Small business and Obamacare: A continuous story of uncertainty

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ABSTRACT

The PPACA (abbreviated Affordable Care Act/or ACA), known popularly as Obamacare, called for the creation of an Internet-based healthcare coverage shopping portal, Healthcare.gov. As part of this portal, the law also established the Small Business Health Options Program (SHOP) for employers (based on the number of full-time-equivalent (FTE) employees in their workforce). The law included an individual mandate to purchase health care coverage as well as an employer mandate to provide coverage for employees (again, based on FTEs/head count). Both individuals and small businesses are under threat of significant penalties in connection with these mandates. Shortly after the launch of the Healthcare.gov site, major technical, security, and design problems became apparent, and these also spilled over to affect the SHOP portal, causing delays. More recently, evidence is suggesting that while the functionality issues may have since been somewhat improved, small businesses appear to be rejecting the SHOP exchanges for other reasons, not the least of which is the high cost of providing health care coverage. At the same time, these costs are projected to keep rising, and political posturing has been afoot, suggesting the potential for a revision, or a repeal and replacement of the law in its entirety.

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

INTRODUCTION

This paper explores small business issues in connection with the Patient Protection and Affordable Care Act[1] (otherwise known as the ACA/Obamacare) as amended by the Health Care and Education Reconciliation Act[2]. "The law made fundamental changes to how health care is financed, delivered and structured" (Hatch, Upton, & Burr, 2015). The ability to obtain affordable health coverage long been a top concern among small businesses as well (Dennis, 2013). Many analysts have dug into slices of Census data only to proclaim that in the context of the small business environment, only a small percentage of firms are affected. To the contrary, due to the individual mandate and the taxation of health insurers (which is passed on to consumers), every business, and every citizen, is in some way impacted by Obamacare (Lahm, 2014). Additional costs can be seen in both dollars and a less understood but nevertheless very real compliance burden (Lowry & Gravelle, 2014). Several years in, many employers remain uncertain about the implications of the law for their business. A rollout that was fraught with delays and confusion has only exacerbated these concerns (Clark, 2014; Neddleman & Colvin, 2014; Radnofsky & Francis, 2014; Taulli, 2013).

The Healthcare.gov portal (a.k.a., marketplace, healthcare exchanges), was created under the ACA and meant to serve individual consumers with particular interest in those who had previously been uninsured and/or uninsurable. Also under the ACA, the Small Business Health Options Program (SHOP) portal (part of the HealthCare.gov site) was meant to serve small businesses that met certain size criteria as defined by FTE employees ("SHOP health plan information for small businesses," 2013). Notwithstanding the fact that almost eight out of ten small businesses are categorized as non-employer firms according to the U.S. Small Business Administration (SBA)[3], the organization of the marketplaces appears to have led to a de-facto separation between the portals and intended users, since the ACA's individual mandate applies to self-employed entrepreneurs and non-employer firms, both. The two healthcare marketplaces do, in effect, impact every single person and business, regardless of size or FTE employee head-count. Family businesses may be particularly entangled by the law (Salley, Baron, & Walsh, 2014). "Unbeknownst to the policymakers responsible for the Affordable Care Act, the legislation created a tax 'bias' that will carry serious estate plan consequences and delay the process by which the next generation will become responsible stewards of the family enterprise" (Salley et al., 2014, p. 19). For many small businesses and individuals, Obamacare is regarded as a disaster (Leland, 2016).

LITERATURE REVIEW

The purpose of this paper is to make a meaningful contribution to the literature that is specific to the discipline of entrepreneurship. It was known at the outset that the PPACA/ACA/Obamacare at large has been responsible for generating a vast body of content from popular media, scholarly and other sources. In conducting this literature review, as a first step a strategy was employed using Ebsco databases to identify scholarly contributions across disciplines as a whole on the Affordable Care Act (PPACA, ACA, Obamacare, et al). For

[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).
[3] FAQs. (June, 2016). Retrieved from https://www.sba.gov/sites/default/files/advocacy/SB-FAQ-2016_WEB.pdf

instance, a search with the following parameters returned 160,241 items: all (Ebsco) databases; the terms Obamacare OR Affordable Care Act. Upon applying search settings to isolate scholarly sources with full text availability results were narrowed to 16,791 items.

To further isolate contributions that are specific to the disciplines of entrepreneurship (and small business, etc.), several databases considered extraneous (e.g., *Art & Architecture Complete*) were subsequently deselected, leaving *Academic Search Complete, Business Source Complete,* and *Entrepreneurial Studies Source* as those that remained selected in search settings, which returned 34,166 items. Once again, further settings were employed to narrow search results to scholarly (peer reviewed) journals with full text availability, returning 5,831 items. However, upon reviewing these items journal names such as *Journal of Health & Human Services Administration*, *Journal of Gastrointestinal Surgery,* and *American Journal of Criminal Law* were observed. As these journals are not connected with the entrepreneurship discipline, further steps were deemed necessary. Using the same search terms above and selecting scholarly peer reviewed journals with full text availability while eliminating *Academic Search Complete* returned 2,138 items.

