

Small business and Obamacare: It's just “way too complicated”

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ABSTRACT

The Patient Protection and Affordable Care Act¹ (ACA, a.k.a., Obamacare), by virtue of its name, was promoted as the means by which the federal government would step in and tame a U.S. health care system that was afflicted by ever-increasing costs and unattainable benefits for many who were uninsured (and uninsurable). The ACA was already a lengthy and complex piece of legislation when it was enacted, yet it was subsequently amended² and afterwards, thousands upon thousands of pages of rules and regulations as well as opinions and interpretations on the part of various governmental agencies in connection with the implementation of the law have since been added. It has not helped that much of this content has been generated in iterations, because the ACA's implementation has been a process plagued with numerous delays and modifications. This paper explores an aspect of the Affordable Care Act that has received little attention: the law itself, along with the myriad rules and regulations associated with its implementation, has imposed a substantial burden of compliance on small businesses and entrepreneurs. While the popular and business press has regularly covered the costs of health insurance and many surface features of the law, its complexity will cause small business owners to suffer a steep learning curve in order to understand and comply with its provisions. As these are exasperatingly complex, most entrepreneurs will likely be forced to respond—perhaps in ways that are unaffordable—such as calling upon professionals for help.

Key Words: Obamacare, Affordable Care Act (ACA), small business, economy, government regulation

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¹ Patient Protection and Affordable Care Act, Public Law 111 - 148 (H.R. 3590) C.F.R. (2010).

² Health Care and Education Reconciliation Act, Public Law 111 - 152 (H.R. 4872) C.F.R. (2010).

INTRODUCTION

Popularly known as Obamacare, the ACA is clearly a complicated piece of legislation, the impact of which is creating ripple effects in the small business community, and thereby the economy and society at large. As such, as researchers we anticipate significant impacts both domestically and ultimately, internationally. In some cases, the complexity of the law produces “winners,” such as accounting, law firms, and other consultancies which are called upon to help their clients respond³, obviously for remuneration. According to 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.” Meanwhile, numerous delays (Lahm, 2014; “PPACA implementation failures: Answers from HHS,” 2013; Radnofsky, Weaver, & Needleman, 2013; Roy, 2013) and problems have afflicted the law’s implementation and created considerable uncertainty (Amato & Schreiber, 2013; Cannon, 2012; Feulner, 2013) and grief for small businesses. An analysis of the economic effects on small businesses was conducted by the Congressional Research Service in a report entitled “*The Affordable Care Act and Small Business: Economic Issues*” discussed the reasons for small businesses not signing up for the small business health care tax credit in 2010:

Less than 4% of small businesses that could have been eligible for the small business health care tax credit in 2010 actually claimed it. According to a report by the Government Accountability Office (GAO), many business owners felt that (1) the credit was too small of an incentive to begin offering insurance; (2) even if these small employers offered health insurance, some employees declined coverage because they could not afford their share of the premium; and (3) *the rules were too complex* [emphasis added]. President Obama has proposed simplifying and expanding the credit. (Lowry & Gravelle, 2014, Summary).

Complicated and convoluted and transformational and problematical—the ACA and its companion laws, rules, regulations, and policies add up to thousands of pages of documents generated under numerous federal agencies including DHHS, IRS, DOL, Treasury, etc., not to overlook those at the state level. The enormity of communication and coordination efforts among and between these agencies is a more than a bureaucratic mess. Rather, they portend a nightmare scenario of near apocalyptic proportions. For example, some of the provisions of Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA) are interwoven into the ACA like tentacles from more than 70,000 pages in our federal tax code (Henchman, 2014). In 2012 the United States Supreme Court found the ACA to be constitutional, essentially by overwriting the law Congress submitted and reframing it as a tax, not a mandate to purchase insurance (Lemper, 2013; Musumeci, 2012; “National Federation of Independent Business v. Sebelius, Slip Opinion, No. 11–393,” 2012)⁴.

As part of the implementation of the ACA, small businesses had been directed to use an area of the HealthCare.gov website to sign-up for the Small Business Health Options Program

³ Although beyond the scope of this present paper and anecdotal, a partner in a mid-sized accounting firm who works with small business as clients was asked how much of the firm’s work could be directly attributed to Obamacare. The given response was: “in a word, staggering.” This suggests a possible area for future research.

⁴ An informant with a great deal of experience in the legislative process was also consulted, and opined that the only way for Obamacare to become fully enacted into law would be through the courts.

(SHOP). Small businesses with fewer than 50 full-time equivalent (FTE) employees had previously been directed to use SHOP if they wished to provide insurance for their employees ("What is the SHOP Marketplace?," 2013). But, "technical problems caused the federal government, which is operating SHOPS in 36 states, to delay launching online marketplaces by a year, until this November [i.e., 2014]" (Clark, 2014). Thus, it was announced that small business employers with fewer than 50 FTE employees would not be able to use the SHOP marketplace, after all, at least not on the HealthCare.gov site, until it was ready to handle such users (Chandler, 2014; Wayne, 2014). While much attention has been paid to the various delays (starting with design flaws with the HealthCare.gov site that was supposed to serve as a portal for individual and small business enrollees), as well as the cost of premiums, the size of deductibles, and other policy features, the concerns of small businesses in connection with administrative overhead have largely gone unnoticed. This paper explores the burden that has already been placed upon small businesses and entrepreneurs, who will suffer a steep learning curve in understanding their obligations under the law, especially given that thus far rules for compliance have been a moving target.

