NATIONAL RESOURCE CENTER *for*
PARTICIPANT-DIRECTED SERVICES

Issue Brief January 2014

FMS Membership Edition

THE IMPACT OF THE AFFORDABLE CARE ACT ON EMPLOYERS AND EMPLOYEES IN PARTICIPANT DIRECTION

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The Impact of the Affordable Care Act on Employers and Employees in Participant Direction

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Executive Summary:

The Affordable Care Act (ACA) provides new ways for employers and their workers to obtain health insurance, and also mandates that large employers provide health insurance to their workers or pay a penalty. The issue brief discusses both the opportunities and challenges posed by these changes for Financial Management Services (FMS) providers and the workers they serve.

For employees, the ACA imposes penalties on those who are not covered by a health insurance plan, but also introduces two new ways of obtaining health insurance. First, the ACA creates Health Insurance Marketplaces in each state where individuals can compare plans and buy insurance. Individuals can receive federal subsidies to buy insurance in the marketplace if their household income is between 100% and 400% of the Federal Poverty level, and if they do not have access to affordable employer-provided health insurance. Second, the ACA gives states the option to expand Medicaid to cover all adults with incomes below 138% of the Federal Poverty Level, significantly broadening Medicaid eligibility in participating states especially for adults without dependents.

For providers operating under the Fiscal/Employer Agent model of participant direction, the ACA does not require participant employers to provide health insurance to their workers. However, participants who wish to offer their workers the opportunity to enroll in a group plan will be able to do so via the Small Employer Health Options Program (SHOP) marketplace created by the ACA. Employers do not have to contribute to the cost of premiums in order to offer a SHOP plan, but they may be eligible for a tax credit if they choose to cover at least 50% of the cost.

Providers operating under the Agency with Choice model of participant direction and who employ more than 50 full-time equivalent workers will have to pay tax penalties if they do not offer health insurance to their full-time workers and their dependents starting in 2015. The brief examines the data provided by a typical Agency with Choice employer and finds that 14% of the workers had enough hours to qualify as full-time workers based on a one year measurement period. Such workers will have to be offered health coverage in order to avoid tax penalties.

FMS providers, as well as workers in participant direction programs, should familiarize themselves with the ACA in order to take advantage of the opportunities it offers and to avoid potential tax penalties.

Acknowledgements:

We would like to express our very great appreciation to Mollie Murphy and Mike Hanshew for their valuable insights and contributions to the development of this issue brief. Without their content expertise, this brief would not have been made possible. Special thanks also to Merle Edwards-Orr, Suzanne Crisp, Molly Morris, Sierra Horn and Joe Keune for the support they provided throughout the entire development process. Without the guidance of all involved, the paper would not have met the high standards of the National Resource Center for Participant-Directed Services.

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Introduction

This issue brief outlines the impact of the health care coverage expansion provision of the Affordable Care Act (ACA) in participant direction. Part I describes the Medicaid expansion as well as the Health Insurance Marketplace and associated federal subsidies, and explains how employees can use these new vehicles to obtain insurance that is not job-related. Part II discusses options for obtaining health insurance for employees of participants enrolled in programs operating under the Fiscal/Employer Agent (F/EA) Model. Part III discusses the implications for providers using the Agency with Choice model. Using wage and hour data provided by one such provider, it estimates the potential impact of the employer responsibility mandate of the ACA over the course of one year for the agency employer, as well as the availability of Medicaid and federal subsidies for the employees.

The ACA also imposes a mandate on individuals to obtain health insurance or face penalties. These penalties go into effect in 2014 and will increase substantially over the subsequent two years.[1] This issue brief is addressed towards employers and therefore does not go into detail about the individual penalties. However, employers should be aware that the demand for health insurance benefits will probably increase as the individual penalty is implemented. Employers who are able to provide health insurance, or, in the alternative, educate their employees about their options for obtaining coverage individually (described in Part I of this brief), may be better positioned to recruit and retain qualified workers.

I. New Options for Individual Health Insurance Coverage

The ACA expands the ways in which individuals will be able to obtain health insurance. It creates a new marketplace where individuals can shop for health insurance plans whose cost will be federally subsidized for those meeting certain income thresholds. It also provides strong financial incentives for states to expand Medicaid coverage to individuals and families with incomes below 138% of the Federal Poverty Level.