At this point it should be noted that Version 5.6 of a list compiled and maintained by Katz (2012) entitled, "*Core publications in entrepreneurship and related fields: A guide to getting published,*" was regarded as authoritative for purposes of this present research to isolate entrepreneurship-focused scholarly sources. (Thus, eliminating journals based on titles such as those named above was ultimately systematic as compared to haphazard.) The terms Obamacare OR Affordable Care Act were then searched in combination (AND) with the term small business, returning 53 items, and again in combination with (AND) entrepreneur, returning 10 items. Then deselecting scholarly peer reviewed journals returned 575 items (with AND small business), and 66 items (with AND entrepreneur). Upon deselecting scholarly peer reviewed journals titles from the business popular press of course reemerged in the search results. The above described efforts established that a dearth of scholarly research contributions currently exists from entrepreneurship scholars and generally, the volume of ongoing coverage in the popular media has by far outpaced researchers across disciplines at large.

As such it was established that a conceptual, exploratory approach is justified here under a qualitative research framework. Under such a framework, additional products from a culture at large are characterized as artifacts and legitimate sources for analysis, i.e., data (Creswell, 1994; Hodder, 1994; Strauss & Corbin, 1994). This does not imply that such data is to be interpreted at face value and without cross-examination. Rather, the researcher must question the veracity and applicability of data using techniques such as triangulation (Caporaso, 1995; Maxwell, 1992). Where data from multiple sources may coincide, the researcher may have increased confidence in an effort to better understand a phenomenon under study. Analysis may also result in the dismissal of data as being accurate or reliable. A constructivist approach (Barry, 1996; Schwandt, 1994) results in building theoretical frameworks (Alasuutari, 1997; Strauss & Corbin, 1990, 1994).

This present research utilizes a database of over three hundred artifacts which have been collected over a three year period using multiple search strategies. For instance, Ebsco databases do not index all that might be available as legitimate content for analysis. As examples, government documents including the law itself (noting that the Affordable Care Act was actually amended by the Health Care and Education Reconciliation Act of 2010), implementation documents such as IRS forms and accompanying instructions, messaging from the department of Health and Human Services (the operators of HealthCare.gov), transcripts from congressional

hearings, and content from health organizations (e.g., Kaiser Foundation, World Health Organization), trade associations and other research organizations (e.g., NFIB Research Foundation) have been collected and explored. In some cases, sources such as the business press, blogs, pundits and others have pointed to research resources (with or without creating an easy-to-follow breadcrumb trail) and have also been useful in some way.

Entrepreneurship is by its nature a discipline with many potential inputs. When the scholarly literature from one discipline is lacking, it may be assumed that the literature from other disciplines (and hence databases and other sources) may serve to provide transferable insights and ultimately, lead to contributions. As examples, databases associated with health care administration, law, tax, accounting, public policy, and other disciplines have been consulted. Example titles from a search of the *ProQuest Health Management* database included: *Benefits Quarterly, Journal of Law, Medicine & Ethics, Health Affairs* and *Journal of Health Politics*, *Health Services Research* (establishing the while scholars and academicians in the entrepreneurship discipline are only beginning to explore the implications of the ACA, other disciplines are vigorously attending to this important topic). Thus, while this present work is justifiably conceptual in nature a rigorous scholarly methodology has nevertheless been employed.

DISCUSSION

Some dominant themes that have emerged regarding the implementation of the ACA and its impact on small businesses: "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). Following such an assessment, then it stands to reason that efforts to curtail costs were (and remain) warranted. The government's solution via the ACA was to step in and impose a restructuring of the health insurance marketplace in a massive economic redistribution scheme. The discussion that follows addresses other issues that continue to beset the ACA and its implementation, seven full years after it was first enacted.

FINDING OUT "WHAT IS IN IT"

Nancy Pelosi, Speaker of the United States House of Representatives, said at the 2010 Legislative Conference for the National Association of Counties: "But we have to pass the [health care] bill so that you can find out what is in it — away from the fog of the controversy" (Pelosi, 2010). It has been reported that some members of the 111th Congress (which passed the ACA) did not read the full text of the law or comprehend its consequences — even for themselves and their staff members — before it was passed (Moffit, Haislmaier, & Morris, 2013; Quinn, 2015). These accounts are supported when "some of the lawmakers who wrote and voted for the bill have themselves expressed confusion about the rules" (Harrison, 2014).