Numerous instances involving "passing the buck" have been observed, wherein one government agency specifically disclaims responsibility for providing specific advice or instructions, directing affected small businesses to yet another and another supposed resource. Small businesses that are attempting in good faith to comply with the provisions and regulations of the Affordable Care Act have to expend either time or considerable financial resources to pay for professional assistance to comply. The actual price of compliance must also be measured by the distraction from running their businesses. Altogether, understanding and trying to abide by Obamacare, when one should be attending to growing businesses (and creating jobs) in an already challenging economic environment, is "way too complicated."

REVIEW OF LITERATURE

Scholars in the disciplines of small business and entrepreneurship have yet to create a robust flow of research pertaining to the Patient Protection and Affordable Care Act. As such, this paper is an attempt to make an early contribution to the literature of these disciplines. Initial efforts in our searches began with databases which seemed appropriate (and targeted to our purposes) such as *ProQuest Entrepreneurship*. Using terms including "Affordable Care Act," "Obamacare," and "small business" (singly and in combination with one another), on this database yielded only a smattering of results. For instance, one such search using the terms "Affordable Care Act" AND "small business" yielded 22 returns, with 19 flagged as "scholarly" and the remainder trade publications, when filters were applied for scholarly articles and full text. Nevertheless, upon examining these returns, it quickly became apparent that the bulk of the research and discussion of this topic—although vital to small businesses and entrepreneurs in the practitioner community—in terms of scholarly literature has been published by other disciplines.

Upon searching in databases that largely cater to these other disciplines (notwithstanding our understanding that entrepreneurship is multi-disciplinary) such as the *ProQuest Accounting & Tax Database*, we found search results to be somewhat more robust (although we were surprised that there was not even more scholarly literature than what we found). One search on "Affordable Care Act" yielded 65 returns, 43 of which were categorized as "scholarly." Journal titles which tended to carry repeated insertions into the literature included: *Journal of Financial Planning*, *Journal of Insurance Regulation*, and several from either *Vanderbilt-* or *Stanford Law*

Review. It was not until we queried the *ProQuest Health Management* database that we saw a significant body of research had been developing based on scholarly contributions from those who may be focused on “the field of health administration” (as per the database description). Searching this database using the term “Affordable Care Act” yielded 2054 results (applying the same filters as described above), comprised of 2024 scholarly and 35 trade publications as the outlets.

In addition to ProQuest as a provider of current and relevant database content, further search efforts included Ebsco databases including: *Academic Search Complete, Business Source Complete, Entrepreneurial Studies Source, and Small Business Reference Center.* These additional database searches revealed a similar paucity of scholarly contributions that were specific to small business and entrepreneurship. In consideration of the above, we utilized the list that has been created and maintained by Katz (2012) entitled “*Core publications in entrepreneurship and related fields: A guide to getting published*” for purposes of comparison. While scholarly, most returns, regardless of the databases that we searched, were not specific to small business and/or entrepreneurship. Besides those named above, other 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. While all of these above articles were valued in our literature review process, we concluded that contributions to the literature that might be more likely referred to by scholars interested specifically in small business and entrepreneurship are sorely needed.

The popular news media, trade publications (and associations), government outlets, and others are indeed providing a full-throated and unbroken response to the ACA. Thus, our search strategies were modified such that we next sought information that could be reviewed in the ACA law itself, reports, and other government documents, associations and credible research organizations as providers of findings and data which we might review. These data sources (as cited, and a far larger set which we consulted) have been systematically aggregated and incorporated into our own analysis and used to develop the conceptual paper which follows.

Changing the Risk Pool Changes the Game

“As Obamacare’s big provisions take effect, they are indeed transforming America’s insurance market” (“Obamacare: The law’s delay-Re-writing health reform on the fly,” 2014). The health insurance policy cancellations discussed below might be considered in light of previous assurances from President Obama (and others who promoted the law’s passage) that individuals could keep their doctor relationships and existing health care plans if that is what they wanted. During a speech in Iowa Mr. Obama (2010) 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.

In June 2010, the *Federal Register* included findings from an analysis which estimated that small and larger employer plan cancellations would take place in significant numbers (“Rules and Regulations,” 2010). Cumulative percentages of small employers that would lose

grandfathered plans by 2013 were estimated as follows: on the high-end, 80%, 49% on the low-end, and 66% as a mid-range estimate. For the sake of comparison, estimates for large employers (defined in the *Federal Register* as those with 100 or more employees) that were expected to no longer have grandfathered plans by 2013 were also indicated in percentages as follows: on the high-end, 64%, 34% on the low-end, and 45% as a mid-range estimate. (For employers of all sizes see table on p. 34545 in the *Federal Register* edition, as cited.)

