Obamacare and small business: Delays and "glitches" exacerbate uncertainty and economic consequences

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ABSTRACT

The Patient Protection and Affordable Care Act, known popularly as Obamacare, introduced sweeping changes to the healthcare system in the United States. The now infamous observation from Nancy Pelosi[1], Speaker of the United States House of Representatives, "we have to pass the [health care] bill so that you can find out, what is in it," is beginning to come to fruition. The problem plagued launch of the insurance exchange marketplace, via the HealthCare.gov website, has sparked frustrations and criticisms from the consuming public. The technical difficulties with the website were initially characterized by officials as "glitches," but it was subsequently obvious that problems were more severe and would require significant repairs while also leading to delays. Insurance issuers have sent millions of cancellation notices and more are expected to come. Both individuals and small businesses are threatened by penalties if they fail to obtain insurance on time, yet the exchanges are still not fully functioning. Those who have been able to obtain information on new policy pricing are widely reporting sticker shock. Enrollments have not met expectations for the system as a whole to function as intended, and this has led to uncertainties which most assuredly will have economic consequences. Scholarly researchers have not as yet addressed Obamacare adequately, and this present paper represents an initial effort to create conceptual frameworks.

Keywords: Obamacare, ACA, Affordable Care Act, ACA, Health Care, Small Business, Entrepreneurship, Economic Stresses

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[1] "Nancy Pelosi Pass the Bill to find out what is in it," 2010

INTRODUCTION

According to the National Bureau of Economic Research, "The most important long-run fiscal problem facing the United States is the rising cost of health care, which is the largest and single fastest growing element of both Federal and State government spending" (Gruber, 2012, p. 4). The Patient Protection and Affordable Care Act, (abbreviated PPACA, or shorter still, ACA), (Public Law 111-148) ("Patient Protection and Affordable Care Act," 2010), as well as amendments in the Health Care And Education Reconciliation Act of 2010 (Public Law 111 - 152) ("Health Care And Education Reconciliation Act," 2010), more popularly known as Obamacare, is "legislation that created the greatest single expansion of health care access and coverage in American history" (Neiburger, 2011). The law was intended, as is suggested by its name, to make health care more affordable. However, the rollout of Obamacare has been plagued by technical problems, criticisms and controversy. Central to the implementation of the law, has been the creation of health care insurance exchanges under the direction of the U.S. Department of Health and Human Services (HHS). The website known as HealthCare.gov, which opened on October 1, 2013, is the primary destination to which individuals and businesses have been directed to participate in these exchanges (otherwise known as the Marketplace).

From the very beginning, HealthCare.gov subjected users to freezing, crashing, and other site problems. At first these were characterized as mere "glitches" (Chumley, 2013; Weigel, 2013), but subsequent investigations have evidenced more severe problems including major security concerns and other issues that go far beyond such an upbeat description (minimizing design flaws) as that which was suggested in the first few days following the website's launch. Prior to the opening of the health care marketplace exchanges, it was evident that "many consumers were confused" (Siegel Bernard, 2013) about how they would actually work. The fact that exchanges have since been opened, yet plagued with problems (Ferenstein, 2013; "Health insurance exchanges: An update from the administration," 2013; Pearson, 2013; Radnofsky, Weaver, & Needleman, 2013; Young, 2013), could only exacerbate any sense of confusion and thereby contribute to uncertainty. "These problems are preventing people from buying a product, health insurance, that Obamacare forces them to buy, under penalty from the IRS" (Roy, 2013b).

Commitments to address the website issues were given (Pearson, 2013; Wallace, 2013; Young, 2013), targeting a November 1, 2013 date. As of the time of this writing, the date has not been changed but the level of functioning of the website has been ratcheted down from fully functioning to eighty percent. Insurance companies have sent millions of cancellation notices, and the Obama administration has responded by announcing that policies that have been cancelled can be restored through 2014 (Barrineau & Dastagir, 2013), but at best, a reinstatement of these cancelled policies will be up to insurance companies and insurance commissioners in the various states where individual policies have been cancelled. It has been predicted that small and larger employer plan cancellations will follow (as the media seems to have recently discovered analysis that was published in the *Federal Register* as of June 2010, discussed below). Then, there are issues of skyrocketing prices for some policies, especially those of individuals and families who are ineligible for tax credits or subsidies, as the nature of the risk pool as a whole in the United States is changed under the law. As a whole, the rollout has been widely acknowledged to be a "debacle" ("Health insurance exchanges: An update from the administration," 2013; Howell, 2013; Wallace, 2013).