The GPO version of the document is 906 pages long, configured in parts, sections, subsections, and parts of parts ("Patient Protection and Affordable Care Act," 2010). It is, indeed, an amazing act of human collaboration on the part of its many authors, besides being an "act" in a legislative sense of the word. Substantial portions of the document are arguably in direct conflict with any semblance of readability by an average citizen, such as the passage

quoted below for purposes of illustration (formatting is approximated from the original document, p. 904):

> (1) CREDIT MOVED TO SUBPART RELATING TO REFUNDABLE CREDITS.—The Internal Revenue Code of 1986 is amended—
> (A) by redesignating section 23, as amended by sub-section (a), as section 36C, and
> (B) by moving section 36C (as so redesignated) from subpart A of part IV of subchapter A of chapter 1 to the location immediately before section 37 in subpart C of part IV of subchapter A of chapter 1.

PAPERWORK, TAXES AND PENALTIES

Affordability is enabled by efficient processes, and the many layers of regulatory complexity and the burdensome compliance costs this law has generated are a crippling impediment to efficiency. There is no doubt that the framers of the law exercised a very heavy hand in terms of enforcement directed towards small businesses. According to National Federation of Small Business's (NFIB) Research Foundation:

> As of July 1, 2015, employers who offer reimbursement for employees' individual market health insurance can be fined $100 per day, per employee or $36,500 per employee, per year. Currently, 16 percent of small employers are in violation of the new rule and are subject to the steep fines. (Wade, 2015, p. 2)

"Ending insurance rules that discriminated against groups that tend to have higher medical costs — older people, those with chronic illnesses, child-bearing women — means that those with lower medical costs will pay more" (Radnofsky, 2014). The business model that was intended to make the ACA work (at least as evidenced by the work product of those who authored and passed the law) included partial funding by a combination of mandatory participation (and collecting premiums for coverages where there would be no pay-out), penalties, and new forms of taxation.

One such tax was cited by M.I.T. economist John Gruber, regarded as the primary architect of the Mitt Romney policy on which Obamacare was based (Bobic, 2013), Gruber observed that the American people would not realize that a tax on insurance companies — the Health Insurance Tax, or HIT — would be passed along such that it was in effect a new tax on consumers, thereby increasing health care costs (Marcus, 2014). This same logic is applied in many industries, such as real estate, where so-called buyer's agents are supposedly paid by the seller (yet when the buyer gives the seller an amount that pays the entire real estate commission and the price of a property, it is obvious who *really* pays). In a *Washington Post* article, one insurance broker similarly "pointed out that it's the insurance company that pays the broker for the connection, not the small business" (Harrison, 2014). The discussion that follows addresses other issues that continue to plague the ACA and its implementation, more than five years after it was enacted.

SHOP "A MASSIVE FLOP"?

The HealthCare.gov website was unveiled to the public on October 1, 2013 and immediately problems became apparent (Chumley, 2013; Tanner, 2013a; Young, 2013). Upon its launch "the website sputtered, hiccupped and crashed like a failed design for a 'flying machine' at the advent of aviation" (Lahm, 2015, p. 17). On this same day, president Obama addressed Americans in the White House Rose Garden suggesting: "Just visit healthcare.gov, and there you can compare insurance plans, side by side, the same way you'd shop for a plane ticket on Kayak or a TV on Amazon" (Obama, 2013). Subsequently, after it also become evident that the SHOP exchange site would require significant revisions, its launch was postponed as well (Radnofsky, Weaver, & Needleman, 2013; Taulli, 2013). Besides the issues with the web portals, the implementation of the ACA has been plagued by numerous delays that resulted in uncertainties for small businesses (Clark, 2014; Tozzi, 2014a).

Small Business Health Options Program (SHOP) exchange, which is meant to be the portal for small businesses to obtain health insurance under the ACA, is a part of the HealthCare.gov website (and the law does call for the establishment of such portals using the Internet as a delivery platform). HealthCare.gov has been widely recognized (i.e., severely criticized) for its initial serious flaws — beginning in the first few days after its launch on October 1, 2013 — as well as ongoing issues (Chumley, 2013; Tanner, 2013a; Weigel, 2013; Young, 2013). Because of the issues with the launch of HealthCare.gov (i.e., parent site), the opening of the SHOP exchange was postponed so that flaws could be addressed. In late October of 2014 a test version of the revised SHOP exchanges was announced. Yet some have suggested that technical problems persist. An article in the *Wall Street Journal* observed: "The glitches [on the revised SHOP test site] range from business owners being unable to create accounts — a significant potential obstacle — to the lack of easy-to-spot instructions on the site" (Janofsky & Radnofsky, 2014).

Despite this one year delay and the additional resources expended to fix the SHOP exchange site, "they [small business users] initially will be missing some functions for technical reasons, including the option for employers to contribute different amounts for part- and full-time employees" (Radnofsky, 2014). Further, the SHOP site apparently may have underlying design flaws. The above cited *Wall Street Journal* article also included quotes from several would-be users. One was from a CFO who was acting on behalf of a small business (20 persons) and found that her own personal social security information was used in connection with the businesses' health care account, and observed that such a process "assumes the business owner herself is setting up the account, rather than, say, a CFO or human-resources administrator."