Losing grandfathered plans meant that employer plans were predicted to be replaced by new plans so as to be compliant with Obamacare's minimum standards, meaning a set of ten core benefits (Davis, 2013; "What is the SHOP Marketplace?," 2013). The core benefits list was clearly designed to create a subsidy that could underwrite the costs of healthcare for other parties in a redistribution scheme. For example, by requiring policy holders to carry coverages for certain benefits that they would reasonably never claim, such as maternity and newborn benefits for a female whose desire or capacity for child-bearing had already passed, the revenues that were to be collected but not disbursed to contributors could subsidize others' claims (or those who had previously been uninsured before the law's passage, et cetera).

Yet, imposing new minimum standards is only one contributing factor to increases in premium costs. As indicated in Figure 1, generally changing the risk pool completely changes the game. When lifetime caps are no longer applied, exclusions for pre-existing conditions no longer exist, and individuals who may have been previously uninsured or uninsurable (there is an overarching reason for this—insurers, for whatever reason, deemed these individuals to be too costly before the ACA), premiums, deductibles, and co-pays will (i.e., must) rise. "Glitches" (Radnofsky et al., 2013; Young, 2013) with the HealthCare.gov website, changes under presidential executive orders and other postponements and delays (Lahm, 2014), and ongoing court challenges do not change the risk pool *per se*, but they do create uncertainties for all parties (insurers and insureds, small businesses, large employers, the public at large).

When one synthesizes the information above, the combination of a possible large-scale cancellation of business health insurance policies, a lack of readiness to address replacement policy purchasing needs (e.g., based on SHOP readiness failures and other delays to date), the likelihood of higher costs due to changes in the risk pool, and in general, a firmly established track record of fumbling the proverbial ACA implementation ball, cause for concern is readily apparent.

Risk and Costs for Small Businesses Increase Due to Uncertainty

In reviewing the recent history of the Affordable Care Act relating to small businesses, there is no question that the changes to the implementation including rules and related regulations have added risks to the business environment and fostered a period of extreme uncertainty. Some of the uncertainties we discuss in this paper include changes to, or the postponement of, certain provisions of the ACA as well as the uncertainty created by not knowing when or if the many interim rules and regulations will be finalized. A major dilemma facing all of us—the President, the Congress, insurance companies, employers, and individuals—is the challenges to the constitutionality of the law in its entirety. The ACA has already survived one major Supreme Court challenge. In June, 2012 the Supreme Court handed down a 5 to 4 decision that deemed the mandate forcing individuals pay a financial penalty if they do not obtain coverage to be characterized as a tax ("National Federation of Independent Business v. Sebelius, Slip Opinion, No. 11–393," 2012).

Other cases are wending their way through the federal courts that challenge the ability of the Internal Revenue Service (IRS) to issue rules that extend premium tax subsidies. Challengers to the IRS ruling are against penalizing those who do not obtain coverage by forcing them to pay tax penalties. According to an analysis from the Commonwealth Fund the outcome of judicial proceedings is “up in the air” (Rosenbaum, 2014):

On July 22, judicial panels on two of the highest courts in the land—the D.C. Circuit Court of Appeals and the Court of Appeals for the Fourth Circuit (which covers Maryland, North and South Carolina, Virginia, and West Virginia)—issued diametrically opposed decisions. In *Halbig v Burwell*, a three-judge panel on the D.C. Circuit held for the plaintiffs, finding that the IRS rule directly contravened the plain terms of the ACA and that the agency therefore had abused its authority to act. In *King v Burwell*, a three-judge panel on the Fourth Circuit concluded first, that the terms of the ACA, as well as its history, were sufficiently ambiguous to point in *no* clear direction about the meaning of the law; and second, that in such a situation, the appropriate judicial response was to defer to the authoritative interpretation of the federal agency in charge, in this case the IRS.

Changes or Postponements of Provisions

The Affordable Care Act was so large and so invasive of existing laws, rules and regulations that there was no way the ACA could avoid a plethora of changes or postponements while those affected by the new way of providing health care to the American people argued over the details. And we would add, upon “finding out what is in it” (Pelosi, 2010). According to the Galen Institute, “42 significant changes already have been made to Obama Care: at least 24 that President Obama has made unilaterally, 16 that Congress has passed and the president has signed, and 2 by the Supreme Court” (Hartsfield & Turner, 2014). Many of the provisions of the ACA were or are being postponed or delayed mainly by the Executive Branch as described in the Galen Institute report and in a report from the CATO Institute. According to Michael D. Tanner, a senior fellow, some of the significant postponements include:

Among provisions that have been postponed are: the employer mandate; reporting requirements related to the employer mandate and subsidy determinations; small business exchange (SHOP) enrollment; out-of-pocket caps (in some instances); cuts to disproportionate share hospitals; and the Basic Health Plan option. The administration has also extended the deadline for the closure of state high-risk pools and the dead-line for health plans to comply with the essential health benefits in the law. Most recently, the administration exempted individuals whose policies have been cancelled from the individual mandate. (Tanner, 2014, see Note 8, pg. 40)

According to a report by the Congressional Research Service entitled, “The Affordable Care Act and Small Business: Economic Issues,” (Lowry & Gravelle, 2014) postponing the employer shared responsibility or employer mandate provisions of the ACA has created enormous uncertainties in operating a business. The purpose of this provision of Obamacare is

to encourage employers to provide affordable coverage to their employees. The ACA law requires employers that offer health insurance coverage to full-time (FTE) employees, who receive a tax credit for the premiums they individually pay for, to pay a monthly imposed penalty for not providing health insurance that meets the standards in the ACA (affordable and adequacy).

The first postponement of employer mandate provision of the ACA by President Obama was in July 2013 changing the date the mandate would be enforced by one year from January 1, 2014 to January 1, 2015 for businesses employing more than 100 full-time equivalent employees. In February of 2014 the President extended to enforcement date for the second time ("Treasury and IRS Issue Final Regulations Implementing Employer Shared Responsibility Under the Affordable Care Act for 2015 ", 2014), and this applied to small businesses with fewer than 50 full-time equivalent employees making averages wages that are less than \$50,000. As a result of this postponement these businesses were no longer required to provide coverage or to complete any reporting forms "in 2015, or in any year, under the Affordable Care Act" (*Ibid.*). Firms with 50 to 99 full-time employees that did not provide coverage must report on their employee coverage in 2015 but have until 2016 to make penalty payments under the employer shared responsibility provision of ACA. Larger employers will now phase in the percentage of full-time employees they must provide coverage for from 70 percent in 2015 to 95 percent in 2016, but they will nevertheless pay penalties starting in 2015.

Finalizing interim rules and regulations is an iterative process. The Executive Branch is tasked with developing the rules and regulations that implement the legislation that has created and amended the Affordable Care Act. The usual process includes the promulgation of the enacting rule or regulation language, posting the language of the proposed interim rule or regulation for the purpose of attracting comments from the public (individuals, organizations that will be affected by the rule or regulation, states, etc.), publishing the interim final rule, more comments, and finally presenting the final rule or regulation.

In the case of Obamacare, besides court challenges, postponements and other issues, the Congress has exacerbated the difficulties that are inherent in the process of developing implementation rules and procedures by passing legislation which contained provisions that amended the original law. Some of the provisions of enacted public law that amend the ACA by making specific changes to the rules and regulations have been put into effect by the Executive Branch. For example the 112th Congress passed P.L. 112-9, instructing the Internal Revenue Service to make changes to the federal tax code (Redhead, Tollestrup, Liu, & Brass, 2013):

Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011. Amended IRC Section 6041, as amended by ACA Section 9006, to repeal the requirement that businesses file an information report (IRS Form 1099) whenever they pay a vendor more than \$600 for goods in a single year. To pay for the 1099 repeal, P. L. 112-9 further amended IRC Section 36B, as added by ACA Section 1401(a), by modifying the amount of excess premium tax credits that individuals would have to repay based on household income (see entry for P.L. 111-309, above).

The typical small business owner located far away from Washington would be very puzzled at the complexity and confusion of legislative process, and certainly the subsequent implementation process. An example of the seemingly never-ending rule and regulation making

process is found in Figure 2. Notwithstanding the “normalness” of such an iterative process as that which takes place when laws are implemented, we expect that the majority of the public at large would be left to wonder, when “Final, Final, Rules” might be implemented. Further, for a small business owner, we submit that following all of these convoluted changes and trying to oblige the law would present an enormous distraction, thereby adding significantly to the burden of compliance.

Down a Rabbit Hole: Following IRS Tax Provisions

The authors of this present paper subjected themselves to trying to follow one of the 33 (thirty-three) tax provisions under the ACA as indicated on an IRS web page (“Affordable Care Act Tax Provisions,” 2014). Each of these provisions is indicated in Figure 3, by name. In deriving the list of items for the figure, details in the form of narrative descriptions, which included numerous hyperlinks to a plethora of other information, were omitted. As such, we illustrated just the names of the provisions. The first of these provisions (upper left) was entitled, “Effect of Sequestration on Small Business Health Care Tax Credit” (*Ibid.*). In the spirit of immersion in our research efforts, we decided to try to follow the indicated steps under this one provision as though we were the owner of a small business that offered its employees the opportunity to participate in an employer-sponsored fully-insured small group health plan. We were hoping to get answers to the following questions: How much of the rebate goes to the company since it helped pay for the health care policy? When can the check be cashed and when must the rebate be paid to the participating employees? What can the rebate funds be used for? Since the employees will be getting a check does that money count as income?