Given that small businesses are responsible for creating approximately two-thirds of net new jobs ("Frequently Asked Questions about small business," 2012) and the unemployment rate has continued to persist at levels above seven percent since they first reached that point in December 2007 ("BLS: Labor force statistics from the Current Population Survey," 2013), effects of the Patient Protection and Affordable Care Act (ACA)—whether positive or negative—should be of concern to entrepreneurship scholars. Small businesses create the majority of jobs in the U.S. economy. Yet, they have "continued to face an uphill battle" ("The small business economy," 2012). As this present paper is being written, coverage from media outlets is nearly overwhelming. Yet, a paucity of research exists in the scholarly literature to date.

LITERATURE REVIEW

Upon undertaking the task of reviewing previous research that may have been conducted on Obamacare and its impact on small business, numerous attempts to identify previous works from scholarly literature were made. Search efforts included the Ebsco databases: *Academic Search Complete, Business Source Complete, Entrepreneurial Studies Source, and Small Business Reference Center*. Database searches returned approximately 115 items using the search terms "small businesses and Obamacare" combined. However, upon applying a search filter to limit returns to scholarly/peer reviewed articles only, the number of returned items was reduced to two. Neither of these two items were in scholarly journals that are specifically associated with small business or entrepreneurship as a primary focus. For purposes of comparison in rendering the above statement, the list that has been created and maintained by Katz (2012) entitled "*Core publications in entrepreneurship and related fields: A guide to getting published*" was employed. Following the same procedures suggested above, except using the search terms "small business and affordable care act," returned 553 unfiltered results. Upon applying a search filter to limit results to scholarly/peer reviewed journal articles, 68 were identified; a subsequent sort display procedure eliminated "exact duplicates," further reducing the number of items to 50.

While scholarly, many of these 50 items appeared in outlets that were not necessarily specific to small business and/or entrepreneurship. Example journal titles included *Health Affairs* (several), *Journal of Health Politics, Benefits Quarterly, Journal of Law, Medicine & Ethics, New England Journal of Medicine, Health Services Research*, and the like. A few items became evident that were business law and accounting related outlets such as *CPA Journal* (notwithstanding the scholarly article filter that was applied, this publication is targeted to the practice of public accountancy). While all of these articles are valued, having established through search efforts that the business disciplines at large, and especially small business and entrepreneurship journals, have failed to recognize the topic at hand, it was concluded that contributions to the literature are needed. Given the constant coverage in the popular news media of the Affordable Care Act and its ripple effects for the economy domestically and internationally, clearly, this topic should be considered relevant to small business and entrepreneurship scholars.

Following the above described efforts, search approaches were modified to include the search engines *Google* and *Google Scholar*. Items sought included information from business periodicals, consumer and news media outlets media. Where media such as business publications (e.g., *Bloomberg Business Week, Wall Street Journal, Forbes*) and websites

identified polls, studies, or government documents, rather than accepting any offered reporting or analysis as final, original sources were sought. Although finding these original sources was not always possible (due to inexact citation methods often used in consumer-oriented reporting), many were indeed identified. Because Obamacare is a subject of immense controversy and coverage, ample artifacts were found for review.