"About 20 percent of the tax filers who had Federally-facilitated Marketplace coverage in 2014 and used tax credits to lower their premium costs – about 800,000" (Cohn, 2015; "What consumers need to know about corrected Form 1095-As," 2015) were issued an incorrect benchmark plan premium amount in their Form 1095-As. This premium amount is used as part of the calculation to determine the amount of the tax credit that the taxpayer would be eligible to receive (*Ibid.*). "This latest problem is one in a string of issues that have faced HealthCare.gov since its inception" (Goldstein, 2015). One might gather that the SHOP exchanges are still troubled, not just in connection with the technical issues discussed above, but by logical inference in that when the news is good, it tends to be released by government officials, and when it is not, it tends to be withheld. The Centers for Medicaid and Medicare Services (CMS) is responsible for releasing enrollment data, but it has on several occasions since the inception of HealthCare.gov been less than forthcoming (or prompt, one or the other or perhaps both) in

doing so (Demko, 2014; "How many people have enrolled in the Obamacare exchanges?," 2013; Hu, 2013). As such, "deciphering exactly how many individuals have obtained coverage through the SHOP exchanges is impossible" (Demko, 2014).

Some states have opted to create their own health insurance marketplace exchanges including state-run versions of the SHOP exchange (Coombs, 2013; Manning, 2012), and some of these sites still have problems as well. "Despite spending more than $1 billion in federal taxpayer grants to build it, the 'Covered California' exchange gets an average one-star rating on the popular review site, Yelp. Customers complain about extreme hold times, wrong information, the inability to cancel or update plans, and so on" ("California points to ObamaCare's grim future," 2015).

Time has passed, and while some of the technology/functionality issues with the portals have been abated, small businesses are not flocking to the SHOP exchanges. Writing for *Forbes* magazine, Pipes observed:

> In reality, SHOP has been a massive flop. Earlier this year, the Congressional Budget Office projected that a million people would enroll. Instead, 85,000 workers from 11,000 companies have done so. Those 85,000 represent less than 1 percent of all workers covered by small-group plans outside Obamacare's exchanges. (2015)

COST SHIFTING

Congress set out to change the way that health insurance is sold, such that supposedly all citizens could and would have it (lest they be penalized by the IRS), and it did so in collaboration with insurers, even providing remuneration in the event that those insurers might lose money (with the government generously stepping in to make up for their losses). Under a risk corridor program the Obama administration apparently promised to "pay insurers whatever it takes to cover any big losses they incur" (Haislmaier, 2014). However, "economists typically assume that in the long run it is workers who pay for health benefits through reductions in wages or other employee benefits" (Buchmueller & Monheit, 2009, p. 192).

As observed in a *Business Week* article, "11 million workers in small businesses are likely to pay more for health insurance under the Affordable Care Act, according to the report from Medicare's chief actuary" (Tozzi, 2014b). "Many [small to medium sized businesses] will be forced to raise their employees' share of premium payments or, worse, lay off workers to pay the escalating costs of health care for their core employees" (Marcus, 2014). Other consequences of the ACA include "narrow networks and plans with high levels of cost-sharing, where the consumer shoulders significant medical bills" (Fitzgerald, 2014, p. 9). HDHPs (High Deductible Health Plans) comprise a large share of health plans, both employment-based and those that are directly purchased, and this is a trend that is predicted to continue (Murphy, 2016).

An article in a publication for insurance brokerages, *Benefits Selling*, featured industry predictions for the year 2015 (and presumably beyond), wherein one industry expert suggested (about the future): "Everyone will have a high-deductible plan/HSA/HRA or some type of plan that forces the employee into consumerism" (Fadal, Christenson, Davis, & De La Rosa, 2014, p. 56). This would be consistent with the observation that "disruption is inherent in any approach that corrects the risk segmentation of unregulated markets" (Feder, 2014, p. 10).

Based on data from the first 6 months of 2014, among persons under age 65 with private health insurance, 35.3% with employment-based coverage were enrolled in an HDHP" (Martinez & Cohen, 2014, p. 6). "In a broad study that reportedly evaluated the health data of 46 state health exchange plans, HealthPocket.com came up with this finding: Drug copayments in the 2014 Obamacare state exchanges are up an average of 34%" (Norton, 2014). As such, "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). Ultimately, it is providers who must deliver care and it remains unclear as to how the ACA has done anything to make the lives of doctors, nurses, clinicians, and technicians, as well as non-clinical staff such as administrators, office managers, and billing specialists any easier.

"BALANCE BILLING" AND SHRINKING NETWORKS

According to a *Kaiser Health News* article "balance billing" (Appleby, 2015) refers to a practice of sending a patient a bill for amounts that were not covered due to services not being provided within a health insurer's defined network:

> Sometimes, that's because they [patients] got incorrect or incomplete information from their insurer or health-care provider. Sometimes, it's because a physician has multiple offices, and not all are in network…Sometimes, it's because a participating hospital relies on out-of-network doctors, including emergency room physicians, anesthesiologists and radiologists. (*Ibid*.)