We assumed the business had purchased a small group insurance policy with similar provisions as compared to those that many small business owners might purchase. Along comes the tie-in between sequestration and the advent of the Medical Loss Ratio (MLR) rebate under the ACA (also indicated in the “Affordable Care Act Provisions” figure). Following the details of the MLR provision (“Affordable Care Act of 2010: News Releases, Multimedia and Legal Guidance,” 2014; Turner, 2011), it involves an intake versus expense ratio on the part of insurance companies and a requirement to issue rebate checks back to policy holders if these ratios are not met. “Individual and small employer plans must spend at least 80% of the premium dollars on benefits and quality improvement” (Cauchi & Landess, 2014).

Under sequestration, the amount of these rebates is reduced by 7.2 percent in fiscal year 2014 (“Affordable Care Act Tax Provisions,” 2014). However, “states may apply for waivers to allow a different timetable or percentages on a temporary, annual basis between 2011 and 2014” (Cauchi & Landess, 2014). Notwithstanding the further complexity of variations based on state waivers, we found that following the steps based on federal tax provisions was already difficult enough. The basic scenario is, a small employer receives a rebate check, but then is obliged to handle depositing that check and disbursing its proceeds under a set of very complicated rules (Turner, 2011).

The rebate comes in the form of a check from the company’s health insurance provider that is labeled “Medical Loss Ratio Rebate” (“Affordable Care Act Tax Provisions,” 2014). Many small business owners may at first be puzzled when receiving such a check, but that initial reaction is likely to grow even worse. We presume it would be logical to expect that the health insurance company (e.g., agent) would be contacted so that the owner might find out why he or she received such a check (editorial note: do continue reading, because a great deal of trouble

can arise if the check is not processed properly). The insurance company representative would then in-turn explain that the rebate is required under the Medical Loss Ratio Requirements of the Patient Protection and Affordable Care Act (PPACA). The insurance company would likely also advise that the business owner should contact his or her tax attorney or CPA before cashing the check to make sure the company is in compliance with the provisions of the ACA.

Before incurring the billable hours with the company's tax attorney or CPA (Neiburger, 2011) many owners might try to find out more about Medical Loss Ratio Requirements of the Patient Protection and Affordable Care Act (just as we did). The authors conducted a *Google* search as though we were the owner of a small business who had received such a rebate check. We entered the topic "medical loss ratio rebate" and as reported in the search summary, the term garnered 71,800 results. In perusing the first several pages, we found links to payroll processors, the IRS, numerous other federal agencies, insurance companies, consultancies, the business press, and others.

One resource we visited was at the Congressional Research Service website where we found a document describing the rebate process entitled, "Medical Loss Ratio requirements under the Patient Protection and Affordable Care Act (ACA): Issues for Congress" (Kirchoff & Mulvey, 2012). According to what we read there, the reason insurance companies send Medical Loss Ratio rebate checks to plan sponsors was due to the insurance company not meeting the minimum standard of spending 80% of the total premiums received from all insured small group health plans to pay for clinical services. However, as we had already come to understand this, the information did little to satisfy our initial questions posed as a hypothetical small business owner.

We clicked to a document entitled, "Guidance on rebates for group health plans paid pursuant to the Medical Loss Ratio Requirements of the Public Health Service Act" ("Guidance on rebates for group health plans paid pursuant to the Medical Loss Ratio Requirements of the Public Health Service Act [Technical Release No. 2011-04]," 2011), to see if the U.S. Department of Labor (DOL) website could shed any light on the subject. Our initial concerns upon noting that this document was a "Technical Release" (again, as we imagined being in the shoes of a typical small business owner) were affirmed. We read that as it pertains to the Medical Loss Ratio (MLR):

Decisions on how to apply or expend the plan's portion of a rebate are subject to ERISA's general standards of fiduciary conduct. Under section 404(a)(1) of ERISA, the responsible plan fiduciaries must act prudently, solely in the interest of the plan participants and beneficiaries, and in accordance with the terms of the plan to the extent consistent with the provisions of ERISA.

We also noted the following comment: "when rebates are issued to such policyholders, issues concerning the status of such funds under ERISA and how such funds must be handled necessarily arise" (*Ibid.*). Our search for information concerning the disposition of a rebate check still had not told us anything other than the receiving plan sponsor must comply with ERISA and the funds go to the plan participants. The final piece of information we gleaned from the DOL document inspired the heading ("Rabbit Hole") for this part of our present paper. It was a disclaimer which stated: "The Department expresses no view concerning the tax consequences of any action taken by a policyholder with regard to the receipt, holding, or

distribution of the rebate. Such issues are exclusively within the jurisdiction of the Internal Revenue Service.”