METHOD

The application of a qualitative research frame was identified as appropriate based on a paucity of existing scholarly research in the literature of business, small business, and entrepreneurship to date. The goal of qualitative inquiry is to achieve understanding (Maykut & Morehouse, 1994). Qualitative research methods provide a framework for discovery and to develop contextual findings. The development of contextual findings can be a precursor for future research, and qualitative methods are well suited as a means by which one may "uncover and understand what lies behind any phenomenon about which little is yet known" (Strauss & Corbin, 1990, p. 19). These qualitative methods are meant to tackle research problems from a different point of view as compared to quantitative methods, in that findings are not intended to be predictive or generalizable and demonstrate "proof" (Glesne & Peshkin, 1992, p. 21). The different points of view embedded in qualitative versus quantitative frameworks, however, does not discourage the use of mixed data sources on the part of the researcher; qualitative researchers may use numerous types of data to support their inquiries (*ibid*.).

Qualitative designs may incorporate any cultural artifact(s) (Fiske, 1994; Hodder, 1994). Examples of such artifacts that could be used as data may include interviews, direct observations, documents of numerous types such as field notes, diaries, and personal letters, or documents from public sources, biographies, software, audio, video, artwork, or still photography (Creswell, 1994, pp. 148-149). Given the acceptance of a wide variety of cultural artifacts as potential data sources, entire cultures (Hodder, 1994; Hofstede, Neuijen, Ohayv, & Sanders, 1990) or subparts such as the functioning of individuals, organizations, groups (Strauss & Corbin, 1990) may be studied in qualitative inquiry. Such sources also suggest interpretive and constructivist approaches (Barry, 1996; Schwandt, 1994) aimed at achieving understanding.

Data Sources, Collection, and Analysis

"The goal of qualitative research is to discover patterns which emerge after close observation, careful documentation, and thoughtful analysis" (Maykut & Morehouse, 1994, p. 21). Concurrent data collection and analysis, when regarded as an ongoing and iterative process, allow the researcher to develop grounded theory and new conceptual interpretations of phenomenon (Glesne & Peshkin, 1992; Strauss & Corbin, 1990), "particularly social phenomenon" (Maykut & Morehouse, 1994, pp. 43-44). Miles and Huberman (1994) defined qualitative analysis as "consisting of three concurrent flows of activity: data reduction, data display, and conclusion drawing/verification" which all take place along with data collection (pp. 10-12). In other words, while still continuing to collect data, engaging in analysis entails creating/sorting categories, formatting information, and reporting the results (Creswell, 1994). Government documents (laws, hearings, reports), business and professional periodicals, websites (public and private sector), and news media reports (in all formats, such as print, audio, and

video) were all used in this research. These data sources (as cited) have been used to develop narrative remarks and illustrations to support the conceptual frameworks which follow.

DISCUSSION

The following discussion is organized to address predominate themes which are associated with the impact of Obamacare and small businesses. There have been several reports and analyses presented in the media which essentially suggest that the majority of citizens, because they already obtain their health care coverage through employers and are likely to continue to do so, are not affected by Obamacare. However, the conceptual framework presented demonstrates an opposing view: it suggests that virtually all citizens are affected in some ways, as the law manifests both positive and negative consequences.

Not Calling Employer Shared Responsibility Payments (ESRPs) What They Are: Penalties

The U.S. Small Business Administration (SBA) applies standards such as number of employees and receipts to establish the size of businesses, and these standards may vary by industry ("Small business size standards," 2013). Historically, as a broader generalization the SBA has used the threshold of fewer than 500 employees to define what may be identified as small businesses by virtue of size. Under this definition over 99 percent of all businesses are categorized as small businesses ("Frequently Asked Questions about small business," 2012). Notwithstanding the SBA's "500 or fewer" threshold, Obamacare has added a layer of complexity and requires small businesses with the equivalent of 50 full-time employees (known as FTEs or Full Time Equivalents) to pay an Employer Shared Responsibility Payment (ESRP) if they do not provide health insurance for employees, and that coverage must meet "certain standards" ("Do I have to offer health coverage to my employees?," 2013).

As per the business section of the HealthCare.gov website, "No employer has to offer coverage. Some large businesses that don't offer coverage meeting certain standards may have to make a shared responsibility payment in 2015" (*Ibid*.). It should also be clarified that challenging calculations may be entailed for small businesses to derive their FTE's, as the hours of both full- and part-time employees as well as those of seasonal employees are to be counted in order to derive their FTEs, which are a first step in a process for calculating "responsibility" (Amato & Schreiber, 2013; Brighenti, 2011; "Small business health care tax credit questions and answers: Determining FTEs and average annual wages," 2013).