Thus, even when those services may have been provided under circumstances that may have reasonably led a consumer to believe that they were receiving services in-network, such as when the patient goes to the trouble to look up facilities that are (supposedly) covered, services may not be covered, after all.

In fact, there is some evidence that insurers are manipulating provider networks to the detriment of supposed "covered" individuals. Because individuals with health issues such as pre-existing conditions (Cannon, 2012; Musumeci, 2012) cannot be rejected or charged more under the ACA, insurers are using network configurations (e.g., smaller, more tightly defined networks) to reduce costs (Appleby, 2015). Arguably, this creates an incentive for insurers to play a shell-game with consumers who must determine which personnel and which services are indeed in-network, i.e., "services received from a preferred provider" (Claxton, Rae, Panchal, & Damico, 2014, p. 11).

One might even envisage a vigilant consumer demanding that health care personnel display an in-network ID card and certify that each and every procedure is fully covered under an insurance plan. Clearly, insurers are in a position to play a shell game with network configurations and there remains a built-in incentive for doing so (just as there is an incentive to deny claims and constrain access through smaller networks). Meanwhile, "insurers defend the move to smaller networks of doctors and hospitals as a way to provide the low-cost plans that consumers say they want" (Appleby, 2015).

FRAUD TAKES A BIG BITE

According to the National Health Care Anti-Fraud Association (NHCAA) the financial losses from health care fraud are estimated to be "in the tens of billions of dollars each year" ("The challenge of health care fraud," 2015). As established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[4], the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) jointly operate a Health Care Fraud and Abuse Control Program (HCFAC). The HCFAC coordinates law enforcement efforts to curtail health care fraud among Federal, State and local law enforcement agencies. In its 2016 annual report, HCFAC stated that the "Federal Government won or negotiated over $1.9 billion in health care fraud judgments and settlements" ("The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program annual report for fiscal year 2015," 2016).

According to National Health Expenditure Accounts (NHEA) data (estimates) published by the Centers for Medicare & Medicaid Services (CMS), healthcare spending in the U.S. reached $3.0 trillion in 2014, amounting to 17.5 percent of the nation's Gross Domestic Product ("National health expenditure highlights 2014"). While the NHCAA's estimate of "tens of billions" does not allow for calculations against the $1.9 billion in judgments and settlements reported by HCFAC, if the former entities' estimates are correct one thing is clear: financial losses are far greater than the dollars amounts being recovered. This translates to increased costs for insurers, which are obviously — just like the much maligned health insurance tax (HIT) (Klass, 2015; Marcus, 2014) — passed along in the form of higher health insurance policy premiums for individuals and small businesses alike.

IMPACT ON SMALL BUSINESSES

It is well known that a majority of large employers provide health insurance in some form or fashion (paying all or part of policy costs for employees). As such, employers play an important role in providing health care for significant portions of the population. This employer involvement in health care is distinctive to the United States, and comes with implications and consequences not seen elsewhere (Buchmueller & Monheit, 2009, p. 187). Given that small businesses are already struggling (Cannon, 2012; Phillips Erb, 2015; Wade, 2015) and under the ACA carry much of this burden, in taking a longer-term view such cost projections do not seem to bode well for an economy which relies on entrepreneurs as job creators.

Seeking to avoid new costs and administrative burdens, some small businesses such as restaurants have adopted the strategy of cutting down on full-time employees. (Bell, 2015). Small businesses often employ seasonal and non-traditional staff, which adds to the complication of quantifying and accounting for employees that must be covered under the law (Moran, 2014, p. 52). "The details are complicated, but essentially multiple part-time workers can equate to several FTEs" (*Ibid.*). As well, markets have changed. In 2016, the employer mandate for companies between 50 and 100 employees came into effect, moving these companies into the higher-premium small group market: "it's cheaper to insure 200 people under a single contract than it is to insure 40 groups of five under 40 contracts, or 200 individuals" (Hood, 2014, p. 20).

[4] Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (H.R. 3103), 110 Stat. 1936.

For purposes of Obamacare, the Federal government defines a full-time employee as anyone who works more than 30 hours. The ACA mandates that any business with the "equivalent" of 50 such workers (i.e., 50 30-hour workers, or 60 25-hour workers) must provide coverage, or face a fine. (Bell, 2015). "The new rules require employers to include in their calculations the hours worked by part-time employees; for every 130 hours worked per month, they must add one 'full-time equivalent' to their workforce" (Harrison, 2014). Further, "the $3,120 fine for a full-time subsidized worker is nondeductible, [and] it equates to $5,132 in deductible wages for a retailer facing a combined 39.2% Federal and State tax rate. Spread out over a full year working 40 hours per week, it amounts to a $2.47-per-hour wage hike" (Jed, 2014). As observed in an industry trade publication, *Restaurant Business*, the hidden compliance costs associated with Obamacare are also substantial (Brooks, 2014, p. 76): millions of restaurants, even those not required to provide insurance under the law, have been required to start tracking employee hours worked, and reporting those hours to the IRS to demonstrate compliance (or exemption) (*Ibid*.). Accordingly, estimating the true cost and impact of Obamacare in total is a difficult proposition.