In our process we tried several other websites where we either gleaned no helpful information, referrals elsewhere, and in some cases nothing more than dead links. Given all of the issues with HealthCare.gov site to date, we were not surprised that one of the dead links that we clicked during our search for a better understanding of MLR rebate checks was found there (via a page not found, 404 error). We did further search the site using its internal search box on the term “MLR rebate” and found information directed to employees which indicated that they might receive a rebate “in a number of ways” (“Rate Review & the 80/20 Rule,”) including:

A rebate check in the mail; A lump-sum deposit into the same account that was used to pay the premium, if you paid by credit card or debit card; A direct reduction in your future premium; Your employer may also use one of the above rebate methods, or apply the rebate in a way that benefits employees [*original list bulleted*]. (*Ibid.*)

The Internal Revenue Service did provide an FAQ section under the Medical Loss Ratio (MLR) section of the “Affordable Care Act Tax Provisions” (2014) web page. These FAQs provided a series of scenarios all prefaced with a reference to ERISA fiduciary rules. We found nine different scenarios for group insurance plans that were divided among employees with pre-tax and after-tax premium payments.

The small business owner must decide who gets the rebate: only current year participants; current employees who are current year participants and were prior-year participants; or current employees who are current-year participants; and to all individuals who were prior-year employee participants (even if they are now former employees). And the rebate may be divided in one of three ways (making sure to meet the ERISA fiduciary rules): dividing the rebate evenly amongst all participants; pro rata based on the amount of premium each participant paid; or in some other manner that emulates the amount paid by each participant. Altogether, the small business owner is confronted by 27 different ways to disburse a rebate check. Finally, the sponsor must determine which action to take within three months of receiving the rebate check. Due to severe penalties for errors, the authors agreed the safest (and most expensive) course of action would be to call either a tax lawyer or an accountant and start incurring billable hours.

Small Businesses—Mitigating the Impact

One of the concerns of small business owners over the past thirty years has been the cost of keeping up with sharply rising premiums which have impacted their ability to continue to provide health insurance (Gabel, 2009). To go on offering group health insurance, many businesses (and employers at large) are shifting the burden to employees so that workers must increasingly pay more toward the cost of health care (Bannister, 2013; Buchmueller & Monheit, 2009; "Costs of Premiums For Employer-Provided Health Insurance Jump," 2011; "Obamacare insurance rates," 2013). Whether on their own or caused to do so by Obamacare, employers have also instituted employee wellness programs as another way to reduce health care costs including lower premium increases ("Affordable Care Act and HRSA Programs," 2013; "The Affordable Care Act and wellness programs," 2012; Mattke et al., 2013; Tillman). We certainly

do not argue that such steps with respect to wellness programs—induced by the law or taken by small businesses (larger employers, and even individuals, etc.)—are a bad idea.

However, thus far the launch of Obamacare has been characterized as a “train wreck,” and other disparaging terms (Chumley, 2013; Ferenstein, 2013; Howell, 2013; Straud, 2013). For millions of Americans below the poverty line who are going to receive subsidies for their insurance, the issues we present are probably not within the scope of their perceived concerns, except there is clear evidence that small businesses are attempting to mitigate the impact of the ACA in ways that would impede job creation (Dennis, 2013; Graham, 2013; Mangan, 2013; Shane, 2013; "U.S. Chamber of Commerce Q2 2013 small business survey," 2013). For instance, “one issue of concern is the incentive for firms to reduce part-time employee hours below the 30 that define “full-time” employment (under ACA) as a means to exclude these employees from coverage” (Lowry & Gravelle, 2014). Popular usage has introduced new terms into our language such as the term “29ers”:

Because other federal employment regulations also kick in when a firm crosses the 50 worker threshold, employers are starting to cap payrolls at 49 full-time workers. These firms have come to be known as "49ers." Businesses that hire young and lower-skilled workers are also starting to put a ceiling on the work week of below 30 hours. These firms are the new “29ers.” Part-time workers don't have to be offered insurance under ObamaCare. ("ObamaCare and the '29ers': How the new mandates are already reducing full-time employment," 2013)

In addition to the issues that contribute to uncertainty is the almost unbelievable complexity of complying with the law. While many will simply dismiss the problem of compliance as one that could be solved by hiring an accountant and/or other professional advisors, the reality is that some smaller businesses may have difficulty absorbing these costs of compliance, and if so the law really can be unquestionably described as a burden on the backs of small businesses and entrepreneurs. Further, for those who do attempt to comprehend the regulation to shape their compliance strategies, the complexity is daunting. The true costs are not only in the burden of trying to understand the law, but also in the missed opportunities and distraction of time and energy from running their respective businesses, i.e., that which economists would call opportunity costs. Particularly in a global economy where competitors won't be similarly distracted from their mission of product development, production, promotion, sales, and producing a profit, an owner or manager of a small business may pay a steep price in diverting his or her energies from the marketplace. Thus, Obamacare is creating a competitive disadvantage for American small businesses and the workers they employ.

