

Small Businesses, Poverty, and Social Policy: The Effect of the ACA on the Relationship
between Small Businesses and Poverty

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***Abstract:** The Affordable Care Act, enacted in 2010, was meant to improve health insurance access for the uninsured and hard to insure across the country. However, in doing this, it placed significant burdens on individuals, large businesses, and small businesses. This paper attempts to address those new burdens for small businesses and whether they negatively affect those employed by small businesses, particularly those at or near the poverty line. Overall, small businesses have been shown to help decrease poverty in the communities in which they operate, but the burdens placed on small businesses as a result of the ACA negate this impact. This paper discusses the new costs and benefits associated with the ACA on small businesses and their employees. It also attempts to address this concern from an ethical perspective and provide potential policy recommendations for healthcare legislation moving forward.*

Introduction

Small businesses surround us; we walk into them every day on Main Street of a small town or on the corner of large city blocks. According to the Small Business Administration (SBA), small businesses make up 97.7% of U.S. employer firms (SBA, 2012). They help revitalize struggling communities and promote general economic development in areas all over the world, including the United States. This development also has poverty-reducing effects. However, some social policies implemented by state and federal governments, which are meant to help individuals in poverty, can place significant burdens on the small businesses that often employ them. One such policy is the Affordable Care Act (ACA). It places restrictions and requirements on businesses owners, forcing them to adapt and change business operations in order to stay profitable. Although intended to help the uninsured, which includes many poor people, the ACA causes some adverse effects for employees of small businesses. Policymakers should consider this and carefully evaluate the costs and benefits to both individuals and small businesses when developing social policies meant to help those in poverty.

This paper proceeds in several sections. The first section defines the concept of small businesses. Because there are varied notions of what constitutes a small business, this analysis needs a generally uniform concept. The second section discusses the relationship between small businesses and poverty reduction. Considerable evidence suggests that small businesses decrease poverty, both through income (or economic development) and capability measures. The third section examines the ACA, in relation to small businesses, particularly the new requirements it imposes on them. Next employer reactions and the impact they have on employees will be explored in depth. The concern, however, encompasses more than just economic reasoning; moral and ethical concerns also prove important. The penultimate

section discusses these ethical concerns, and finally, the paper concludes with policy implications as a result of these findings.

What are Small Businesses?

The Small Business Administration (SBA) provides a definition for small businesses that many organizations use when studying and analyzing them. The SBA is an independent federal government agency tasked with providing assistance and protecting the interests of small businesses concerns. It describes these companies according to two different size criteria, which are either millions of dollars in revenue or number of employees (Table of Small Business Size Standards Matched to North American Industry Classification System Codes, 2014). Similarly, it defines a small business concern as one that is “not dominant in the field of operation for which it is bidding on a government contract” (Small Business Act, 2013, p. 8). It must also be both organized for profit and independently owned and operated to qualify as a small business under the Small Business Act.

Because the SBA has no specific number of employees or annual revenue size to classify all small businesses, many researchers create their own parameters. This decreases study comparability; however, a few key themes permeate the current literature. The Corporation for Enterprise Development (CFED) (2004) defines SMEs as any business with fewer than 500 employees. Blanchard, et.al (2012), classify small businesses as establishments with zero to four employees. Gebremariam et al., (2004) and Gebremariam, et al., (2006) define these companies as those with fewer than 500 employees, although acknowledging that most of these companies employ fewer than 100 individuals. Though the definitions vary, they all cap the small business size at 500 employees, which creates a basis for comparison. The literature discussed and analysis in this paper, only include companies with fewer than 500 employees. The ACA, however, provides special provisions for small businesses with fewer than 50

employees, considering businesses with greater than 50 employees large enough to handle some policy burdens and considering businesses with 500 employees rather large. This paper will address the ACA's distinctions in future sections.