While the employer penalty may not directly affect the bottom line of employers with fewer than 50 employees, when employees approach the marginal threshold for incurring a penalty or paying insurance for employees, the law can often impact how business decisions are made. (Lowry & Gravelle, 2014, p. 1). Because the ACA includes both an individual mandate and an employer mandate (Cannon, 2012; Graham, 2013), many bottom-line-minded small business owners and entrepreneurs found themselves on the horns of a dilemma: should they cut hours for workers; cut down on hiring; forego important capital investment and training; or lay people off? (Cassidy, 2014; Klass, 2015).

Many companies have chosen to lay off workers or cut hours from full-time employees, rather than face costs, penalties, and compliance burdens inherent in the law. (Pataki, 2013). Numerous survey targeting small-businesses show employees incurring some of the cost as well, in the form of reduced benefits, lower wages, or shorter hours (Tanner, 2013b). Extended discussion about how such changes in hours from full-time to part-time might negatively impact employee morale and behavior lies beyond the scope of this present analysis, but clearly it would hurt to be on the receiving end of a lay-off notice or cut in hours and benefits. Although under the ACA smaller employers may not be required to offer coverage for full-time employees, "many owners of small ventures and startup entrepreneurs are nonetheless facing big changes to how they obtain their own health coverage, and the benefits they're able to offer employees" (Loten, 2014).

From the outset of the ACA rollout, carriers have cancelled plans in the millions (Gottlieb, 2013; Myers, 2013; Roy, 2013) and the market for individual and small group plans was restructured as well (Beck, 2013; Humer, 2013). "When fewer carriers offer insurance and when fewer options of affordable coverage are available, small businesses are hit the hardest" (Turner, 2011, p. 2). "The hard truth that changing the insurance rules means that some people will have to pay more" (Tozzi, 2014b). Because of increasing costs, "small companies are starting to turn away from offering health plans as they seek to reduce costs(Matthews, Loten, & Weaver, 2014). Although limited in geographic scope, one study by Muller of Grand Valley State University which surveyed small businesses in Michigan, found that only about one fourth of the small firms which provided health insurance options to employees in 2013 and 2014 planned on continuing offering plans in 2015 and 2016 (as reported by Thoms, 2015) – obviously a sharp decrease. Despite this particular study's limitations, such a finding (and

reaction on the part of small business owners) would be similar to what others have noted, i.e., small employers plan to shift costs and/or cancel plans (Klein, 2012).

According to the Small Business Administration, eighty percent of the estimated 28.8 million small businesses in the U.S. have no employees ("SBA: Frequently Asked Questions about small business," 2016). Accordingly, if these small business owners of non-employee firms (most are organized as sole proprietors) do not seek coverage as individuals, then they are required to pay fines (Loten, 2014). "Non-employers are also part of the fabric of the entrepreneurial community at large, and the impact of Obamacare on the entirety of this community should not be underestimated" (Lahm, 2014, p. 143).

KEEP IT? REVISE IT? REPEAL IT? REPLACE IT?

Health care is a schismatic issue which elicits extremely strong responses from individuals as well as small business owners. Certain provisions under the ACA are regarded by many to be desirable improvements (Singh & Palosky, 2016). Among the most popular of these is the ability of eligible persons who are under the age of 26 to remain covered by the health insurance policy of a parent ("Rules and Regulations," 2010, p. 34553). As indicated in Figure 1, based on Kaiser Family Foundation data (Singh & Palosky, 2016), the relative popularity of certain provisions is as follows: ability to stay on parents' insurance plans until age 26 (85%); elimination of out-of-pocket costs for some preventive services (83%); providing financial help (subsidies) for those with low- and moderate-incomes (80%); giving states option of expanding their existing Medicaid programs to cover more low-income, uninsured adults (80%); prohibiting insurance companies from denying coverage because of a person's medical history (69%); and the penalty provision, a decidedly unpopular part of the law, whereby most Americans must have health coverage or pay a fine (35%).

Insurers incurred substantial losses in 2016 (Cox et al., 2016). As a result, in 2017 some insurers have reacted by announcing their withdrawal from the ACA marketplaces or the individual markets in some states (*Ibid*.). Consumers and small businesses (as well as larger ones) have consequently seen sharp increases in premiums. The average American consumer may not necessarily know or be concerned with the losses incurred by insurance companies and health care providers, but they are certainly feeling the consequences of those losses (such as those discussed above, e.g., cost shifting, shrinking networks, limited providers after insurers withdraw from markets, rising deductibles).