The Individual Healthcare Marketplace and Federal Subsidies

Individuals will be able to buy health insurance through new Individual Health Insurance Marketplaces (also referred to as Health Insurance Exchanges) created under the ACA. The marketplaces will be available in all states, however the plans offered and premiums will vary from state to state. Individuals with household incomes below a certain threshold, and who do not have access to affordable coverage through their employers, will be eligible for federal subsidies to offset some of the cost of buying individual insurance through the marketplace.

The lower the person's income, the larger the subsidy will be, so long as the income is above 100% of the Federal Poverty Level. Individuals and families with incomes of less than 100% of the Federal Poverty Level will not be eligible for subsidies. The subsidy also increases with the individual's age but so does the cost of insurance. The subsidy gets phased out completely at an income level that varies between 300-400% of the Federal Poverty Level. The actual phase-out threshold depends on the age of the individual. The following scenarios illustrate the potential size of the subsidies.

[1] For a summary chart explaining the individual mandate penalties, see *The Requirement to Buy Coverage Under the Affordable Care Act* available at http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/

Scenario 1

Worker A is single with no dependents, 21 years old and has an income of $20,000 a year. The cost of an individually-purchased silver-level health insurance plan for Worker A is predicted to be $2,536 a year on average, out of which the federal government would pay $1,514 and Worker A would pay $1,021.[2] If Worker A's income is $30,000 a year, the government would pay only $24 a year leaving Worker A to pay $2,512.

Scenario 2

Worker B is single with no dependents, 50 years old and has an income of $20,000 a year. The cost of an individually-purchased silver-level health insurance plan for Worker B is predicted to be $4,528 a year on average, out of which the federal government would pay $3,506 and Worker B would pay $1,022. If Worker B's income is $30,000 a year, the government would pay $2,016 leaving Worker B to pay $2,512.

When comparing costs between insurance provided by the workplace and marketplace plans, employees will have to consider that the marketplace insurance premium is paid with after--tax -dollars, whereas premiums for employer-provided health insurance are paid pre-tax. Therefore, if an employer-provided plan and marketplace plan cost the same and provide the same benefits, employees will prefer the employer-provided plan because the premium is paid pre-tax.

Medicaid Expansion

The ACA offers states the option to expand Medicaid to cover all individuals with incomes below 138% of the Federal Poverty Level, regardless of assets or family size. (Previously, single adults with no dependents were often not eligible for Medicaid.) However, the Supreme Court ruled that the federal government cannot force states to implement the Medicaid expansion provisions of the ACA.[3] States therefore have the option to either adopt or reject the Medicaid expansion. [4]

In states that adopt the Medicaid expansion, employees with incomes below 138% of the Federal Poverty Level will be eligible for Medicaid coverage and hence will not need to buy health insurance either individually or through their employer.

In states that do not adopt the expansion, Medicaid eligibility varies from state to state and can depend on multiple factors other than income, such as number of dependents. Adults with incomes at or above 100% of the Federal Poverty Level are unlikely to qualify for Medicaid in such states, but they will nevertheless be eligible for federal subsidies if they do not have access to employer-provided affordable insurance. These subsidies will cover most of the cost of individually-purchased health insurance for low-income individuals with incomes at or above 100% of the Federal Poverty Level.

However, adults with incomes below 100% of the Federal Poverty Level will not be eligible for federal subsidies and might also be ineligible for Medicaid, depending on the rules of the state where they live. The

[2] The estimates are based on data provided by The Kaiser Family Foundation, available at http://kff.org/interactive/subsidy-calculator/.. The estimates are based on the predicted average cost of insurance across all U.S. states according to data available in September 2013. The actual cost of health insurance plans will vary.
[3] The decision is available at http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.
[4] A map of where states currently stand on the Medicaid decision is available at: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#map

income threshold for Medicaid qualification for adults in states that are not adopting the expansion is usually lower than the Federal Poverty Level, even for adults with dependents.[5] The biggest impact of a state's decision not to expand Medicaid will probably be felt by childless adults, who will continue to be ineligible for Medicaid in most states that do not adopt the expansion.