According to Neiburger (2011): "The ACA imposes a so called 'shared responsibility payment' (a euphemism for 'penalty')" (p. 69) in connection with the individual mandate (to buy health insurance, or not). This euphemism arose because the Supreme Court reasoned in *National Federation of Independent Business v. Sebelius*: "Those subject to the individual mandate may lawfully forgo health insurance and pay higher taxes, or buy health insurance and pay lower taxes" ("National Federation of Independent Business v. Sebelius, Slip Opinion, No. 11–393," 2012, pp. 12, footnote). This distinction over the use of the wording "penalty" versus "tax," was made an issue because "plaintiffs contend[ed] that Congress's choice of language—stating that individuals "shall" obtain insurance or pay a "penalty"—requires reading §5000A as punishing unlawful conduct, even if that interpretation would render the law unconstitutional" (*Ibid.*, p. 38).

As it applies to nonemployer firms (according to the SBA these comprise the vast majority of small businesses), the equivalent "penalty" is labeled as an Individual Shared Responsibility Payment (Olafson, 2013). Even though nonemployers have no paid employees, they are still are subject to federal income tax (Graham, 2013) as well as the penalties. Many of these nonemployer firms could conceivably be characterized as the most vulnerable in the economy, or the small business equivalent of seedlings in agriculture. These firms are often organized as sole proprietorships and operating home-based businesses. Over three-quarters (78.5 percent) of 27.9 million small business are nonemployer firms ("Frequently Asked Questions about small business," 2012).

"The major provisions of PPACA scheduled to take effect in 2014 affect employers with large numbers of part-time and low-paid workforces. For example, beginning in 2014 employers will be required to extend coverage to all employees working 30+ hours per week or face possible penalties" ("Health reform poses biggest challenges to companies with the most part-time and low-paid employees," 2012). According to a research report from the National Federation of Independent Businesses (NFIB), approximately "5,600 small employers therefore must introduce an offer of employee health insurance coverage by January 1, 2015 (postponed from the legislated January 1, 2014) or face a penalty" (Dennis, 2013). The "30+ hours per week" threshold explains why some employers are cutting hours and curtailing hiring (Shane, 2013).

Small Business Health Options Program (SHOP) Marketplace Pricing

Under the ACA, small business owners with fewer than 50 full-time equivalent (FTE) employees are directed via the HealthCare.gov to use the Small Business Health Options Program (SHOP) if they wish to provide insurance for their employees ("What is the SHOP Marketplace?," 2013). Each state is to offer its own version of the SHOP Marketplace (including rates). In order to be eligible to use SHOP, small businesses must meet other criteria, such as, offering coverage to all of full-time employees, "generally those working 30 or more hours per week on average" (*Ibid.*). Beyond offering SHOP coverage, in some states employees must accept the coverage in sufficient numbers percentage-wise to meet minimum participation thresholds. Small business owners who have no employees are not eligible to use the SHOP Marketplace and are directed to use the individual marketplace. According to the SBA, which in-turn cites U.S. Census data, non-employer firms comprise approximately 78.5 percent of all businesses ("Frequently Asked Questions about small business," 2012; "The small business economy," 2012; "U.S. Census Bureau nonemployer statistics," 2013).

By the same token, firms with over 50 FTE employees are not eligible to use the SHOP Marketplace, although plans are in place to change the threshold to 100 FTE employees beginning in 2016 ("What is the SHOP Marketplace?," 2013). Users may access an Excel file which contains SHOP pricing data for states in federally operated and state-federal partnership health care exchanges on the HealthCare.gov website ("SHOP health plan information for small businesses," 2013).