Taken from an Excel file named "Table 16 National Health Expenditures, Amounts and Average Annual Growth From Previous Year Shown, by Type of Sponsor" ("National health expenditure projections 2016-2025") by the year 2025 U.S. healthcare spending is expected to reach $5,549 trillion. In comparing this amount with the $3,358 trillion estimate for 2016, one finds the in the ten year period from 2016 to 2025 (as illustrated in Figure 2), if estimates hold true or nearly true, the total burden on the U.S. economy attributable to health care expenses will nearly double. Thus, it remains apparent that the cost of health care will continue to place a significant burden on the U.S. economy and therefore its citizenry, and the public at large is voicing differing views about whether to keep, revise, or repeal and replace Obamacare.

CONCLUSION

From the very beginning, with a botched HealthCare.gov website launch (Schlussel, 2013; Michael D. Tanner, 2013; Weigel, 2013; Young, 2013), numerous delays, revisions, and legal wrangling, have resulted in ongoing uncertainty (Secor, 2017) for small businesses and consumers over the fate of their health insurance and health care (Anderson, 2014). Issues that have arisen for businesses include every subcategory, even non-employer firms (due to the individual mandate). Smaller firms (those not reaching specified FTE thresholds) may not be required to furnish health insurance to employees, but if they wish to do so, costs are higher; in the case of larger firms, costs are higher as well.

The Patient Protection and Affordable Care Act (Obamacare) portends a system of health care delivery that at best seems completely inadequate to address the needs of citizens in a manner that is consistent with either its namesake or the promises that were made prior to the law's passage. While some who were previously uninsured have obtained coverage, all are left to contend with the fact that access to health insurance is not the same thing as access to health care itself. Insurers and providers are adapting. Once one has insurance, then the questions become what claims can be denied, exactly, on a person-by-person, location-by-location basis, who is in a provider network; and how high are the premiums, deductibles, co-pays and other expenses (many of which do not count toward total out-of-pocket expenses)? Despite (or perhaps due to) ongoing controversy, numerous legal challenges, and all-but-inevitable repackaging or recreation altogether of a national health insurance and/or health care plan by the 115th Congress and/or its predecessors, the issue that remains at hand – how best to disseminate health care – is likely to have lasting and far-reaching impact on the individuals and businesses who have been a party to the Affordable Care Act (Lange & Marciarille, 2015).