This means that in states that do not adopt the expansion, an employee earning on or slightly above 100% of the Federal Poverty Level, who is not eligible for Medicaid, will nevertheless be eligible for federal subsidies that cover almost the entire cost of health insurance, while an employee earning 99% of the Federal Poverty Level will be ineligible for such subsidies.[6] As an example, for a single individual with income at the Federal Poverty Level of $11,490, the estimated unsubsidized cost of health insurance at the age of 30 is $3,426 per year, out of which $3,196 would be covered by subsidies and $230 is the amount the individual would have to pay out-of-pocket. An individual with income of less than $11,490 per year would not receive any subsidies. This gap in coverage exists because the law regarding subsidies was written with the assumption that the Medicaid expansion would be implemented in all states. Thus, employees with incomes below 100% of the Federal Poverty Level who are nevertheless ineligible for Medicaid in their particular state, and are not offered employer-provided insurance, are most at risk of not being able to afford insurance at all because they cannot receive any subsidies for buying insurance through the Healthcare Marketplace.

II. The Affordable Care Act and the Fiscal/Employer Agent Model

The employer mandate of the ACA that requires large employers to provide health insurance to employees does not apply in the F/EA model of participant direction. In the F/EA model of participant direction a participant, or his or her representative, serves as the common law employer of workers who provide service to the participant. A participant or representative as the employer is not likely to ever be considered a large employer because a single participant is highly unlikely to employ 50 full-time employees, so participants in the F/EA model will not be required to provide health insurance to employees. This is not necessarily a disadvantage for employees of participants in F/EA programs, because an employee who does not have access to affordable employer-provided insurance can qualify for federal subsidies for purchasing individual insurance as long the employee earns over 100% of Federal Poverty Level (as described in Part I of this brief), whereas an employee offered affordable insurance by their employer cannot qualify for subsidies even if the subsidies would have been more advantageous. Due to these subsidies, it is possible that an employee would have to pay less for health insurance if his or her employer (i.e., the participant in the F/EA model) does not offer a health insurance plan. Participants may want to make sure that their workers are aware of all options for obtaining health insurance, especially given that workers will have to pay penalties if they do not have health insurance due to the individual mandate imposed under the ACA.

The ACA provides several other benefits to participant employers and to their employees: including the Small Employer Health Options Program (SHOP), the Small Business Healthcare Tax Credit, individual coverage for employees through Marketplace plans, and expanded Medicaid coverage in participating states.

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[5] A summary of the Medicaid income eligibility limits in all states can be found at: http://kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-adults-at-application-effective-january-1-2014/

[6] For an estimate of the number of people in non-expanding states who will not be eligible for either Medicaid or federal subsidies due to the coverage gap, see the Kaiser Family Foundation state profile reports available at: http://kff.org/state-profiles-uninsured-under-aca/.

The Small Employer Health Options Program (SHOP)

The Small Employer Health Options Program (SHOP) is an insurance marketplace created by the ACA for employers with 50 or fewer employees.[7] It allows small employers to choose a group health plan to offer to their employees. Participants who were previously unable to find group health insurance as small employers will now be able to select a group health plan through SHOP and offer their employees the opportunity to enroll in it.

To be eligible to offer a SHOP plan, an employer must offer coverage to all full-time employees. An employee is considered full-time if that employee works more than 30 hours per week or 130 hours per month. Employers can choose how much or how little they want to contribute towards the premiums. However, at least 70% of employees must choose to enroll in the plan in order for the plan to be purchasable through SHOP (excluding employees who have coverage through another employer plan, Medicare, Medicaid, the military, or veterans' programs). Therefore, a participant who is unable to contribute towards premiums might not have enough interest among employees to offer a plan through SHOP, as the employees may find it more advantageous to buy federally-subsidized health insurance in the individual market.

The Small Business Health Care Tax Credit

Participant employers who offer a plan thorough SHOP and contribute at least 50% of the cost of premiums towards health insurance will be eligible for the Small Business Health Care Tax Credit.[8] Starting in 2014, the maximum credit will be 50% of the premiums paid. The percent of the credit depends on the employer size and average wage; the smaller the employer and the lower its average worker income, the larger the credit will be. Employers with up to 10 employees and average worker wages of up to $25,000 per year are eligible for the maximum credit. However, only households that have an income tax liability would be able to benefit from the credit, because the credit can only be applied towards offsetting a tax liability and cannot be redeemed as a tax rebate. Participants who qualify for Medicaid based on income are therefore unlikely to be able to use the tax credit. However, participants in higher-income households (who are enrolled in Medicaid under the Medicaid Buy-In Program) may have a tax liability that can be offset by the credit. It remains to be seen, however, whether the credit will be allowed in cases where the expenses that lead to the credit is paid with Medicaid funds.