It should perhaps be pointed out that federally operated exchanges are basically those that are provided by the federal government because 26 states rejected the call to set up their own exchanges (Manning, 2012); 10 states implemented shared (state-federal) exchanges; and 15 states set up their own exchanges (Burch & Ketineni, 2013; Lahm, 2013). Thus, notwithstanding the exclusion of the 15 states with their own exchanges, according to the header in this Excel

file, it displays 44,778 records under headings including state, county, plan ("Metal") level, issuer, plan name, type (e.g., PPO, HMO) and rating area, followed by premiums for hypothetical policy classes including a 27 or 50 year old individual, family, single parent family, couple, and a child. One may apply various built-in filters, but for purposes of analysis for this present paper, a sort procedure was executed so as to view monthly family premiums in order of highest to lowest. Again, these rates are presumed by virtue of labeling to be specific to the Small Business Health Options Program (SHOP), which is available to employers with 50 or fewer full-time equivalent (FTE) employees. At the top of the range, family premiums that are applicable to several counties in Alaska were $2208.80 per month ($26,505.60 annually).

Under the ACA, those whose incomes fall below 400 percent of the federal poverty level may receive tax credits to offset the cost of premiums ("Affordable Care Act and HRSA Programs," 2013). Or, in other words, inversely, those whose incomes are above 400 percent of the federal poverty level, as one follows the logic, will not receive tax credits. According to poverty level guidelines discerned from several sources ("2013 Federal Poverty Level Guidelines (All states and DC except Alaska and Hawaii)," 2013; "Medical Assistance and Child Care Assistance Program: 2013 Federal Poverty Level (FPL) guidelines by family size," 2013; "Poverty Guidelines, Research, and Measurement," 2013; Sebelius, 2013), the 2013 poverty guideline for a family of 4 in Alaska is $29,440. 401 percent of this income is $118,054.40.

Thus, it appears that annual premiums for such a family, situated at 1 percent above the 400 percent threshold would comprise approximately 22.45 percent of its gross income. Such a percentage, which in times past would have been near the lending guideline that would have typically been applied when qualifying a buyer for a mortgage, seems to fly in the face of other demands imposed by Obamacare. For instance, "to avoid fines, employers who have 50 or more full-time [i.e., FTE] employees must offer coverage that meets certain minimum requirements. That coverage has to cost no more than 9.5 percent of an employee's income" (Feulner, 2013). This previously cited NFIB report also provided a list of actions to defray costs on the part of employers that face higher premiums, as depicted in Figure 1.

Next, it should also be mentioned that this scenario is calculated based upon a "Gold" plan. "The four levels of health plans – Bronze, Silver, Gold and Platinum – are differentiated based on their actuarial value: the average percentage of health care expenses that will be paid by the plan" (Folger, 2013). "The actuarial value of a plan tells you what percentage of health care costs that health insurance plan is expected to pay for its beneficiaries" (Davis, 2013). The actuarial value of a gold plan, generally, is about 80 percent (Davis, 2013; Folger, 2013). Thus, such a family would also face deductibles, co-pays, and maximum out-of-pocket limits, in addition to those monthly premiums. Out-of-pocket limits under ACA are $6,350 for individuals and $12,700 for families for the year 2014 (Folger, 2013).

Forthcoming Small and Large Employer Cancellations

A table in the June 17, 2010 issue of the *Federal Register* ("Rules and Regulations," 2010, p. 34553) depicted estimates of the percentage of employer insurance plans that were predicted to relinquish their grandfathered status. These estimates were presented in three ranges, low-end, mid-range, and high-end, and expressed in cumulative percentages across the three year period from 2011 to 2013. The grandfathered status refers to plans that the ACA would allow to continue without having to comply with a new core set of benefits. In other words, "certain provisions of the Affordable Care Act do not apply to a group health plan or

health insurance coverage in which an individual was enrolled on March 23, 2010 (a grandfathered health plan)" (Ibid., p. 34545).

At a more granular level, according to HealthCare.gov, health insurance plans offered in the exchanges must cover a core set of benefits. These minimum provisions include: Ambulatory patient services; emergency services; hospitalization (such as surgery); maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services ("What does Marketplace health insurance cover?," 2013). In news reports widely disseminated in the media, and in reference to this more granular level, many individuals have complained about changed policies which have added coverages that do not apply to their particular circumstances. Examples include maternity and pediatric services from the list of minimum provisions above, where no such coverage is applicable (e.g., maternity and newborn benefits for a single male). Paying into the revenue pool of insurers when no claim (at this granular level) is going to occur, in effect subsidizes the costs of other insureds who would likely make claims under one of these specific coverage areas.

