnesota and Wisconsin wish you a joyous holiday season.

Learn more at compeer.com.

(844) 426-6733 | #CHAMPIONRURAL
WISHH Elects Two Illinois Producers to Executive Committee

Two current Illinois Soybean Association (ISA) directors have been elected to the American Soybean Association World Initiative for Soy in Human Health (WISHH) Program Committee for 2018-2019. Officers include Chairman Daryl Cates and Secretary Roberta Simpson-Dolbeare and committee member Bill Wykes, past ISA chairman. Outgoing committee members from Illinois include Stan Born, Tom Kentner and Jeff Lynn. WISHH works to create customers for U.S. soy use in livestock feeds and human foods in developing markets in Asia, Africa and Central America where demand for soy protein is on the rise.

ISA Supports Chicago Ideas Week

The Illinois Soybean Association (ISA) supported Chicago Ideas Week during October. The eighth annual event was built on the idea that sharing new ideas and perspectives can instigate action and help change the world. More than 200 talks, labs and events were held throughout the week, focusing on topics ranging from politics to culture and urban planning to innovation, featuring thought leaders from around the globe. Chicago Ideas Week was a great opportunity to increase ISA’s visibility and leadership with forward-thinking influencers throughout Chicago.

Illinois Farm Families Features Various Fieldprint Platform Applications

The same Field to Market Fieldprint Platform that allows farmers to measure their environmental impact can also help consumers learn where their food comes from via the supply chain. That is the message being delivered by Illinois Farm Families, Illinois farmers who support state and commodity groups and membership associations, including ISA. The platform is a pioneering assessment framework that empowers brands, retailers, suppliers and farmers at every stage in their sustainability journeys, to measure the environmental impacts of commodity crop production and identify opportunities for continuous improvement. Learn more about the online tool at fieldtomarket.org.

More Students Get Involved with Illinois Ag Education

Facilitating Coordination in Agricultural Education (FCAE) officials report total student enrollment in ag education in Illinois this year stands at 33,050, which is an increase in numbers of 1,395 students. In addition, total FFA membership is 18,453, up from 17,535 a year ago and the first time ever that FFA membership has exceeded 18,000 students. FCAE is a state project administered through the Illinois State Board of Education in cooperation with the Illinois Committee for Agricultural Education to improve ag education within the state.

New College of ACES Facilities Highlight Learning Opportunities

Students in the College of Agricultural, Consumer and Environmental Sciences (ACES) at the University of Illinois are learning hands-on about food systems, starting from seed improvement and soil science to commercial food processing and bioprocessing technologies, thanks to new facilities and renovations across campus. The Integrated Bioprocessing Research Laboratory (IBRL), Turner Hall Transformation and the renovated Food Science and Human Nutrition (FSHN) Pilot Processing Plant, located in the Agricultural Engineering Sciences Building, provide new opportunities to learn about the broad range of research and learning in the college through facilities that bridge the gap between scientific discovery and industry application.

Orlando is Site for 2019 Commodity Classic

Commodity Classic, America’s largest farmer-led, farmer-focused convention and trade show, will be held in Orlando, Florida, Feb. 28-March 2, 2019. Commodity Classic offers a robust schedule of high-quality educational sessions and seminars on a wide range of topics of critical importance to farmers. Last year’s Commodity Classic in Anaheim, Calif., attracted thousands of America’s best farmers with an average gross farm income of $1.51 million and average farm size of 2,850 total acres. Established in 1996, Commodity Classic is presented by the American Soybean Association, National Corn Growers Association, National Association of Wheat Growers, National Sorghum Producers and the Association of Equipment Manufacturers. For more information regarding registration, visit www.commodityclassic.com.

Calendar of Events

ISA Board Meeting
> November 26-28 • Bloomington, Ill.

2018 DTN Ag Summit
> December 3-5 • Chicago, Ill.

Soy Transportation Coalition Annual Meeting
> December 9-11 • New Orleans, La.

Soy Leadership Forum
> January 10-11 • Coral Gables, Fla.

Commodity Classic
> February 28-March 2 • Orlando, Fla.
HERE’S HOW THE SOY CHECKOFF WORKS. The national soy checkoff was created as part of the 1990 Farm Bill. The Act & Order that created the soy checkoff requires that all soybean farmers pay into the soy checkoff at the first point of purchase. These funds are then used for promotion, research and education at both the state and national level.

**FARMERS SELL BEANS TO ELEVATORS, PROCESSORS & DEALERS**

1/2 of 1% of the total selling price collected per the national soybean act & order

**ROI TO THE FARMER**

* Led by 73 volunteer soybean farmers, the United Soybean Board (USB) invests and leverages soy checkoff dollars to MAXIMIZE PROFIT OPPORTUNITIES for all U.S. soybean farmers.

unitedsoybean.org
Virus or Antidote?

How your voice can heal democracy

> BY MIKE LEVIN, Illinois Soybean Growers director of public policy and regulatory affairs

Pull up Twitter or turn the TV to any news network and you can cut the tension with a knife. Our country is divided. Certainly, we need differing political opinions and a voice to have a thriving democracy. But gone are the days we could agree to disagree. Now we just disagree.

The signs came way before our current administration: A Pew Research study conducted annually since 1994 shows that across 10 measures, the average partisan gap has more than doubled from 15 percentage points to 36 points. The same study shows that partisan aversion is vast. As of last year, roughly four out of every 10 Republicans or Democrats maintain a very unfavorable opinion of the other. That number was less than 20 percent in 1994.

The question is — can we be resuscitated? Can we restore the health of our democracy? We can, but it requires a shift in how we act and participate.

It requires a change in rhetoric from negative, aggressive and dismissive to actually listening, which often uncovers opportunities to identify what resonates with the other and contributes to a more productive political discussion.