Individual Coverage via the Marketplace or Medicaid

As discussed in Part I of this brief, employees with incomes above 100% of the Federal Poverty Level who do not have access to an affordable employer-provided group health plan will have the option to purchase individual insurance on the Healthcare Marketplace created by the Affordable Care Act. Depending on their income, employees may qualify for federal subsidies to offset the cost of such insurance.

Medicaid coverage may also be available to low-income employees, depending on the Medicaid eligibility rules of each state.

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[7] For an overview, see *What is the SHOP Marketplace?*, available at https://www.healthcare.gov/what-is-the-shop-marketplace/

[8] For more information see *What You Need to Know about the Small Business Health Care Tax Credit,* available at http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers.

Summary of Options for Fiscal/Employer Agents

Under the **Fiscal/Employer Agent (F/EA)** model of FMS, the participant directly hires, schedules, and supervises his or her own workers, serving as the common law employer. To support the participant in this role, the F/EA takes on liability for the federal taxes, manages state and local taxes, and handles payroll duties so that the participant is able to focus on directing his or her services. Two models of Fiscal/Employer Agent exist: Vendor F/EA and Government F/EA. The primary difference between the models is the type of entity operating as the agent. When a government entity operates as the agent, the model is Government F/EA. When a government entity hires a provider to serve as the agent, the model is Vendor F/EA.

Participants in F/EA programs are legally allowed to offer a group health insurance plan to their employees through the new SHOP marketplace for small employers. The Small Business Health Care Tax credit can partially defer the cost of offering such insurance if the participant employer is able to fund at least 50% of the cost of insurance. However, a group plan can only be offered through SHOP if at least 70% of employees choose to enroll in the plan. Therefore participants will probably want to communicate with their workers ahead of time to determine whether there is enough interest in the plan. How a participant could use his or her program or budget funds to pay the employer cost of the insurance will depend on program rules. NRCPDS continues to work to determine how such costs may, or may not, be able to be funded with Medicaid waiver program dollars.

As an alternative to a SHOP group health plan, the employees themselves can purchase individual insurance on the newly created Individual Healthcare Marketplace, and the cost of such insurance will be partially subsidized depending on the employee's household income. Medicaid coverage may also be available for low-income employees, especially in states that are adopting the Medicaid expansion.

Unlike Agency with Choice employers, participants in F/EA programs are not subject to the employer responsibility mandate and will not incur tax penalties if they fail to offer a group health insurance plan, because the employer mandate only applies to employers with 50 or more employees and a single participant is extremely unlikely to employ 50 people. It is nevertheless important for F/EAs to educate participant employers about the health insurance options available for their caregivers, because the long-term sustainability of the F/EA model and its ability to attract employees may depend on offering health insurance options that are competitive with those provided by Agency with Choice and other large employers. Some states may look to the F/EA option as cheaper because there is no requirement to provide health insurance to workers under an F/EA model. However, the lack of health insurance may make F/EA less popular with workers and may therefore limit the ability of participants to recruit caregivers.

If F/EA programs do not offer health insurance benefits while Agency with Choice programs do so, then F/EA may end up being seen by employees and employee advocate groups as the less desirable model of participant direction. F/EAs can counter this perception by exploring ways in which the cost of group health insurance plans obtained through the SHOP marketplace could be covered by their programs, or alternatively by informing participants and their employees about their options for obtaining Medicaid coverage and for purchasing subsidized health insurance on the Individual Marketplace. We might expect that such efforts to inform workers and assist them in obtaining health insurance will help participants recruit and keep qualified workers, in the face of competition for labor from large employers who are likely to be offering health insurance as a job benefit due to the ACA employer mandate.

III. The Affordable Care Act in the Agency with Choice Model

The **Agency with Choice model** of FMS is based upon a joint employer (also sometimes called "co-employer") relationship of the worker(s) that provide services to the participant. An Agency with Choice model is used in programs in which participants receive services from workers that they select and supervise to some degree. Most participant direction program agencies implement this model intending for the agency to be a worker's "primary" employer while the participant is the "managing" or "secondary" employer.