CONCLUSION

The authors of this paper have reviewed and discussed examples of an extremely complex set of rules and regulations as well as opinions and interpretations on the part of various governmental agencies in connection with the implementation of the Affordable Care Act, a.k.a., Obamacare. For those employed by small business or for those who own or manage a small business, the principle of uncertainty adds considerable risk to their environment. Among other concerns, we have identified the following as contributing to uncertainty: the complexity of the

law, the lack of fully developed implementation plan that is riddled by extensions and changes, the issue of enrollment levels and related potential for higher premiums, and the frequency of adjustments, postponements, and changes to the law (and its implementation rules and regulations) have all contributed to the cost of compliance.

Many of the information sources that we explored were interlinked on government websites that led to “rabbit holes,” subjecting users to a virtually impossible morass of information—including that which is conflicting and laden with disclaimers. While much of the coverage of issues pertaining to the implementation of Obamacare in the popular media has focused on topics such as the cost of premiums, deductibles, whether or not individuals could keep their plans and doctors, and costs that are the most apparent, we see a different issue of extraordinary proportions: the burden of compliance for small businesses and entrepreneurs.

The impact of the burdensome regulations and time and expense for a small business to comply is detrimental to the health and well-being of small businesses. It is small business that creates tomorrow’s big businesses, or at least where there is entrepreneurial intent (as compared to seeking to be employed), the chance is greater that they will do so. Having been entrepreneurs before becoming scholars, we know first-hand that the priority of a typical small business should be responding to the marketplace, adjusting product design and production, responding to customer needs, and controlling costs while improving value. This we must do as entrepreneurs in order to survive in an increasingly competitive global economy. Successfully running a small business entails focusing on selling to and servicing customers profitably. We’re still reading and “finding out what’s in the law” (and the myriad rules and regulations both already published and still to come; Figure 4), but we know already that navigating Obamacare, is just “way too complicated.”

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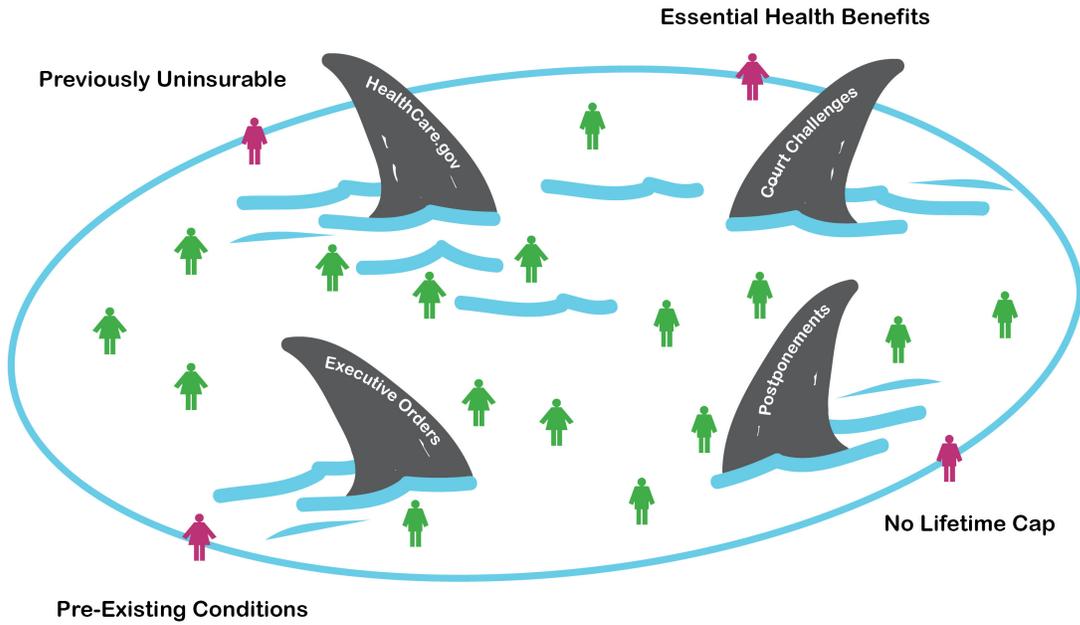
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APPENDIX

Figure 1

Higher Premiums the Result of New Higher Risk Pool Configuration Under ACA



Conceptual figure to illustrate some key components which have changed the nature of the risk pool under the Affordable Care Act. A more or less costly risk pool determines premiums, deductibles, co-pays, and annual out-of-pocket caps. A new higher risk pool has emerged for insurers under the ACA.



Figure 2**Interim Final Rules?**

- [TD 9494](#), Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act
- [TD 9493](#), Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act
- [TD 9491](#), Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections
- [TD 9489](#), Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act
- [TD 9486](#), Final and Temporary Regulations for Indoor Tanning Services; Cosmetic Services; Excise Taxes
- [TD 9482](#), Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under the Patient Protection and Affordable Care Act

When should small businesses expect “Final, Final, Rules”?