It requires putting your ballot where your mouth is. While social media would make us think we're as passionate and vocal as ever about our democracy, voting statistics don't reflect that. In the 2016 election, an average of six in 10 eligible voters cast ballots — according to the United States Elections Project — right about where Illinois hovered. Another Pew Research study from this year shows the U.S. trails most developed countries in voter turnout. The U.S. placed 26 out of 32 among nations in the Organization for Economic Cooperation and Development (OECD).

It requires educating ourselves. What happened to a marketplace of ideas? Instead we tend to live in echo chambers that preserve confirmation bias. We should welcome the opportunity to debate with fellow Americans — in a constructive way — instead of only seeking affirmation from those who think like us. Why? Because it forces us to look at our own arguments: Are they sound? Am I missing facts? Where am I sourcing this information? Be discerning — especially when reading political content on social media. Does it add up? Google it, look for vetted sources, check it out.

One of the greatest American values is the freedom and the power of our voice. There's pride in that. There's weight in that. The question is — will our voice be a virus or the antidote to the success of our democracy?

> By Mike Levin, Illinois Soybean Growers director of public policy and regulatory affairs
WHAT IS HIREDNAG?

HIREDnAg is a USDA-funded project and the first to attempt to understand farmer and rancher health insurance navigation. Our team is made up of research and Extension professionals committed to understanding how health insurance decisions impact farm and ranch families, and using that information to develop educational tools to support a healthy agricultural sector.

I believe we need a vibrant ag economy, and adequate health insurance is a big part of that. Farm business plans typically don’t mention health insurance or how healthcare costs affect the farm. As we face federal and state changes in health insurance, we are capturing those experiences and taking them back to USDA and state officials for additional action.

WHAT ARE THE KEY FINDINGS FROM YOUR RESEARCH?

I had never heard farm families cry over the phone until we began to look into health insurance. Farmers don’t often get asked about their thoughts on having access to healthcare and coverage.

The number one finding from our survey is that health insurance is part of risk management. Farmers need to explore how it fits into their operation and have honest conversations with family members about whether they will have to sell assets for long-term care. It is possible the next generation will have to pay much higher land costs because of healthcare issues.

Second, is the serious impact on young farmers and the importance of obtaining insurance that is affordable. Young farmers are clear that healthcare for their children a priority and that affects the decisions they make about their business. We don’t want farmers to have to lose their farms if something happens to them and they do not have health insurance to manage costs.

Finally, from a rural development perspective, agriculture is a big part of rural communities. Often the best off-farm jobs are in health care, education and the government sectors. There can be huge impacts to farm families and rural economies when there are cutbacks and changes to benefits in the public sector. When we see rural hospital closures, we lose good-paying healthcare jobs and communities are at a disadvantage for attracting new employers.

HOW CAN FARMERS USE THE INFORMATION YOU HAVE DEVELOPED TO MAKE INSURANCE CHOICES?

I encourage farmers to visit the website and first review our tools and resources section. Two videos on the site can be viewed by families for discussion. The Smart Choice and Smart Use Health Insurance resources provide a workbook to review with family members regarding cost, coverage and any upcoming healthcare changes and to compare plans. The resources were put together by University of Maryland and University Delaware Extension specialists.

WHAT SHOULD FARMERS IN GENERAL DO TO MAKE THE BEST HEALTH INSURANCE CHOICES?

Open enrollment is underway, and no matter what plan farmers are covered under, now is a good time to consider how health insurance and coverage will fit into their budgets and farm businesses. The Smart Choice and Smart Use documents provide worksheets for determining costs for various health coverage options and how they fit into monthly spending.

WHAT ARE NEXT STEPS FOR HIREDNAG?

We surveyed farmers and ranchers in 10 states and plan to re-survey them to hear about their experiences during the last two years. We are not officially surveying farmers in Illinois, but want to hear from anyone who wants to discuss. Farmers can contact me at inwood.2@osu.edu.

Shoshanah Inwood, Ph.D., is a rural sociologist, assistant professor at Ohio State University and project director for HIREDnAg. Her work centers on creating economic development through food and agriculture and supporting the next generation of farmers in light of an aging and shrinking farm population. Visit hirednag.net for more information.
“It’s about viewing a healthcare model differently, broadening it to look at social determinants and getting people to think about the differences in how we care for people…That shift in thinking is a challenge…We, as the healthcare industry, especially in rural markets, need to recognize that we need partnerships. We can’t be the answer to everyone’s health issues. If we’re going to be sustainable in rural markets, we can’t compete. We really need to work together.”

KEN BEUTKE | president, OSF Center for Health-Streator, Modern Healthcare, Sept. 8

“Insurance companies can cherry pick profitable markets for participation and are not obliged to provide service to markets with less advantageous risk pools. The demographic realities of rural populations mean rural Americans have greater healthcare needs, making the market less profitable and less desirable for an insurance company with no incentive to assume the risk.”

JESSICA SEIGEL | National Rural Health Association Government Affairs Communications Coordinator

“We are seeing more consultation between small and large hospitals, and telemedicine is how they connect. It can even involve online diagnostics that give live reviews of a patient’s condition in real time. If they are in an ambulance, for example, specialists can monitor what’s going on, and advise the paramedics so they can go straight to where they need to go.”

DOUG WILSON | Illinois director, USDA Rural Development

SUNDAR PICHAI | CEO of GOOGLE, in an interview with NDTVCoalition
Getting your B wrong is frustrating.
Aspire® is a superior boron delivery system combining two forms of boron with potassium in every granule for uniform nutrient distribution. Fields applied with Aspire are proven to improve crop performance with higher yields than standard methods. Ensure your B is right where you need it for optimum plant health.

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