FMS providers operating per the Agency with Choice (AwC) model who have at least 50 full-time equivalent employees will be subject to the employer responsibility mandate under the ACA. The mandate requires large employers to provide health insurance to full-time employees, or pay a penalty.[9]

Using the data provided by an FMS provider operating under the AwC model, we estimated the impact of the ACA on a typical agency employer. The data spans one year and includes the hourly wage and monthly hours worked for 2,576 employees. The employees provide service to participants, and the participants and the agency co-employ the workers under an AwC model of FMS. The agency serves as the primary employer. The following section summarizes our conclusions.

Case Study: The Impact of the ACA on an AwC Provider

What percentage of employees would qualify as full-time employees who must be provided health insurance?

An employee is considered full-time under the ACA if that employee works more than 130 hours per month. The monthly hours of employees in the sample data vary greatly from month to month in no consistent pattern. It is not unusual to find employees who worked over 200 hours in some months and less than 100 in others. Such employees are quite likely to qualify as variable-hour employees, as long as the agency does not know ahead of time whether a particular employee will be working more than 130 hours a month. An agency faced with such a pattern of working hours will most likely benefit from using the variable-hour safe harbor method for determining which employees should be considered full-time. Under the safety harbor method, each employee's hours are calculated over a measurement period of up to a year. If the employee's hours are over 130 per month on average during the chosen measurement period (or 1560 hours total for the year), then the employee is considered full-time.

In the sample data, only 14% of employees worked at least 1560 hours over the entire year. Thus, approximately 14% of employees would be considered full-time and would have to be provided health insurance under the employer responsibility mandate of the ACA.

In states that adopt the Medicaid expansion, which employees would qualify for either Medicaid or subsidies for individually purchased insurance?

[9] For detailed information on the employer mandate and how it applies to AwC providers, see our April 2013 issue brief: *The Affordable Care Act in Participant Direction: Understanding Employer Responsibilities*, http://web.bc.edu/libtools/details.php?entryid=378.

An employer has no way to determine with certainty which employees qualify for Medicaid, because the qualification criteria are based on the employee's family size and on whether the employee's family has other sources of income.

The Medicaid eligibility threshold in states that adopt the expansion is 138% of the Federal Poverty Line. For a single employee with no dependents, this threshold is $15,856 in 2013. For a family of four, the threshold is $32,499.

A single employee with no dependents, working at the ACA full-time threshold of 30 hours a week or 1560 hours a year, would be eligible for Medicaid if the employee's hourly wage is up to $10.16. If that employee works 40 hours a week, the employee would be eligible for Medicaid with an hourly wage of up to $7.62 per hour. However, if that employee has three dependents and the family has no other income, the employee would be eligible for Medicaid if the employee's wage is up to $20.83 per hour if working 30 hours a week, and up to $15.62 per hour if working 40 hours a week. These scenarios illustrate that it would be very difficult for an employer to accurately estimate the number of workers eligible for Medicaid based on hourly wages.

Employees whose household income is above 138% of the Federal Poverty line but below approximately 400% of the Federal Poverty Line (the actual cutoff threshold varies on the individual's age), and who do not have access to affordable employer-provided health insurance, will be eligible for federal subsidies towards the cost of individually purchased insurance. The subsidies get smaller as the income level increases. In our sample, almost 100% of employees have incomes under 400% of the Federal Poverty Line ($45,960). Their eligibility for subsidies ultimately depends on the income level of the entire household, as well as on the number of dependents, and therefore cannot be precisely estimated based on our data. If we assume that the household income level of most employees is similar to their individual income level (compared to the Federal Poverty Level for their entire household size), then (in states that adopt the Medicaid expansion) almost all employees who are not Medicaid-eligible and who are not offered affordable insurance at work should be eligible for federal subsidies towards the cost of individually-purchased insurance.

In states that are not adopting the Medicaid expansion, how many employees would be ineligible for both subsidies and Medicaid?

In states that do not adopt the expansion, it is not possible to determine Medicaid eligibility based on the data provided, because eligibility varies from state to state based on factors such as assets or family size of the workers. Adults without dependents will usually not qualify for Medicaid regardless of income in most states that are not adopting the expansion, but workers with families might qualify.[10] However, even for workers with dependents, the income threshold for qualification for Medicaid is lower than the poverty level in many states. Therefore, the percent of employees who would qualify for Medicaid in non-expansion states would almost certainly be significantly lower than in expansion states.