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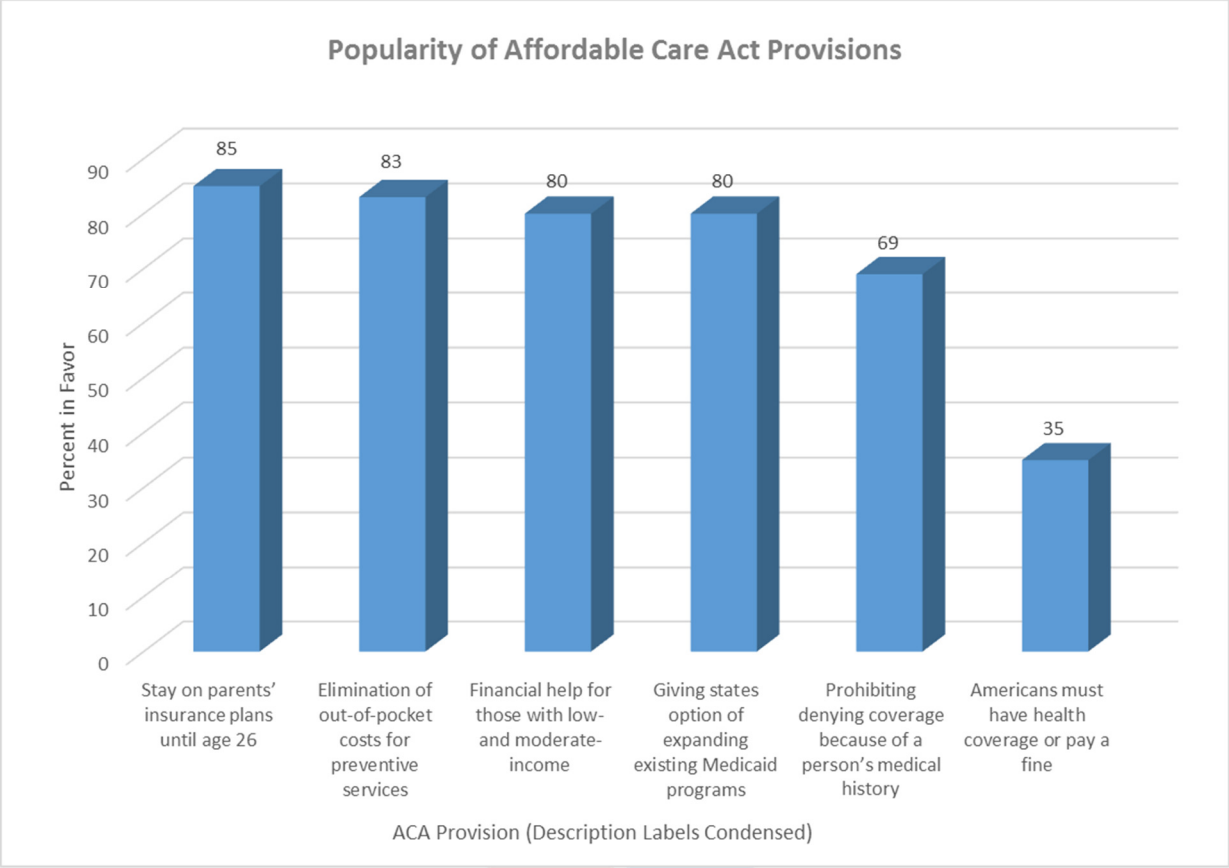
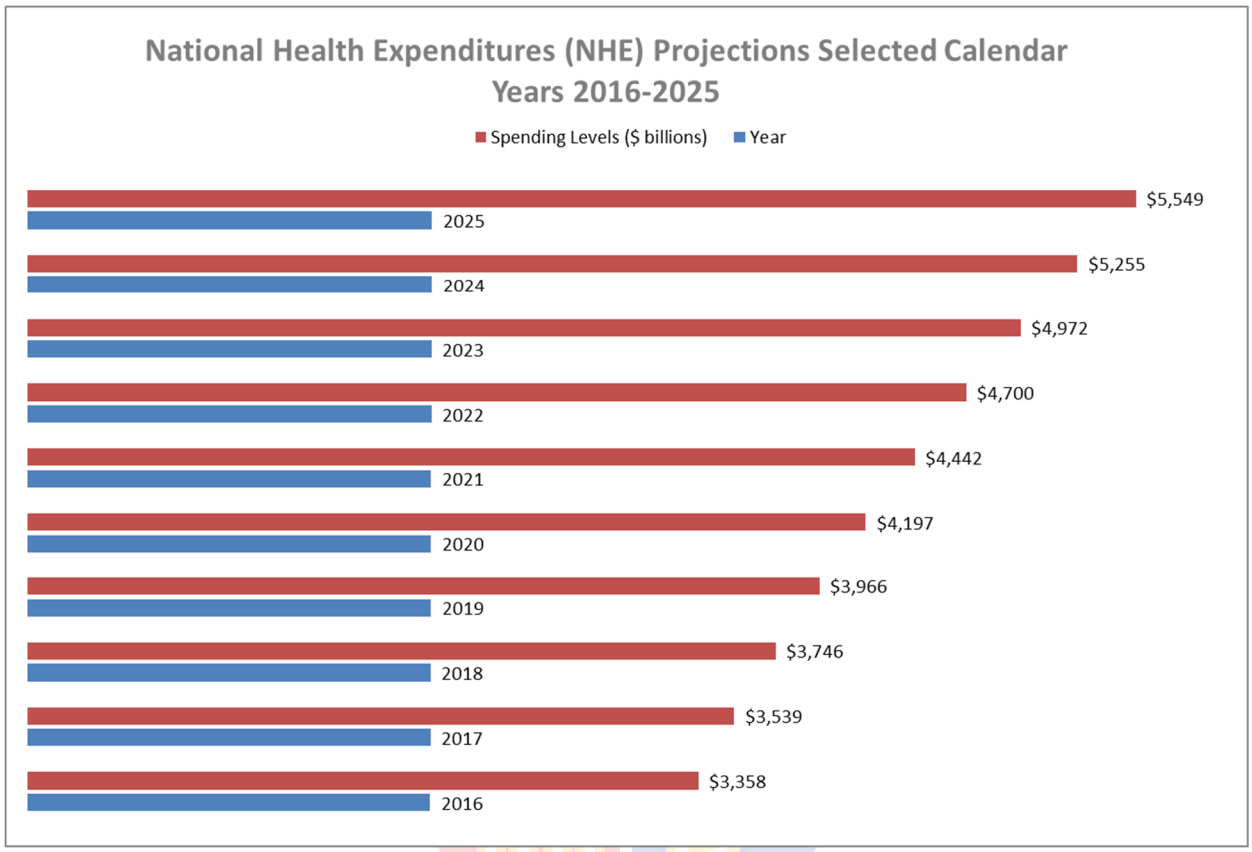
APPENDIX

Figure 1



Source: Derived from Kaiser Family Foundation, Kaiser Health Tracking Poll: November 2016 results. Retrieved February 25, 2017, from http://kff.org/health-reform/press-release/after-the-election-the-public-remains-sharply-divided-on-future-of-the-affordable-care-act/

Figure 2



Source: Derived from an Excel file named "Table 16 National Health Expenditures, Amounts and Average Annual Growth From Previous Year Shown, by Type of Sponsor." Retrieved February 25, 2017, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html