Figure derived from information posted on IRS web page entitled: “Affordable Care Act of 2010- News Releases, Multimedia and Legal Guidance” as of August 22, 2014. Retrieved August 23, 2014, from <http://www.irs.gov/uac/Affordable-Care-Act-of-2010-News-Releases-Multimedia-and-Legal-Guidance>



Figure 3

Affordable Care Act Tax Provisions

Effect of Sequestration on Small Business Health Care Tax Credit	Health Coverage for Older Children
IRC §7216, Disclosure or Use of Information by Tax Return Preparers	Excise Tax on Indoor Tanning Services
Medical Loss Ratio (MLR)	Adoption Credit
Reporting Employer Provided Health Coverage in Form W-2	Transitional Reinsurance Program
Net Investment Income Tax	Medicare Shared Savings Program
Additional Medicare Tax	Qualified Therapeutic Discovery Project Program
Minimum Value	Annual Fee on Health Insurance Providers
Information Reporting on Health Coverage by Employers	Tax-Exempt 501(c) (29) Qualified Nonprofit Health Insurance Issuers
Information Reporting on Health Coverage by Insurers	Medicare Part D Coverage Gap “donut hole” Rebate
Disclosure of Return Information	Additional Requirements for Tax-Exempt Hospitals
Small Business Health Care Tax Credit	Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers
Application of the Affordable Care Act to Health Reimbursement Arrangements, Health Flexible Spending Arrangements and Certain Other Employer Healthcare Arrangements	Modification of Section 833 Treatment of Certain Health Organizations
Health Flexible Spending Arrangements	Limitation on Deduction for Compensation Paid by Certain Health Insurance Providers (amended section 162(m))
Medical Device Excise Tax	Employer Shared Responsibility Payment
Changes to Itemized Deduction for Medical Expenses	Patient-Centered Outcomes Research Institute Fee
Health Insurance Premium Tax Credit	Retiree Drug Subsidies
Individual Shared Responsibility Provision	

Figure derived from information posted on IRS web page entitled: “Affordable Care Act Tax Provisions” as of August 12, 2014. Retrieved August 23, 2014, from <http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions>



Figure 4

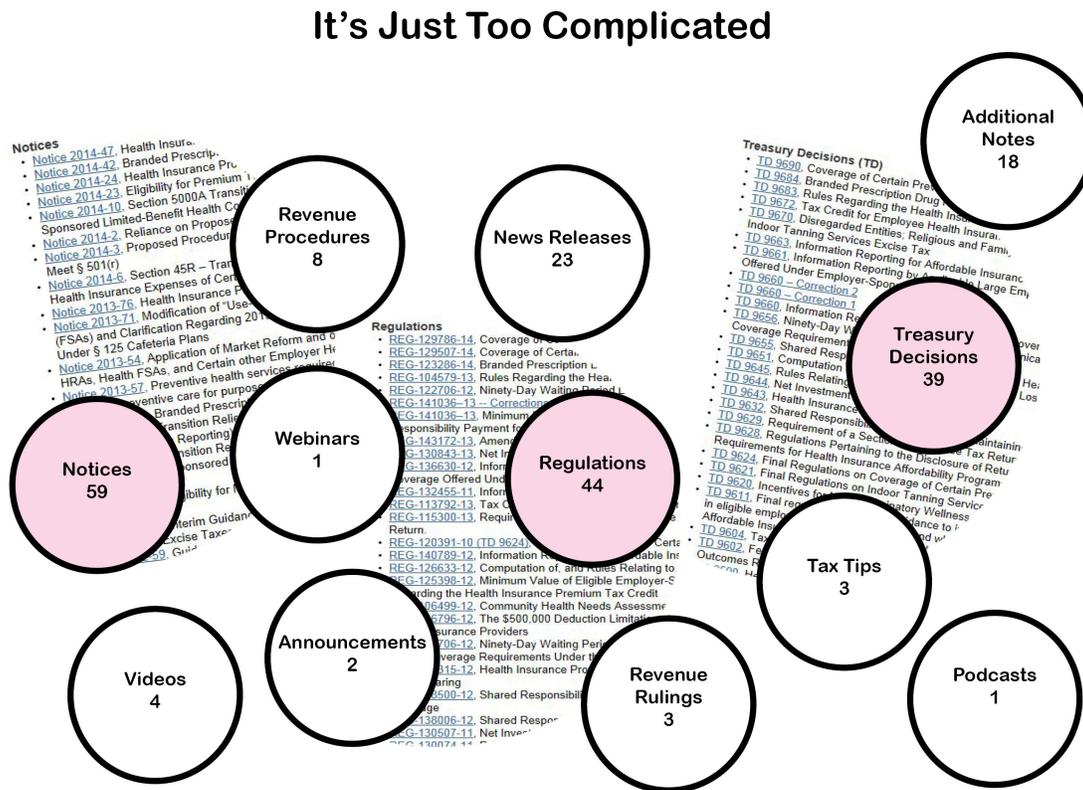


Figure derived from information posted on IRS web page entitled: "Affordable Care Act of 2010- News Releases, Multimedia and Legal Guidance" as of August 22, 2014. Retrieved August 23, 2014, from <http://www.irs.gov/uac/Affordable-Care-Act-of-2010-News-Releases-Multimedia-and-Legal-Guidance>