As explained in Part I, individuals whose incomes are below the Federal Poverty Line will not be eligible for subsidies in the marketplace regardless of whether they are eligible for Medicaid under the rules of their state. In the sample data, based on the single individual poverty line threshold and assuming the employee had no other sources of income, the percentage of employees who would <u>not</u> be eligible for subsidies because their

[10] Medicaid eligibility guidelines by state are available at: http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf

income was below the Federal Poverty Line Figure of $11,490 (based on the 2013 Federal Poverty Line Figure[11]) is 72%.

Summary of Implications for Agency with Choice Providers

AwC providers, as typically large employers, are subject to the employer responsibility mandate that imposes tax penalties if they do not provide health insurance to full-time employees. If no health insurance plan of any kind is offered, the penalties are $2,000 per full-time employee per year for each employee, including for employees who may be receiving Medicaid. If a health insurance plan is offered but the plan does not provide minimum value, or is not affordable with respect to some employees based on their income, the penalty is $3,000 per year but only applies for employees who purchase insurance on the Individual Marketplace and receive federal subsidies. A plan is considered affordable if the cost to the employee for self-only coverage does not exceed 9.5% of the employee's household income. Employers may use the employee's wages as the affordability benchmark instead of the employee's household income, in which case the plan is considered affordable if the cost does not exceed 9.5% of the employee's wages. An employee who is offered unaffordable insurance but is eligible for Medicaid will not trigger the $3,000 penalty. Furthermore, the penalty for an employer who offers a health insurance plan cannot be larger than the penalty the employer would have paid if no plan had been offered. Unlike healthcare premium expenses, tax penalties are not deductible as expenses, so employers should factor in their tax rate when comparing a tax penalty with a healthcare premium expense.

In the sample data, only a small fraction (14%) of employees in Agency with Choice programs are full-time employees. If no insurance is offered to these full-time employees, the penalty would be $2,000 per employee applied to the total number of employees minus 30. However if a health insurance plan is offered, even an unaffordable one, a penalty of $3,000 would be imposed but only for employees who are not eligible for Medicaid and receive subsidies for buying insurance on the Individual Marketplace.

Agencies that offer unaffordable insurance will be exposed to the $3,000 penalty with regards to employees who are eligible for subsidies but not Medicaid. No penalty is imposed for employees who are eligible for Medicaid. Therefore, the total penalty for an agency who offers an unaffordable plan is likely to be lower than if the plan had not been offered at all, because only workers who are not Medicaid-eligible and who actually choose to purchase individual insurance in the marketplace will trigger the $3,000 penalty. Also, due to a penalty cap written into the ACA, the total penalty for an employer who offers a health insurance plan cannot be larger than if the plan would not have been offered. An agency that wants to reduce penalties should therefore offer a group health insurance plan to all full-time employees, even if the insurance would be unaffordable for some employees. The cost of such insurance could be assessed in several ways. Some potential options would be assessing a fixed fee per participant, or assessing the cost as a percentage of payroll applied to all employees.

Conclusion

The ACA brings several important changes to health coverage options for people using participant direction options. For F/EA programs and their participants, the ACA introduces a new group health plan marketplace

[11] Subsidies will only be available once the Health Insurance Exchanges start operation on October 1, 2013, for coverage starting on or after January 1, 2013. Therefore, the 2013 poverty line figure was used with the assumption that average wages in 2013 would be similar to what they were when the data was collected.

that will enable participants to offer health insurance to their workers, and expands the Small Business Health Care tax credit to offset some of the cost of providing such insurance.

The ACA imposes a new requirement on Agency with Choice providers with more than 50 employees to offer affordable health insurance to employees or pay a penalty.

Employees in either F/EA or AwC programs will have two new options for obtaining health insurance. In states that choose to expand Medicaid, all those with household incomes below 138% of the Federal Poverty level will be eligible for Medicaid. In all states, individuals over 100% of Poverty Level will be able to buy private health insurance on a new Health Insurance Marketplace run by the states or federal government. Individuals with household incomes below 300-400% of the Federal Poverty Level, and who do not have access to affordable employer-provided insurance, will be eligible for federal subsidies to offset some of the cost of buying private insurance.