However, what this discussion of grandfathered plans (or their inverse, those that are not grandfathered) actually refers to is in connection with recent revelations before the public at large that individual and group plans, numbering in the millions, might be (are being) cancelled. An article in *Forbes* estimated that 93 million Americans would see their plans cancelled (Roy, 2013a). These cancellations are notwithstanding numerous previous assurances from President Obama that people could keep their existing doctor relationships and health care plans. For example, in a speech in Iowa, he (Mr. Obama) stated:

> From this day forward, all of the cynics, all the naysayers -- they're going to have to confront the reality of what this reform is and what it isn't. They'll have to finally acknowledge this isn't a government takeover of our health care system. They'll see that if Americans like their doctor, they'll be keeping their doctor. You like your plan? You'll be keeping your plan. (Obama, 2010)

Returning to the aforementioned estimates in the *Federal Register* table, small employers were defined as those with 3 to 99 full-time employees. By 2013, the cumulative percentages of small employers that would no longer have grandfathered plans were estimated as follows: on the low-end, 49%; mid-range, 66%; and high-end, 80%. For the sake of comparison, estimates for large employers, defined in the table as those with 100 or more employees, were expected to no longer have grandfathered plans by 2013 in percentages as follows: low-end, 34%; mid-range, 45%; and high-end, 64%.

The "Other Costs" Obamacare on Small Business

Notwithstanding the number one action (66 percent of respondents to the NFIB research) to defray the costs of increased health insurance premiums, as depicted in Figure 1, to "take a lower profit or suffer a loss" the latter, if this should come to pass, is obviously unsustainable. Further, *a priori*, these respondents cannot know as yet what all of the other costs will be. While much of the debate covered by media centers around the more obvious features of Obamacare, such as health insurance policy pricing, terms and conditions, and the functioning (or not) of the

HealthCare.gov website (Chumley, 2013; Howell, 2013; Radnofsky et al., 2013; Young, 2013), some observers have noted other costs, such as the loss of time, energy and dollars that small business owners must invest in order to comply (Lahm, 2013). For instance, as observed by Neiburger (2011):

> Because the ACA creates a new regimen for reporting to the federal government, it will create new work for tax attorneys and CPAs. Computing penalties as well as deductions and credits under the ACA will not be easy. The law is likely to increase taxes on many taxpayers by reducing both medical deductions and the amounts that individuals can place in tax deferred accounts for medical expenses. Reporting provisions will, of course, increase operating costs for most businesses. (p. 62)

It is clear that numerous other costs have not been acknowledged as widely as health insurance policy costs. Thus, the calculus that is often applied in analyses that have been performed in many instances is missing some crucial variables with respect to whatever may be the true cost and impact of Obamacare in total. Economists would identify such implementation burdens as an opportunity cost.

CONCLUSION

Ausick (2013) suggested that Obamacare will be good for small businesses since "it will make it easier for an entrepreneur to start a business because the small business insurance exchanges provide a way for a new business owner to get health insurance for himself or herself and the employees of the business." In theory, "the cost of that insurance also should be lower because the exchanges effectively allow small business to pool their risks to get better rates" (*Ibid.*). Similarly, in an article entitled "*The overblown Obamacare myth about small business*" Pagliery (2013) argued, "it's been uttered by every opponent of health care reform: Obamacare will kill small businesses. But the new law's rules don't apply to the vast majority of small businesses." On the other hand, myriad reports suggest that small businesses are suffering ill effects from Obamacare and are reacting by scaling back hiring and expansion plans and cutting hours for employees (Cannon, 2012; Jacobe, 2013; Mangan, 2013; Shane, 2013; "U.S. Chamber of Commerce Q2 2013 small business survey," 2013). Delays and glitches have exacerbated uncertainty for both small businesses and consumers, and because of these economic consequences are already becoming apparent.

Numerous suggestions for further research are implied, and some of these will be more actionable as the ACA continues to be implemented. A few are presented here for the benefit of future researchers as follows: With more precision, how many billable hours will law firms, CPA firms, consultants and the like generate in responding to small business owners and their questions? How many small businesses will actually receive cancellation notices? What will small business owners do in the long run if they in fact absorb costs or suffer losses from higher premiums (as suggested by the NFIB research)? What if enrollments remain at levels far below original expectations to make the system financially feasible? ("Health insurance marketplace: November enrollment report," 2013). Who are Obamacare's real winners and losers? This present research effort represents an initial foray into an immense topic of importance to the U.S. and consequently, the global economy.

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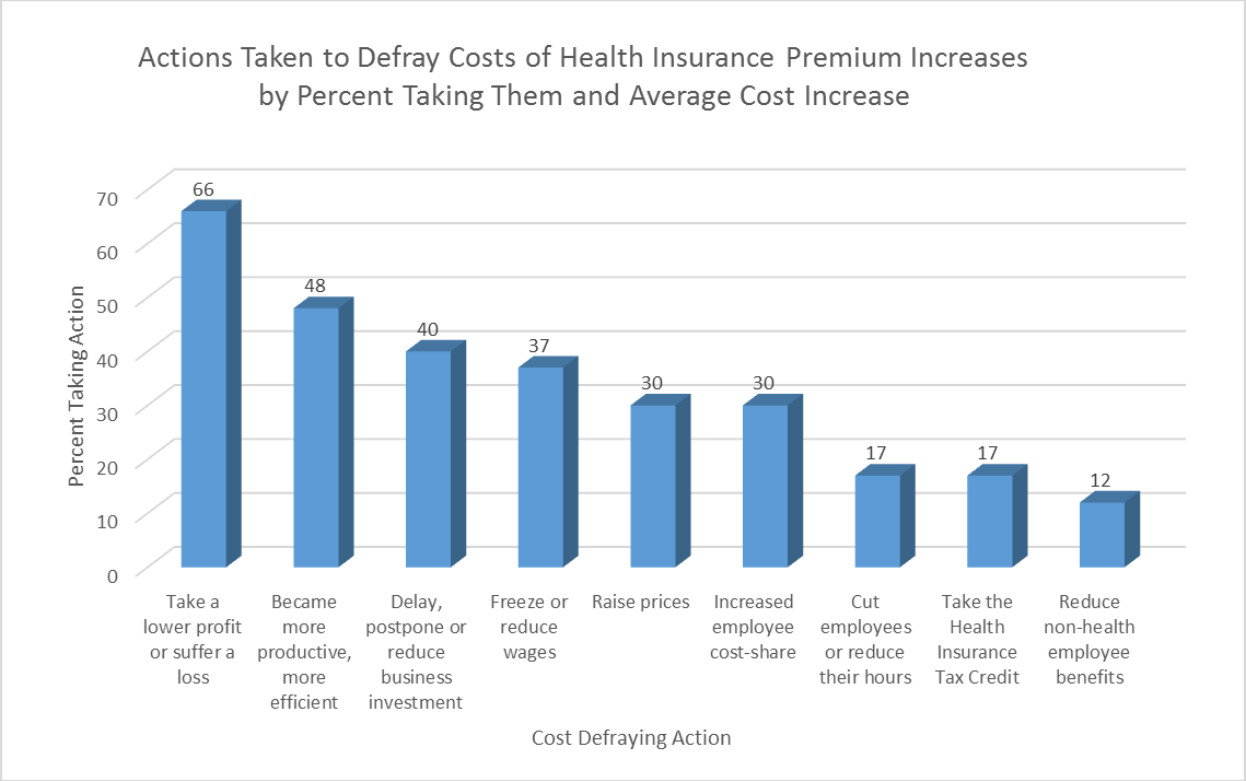
APPENDIX

Figure 1



Source: Derived from NFIB Research Foundation: Small Business's Introduction to the Affordable Care Act – 2013, Part 1. Retrieved November 18, 2013, from http://www.nfib.com/ACAreport