Small Businesses and Poverty

When addressing social policy's impact on small businesses, it is also critical to consider whether promoting these firms' interests brings other social benefits. Research develops a strong connection between small business growth and increased income, health, and wage stability. Gebremariam, et al. (2004) discuss how small businesses alleviate poverty. At the time of their study, West Virginia ranked second to last in per capita income for the entire country. It also fell behind the rest of the Appalachian region in measures of health and wealth.

The authors use econometrics and regression analysis to determine the relationship between small business development, economic growth, and the incidence of poverty in West Virginia, finding that small businesses increase economic growth and decrease poverty. The Real Gross State Product per capita provides a proxy for economic growth, and the headcount measure of poverty provides a proxy for the poverty levels in West Virginia. The headcount measure is simply the percentage of people below the United States' poverty line. Although an imperfect measure, the poverty line develops as a simple way to quantify the relationship between small businesses, economic growth, and poverty. The results show a strong "inverse relationship between the relative size of small business and the incidence of poverty," meaning small businesses in particular help reduce poverty (2004, p. 20). When the number of small businesses in a community increases, the incidence of poverty decreases. In a 2006 paper, the authors conduct similar analysis over counties across Appalachia, finding that promotion of small business decreases poverty in these Appalachian counties. Small

business growth and median household income, their proxy for poverty, are interdependent and grow together (Gebremariam, et al., 2006). These authors' two studies find a significant positive relationship between small business growth and poverty reduction.

Researchers also measure the relationship between small businesses and poverty through employment. Langan (2014) analyzes the relationship between small businesses, the unemployment rate, and the annual average weekly wage. She finds that an increase in the small business ratio, which is the number of small businesses per 1,000 people in a county, is associated with a decrease in the unemployment rate, because new, small firms create jobs as they expand (Langan, 2014). Goods-producing businesses in particular decrease the unemployment rate, decreasing it by .25% on average. A study by Acs, et al. (2008) for the Small Business Administration supports these findings. They find that companies, particularly those with 20-499 employees, cause a positive net employment effect over the time period from 1994 - 2006. Even during the period from 1998 – 2002, which included the dot.com bubble, these companies caused net positive employment effects. These businesses create more employment gains, through growth, than employment losses, through closings or layoffs (Acs, et. al, 2008).

Langan also addresses the relationship between the small business ratio and wages. When breaking small businesses into goods producing or non-goods producing businesses, she discovers particularly interesting results. Goods producing businesses include those in Agriculture, Forestry, Fishing and Hunting; Mining, Quarrying, and Oil and Gas Extraction; Construction; and Manufacturing. Overall, an increase in the small business ratio slightly increases wages, but the increase is so small that it fails to cause a meaningful wage change. For goods producing businesses, however, increasing the small business ratio by one unit increases the average weekly wage by \$1.58.

Lastly, she finds that an increase in the small business ratio slightly, but not significantly, increases the poverty rate; however, an increase in the ratio of goods producing small businesses is associated with reduction in the poverty rate. The fact that non-goods producing service businesses, such as restaurants, tend to pay lower wages or hire part-time employees may explain why Langan finds slight increases in the poverty rate associated with a greater non-goods producing small business ratio. These businesses likely hire from the secondary labor market: the market, which consists of high-turnover, low-pay and usually part-time work. Overall, Langan argues these effects, increasing wages, decreasing the unemployment rate, and decreasing poverty in goods producing small businesses, are positive and significant. She notes, however, that the findings may partially be attributed to the fact that the gap between small and large businesses for wages and benefits have decreased over time. An increase in the small business ratio leads to greater economic growth and positive poverty effects in counties, although the effect varies by business type.

Langan still uses a monetary approach to measure small businesses' impact on poverty. Although important, poverty determinants encompass more than just income deprivation. Blanchard, et al. (2011) develop the relationship between small businesses and health, another important aspect of poverty. Through regression analysis, the authors find that rates of mortality, obesity, and diabetes decrease with a greater concentration of small businesses. They argue that this relationship includes several components, using data from the 2000 Census of Population and Housing, The 2002 County Business Patterns survey data, 2002 Nonemployer Statistics, and the 2007 Centers for Disease Control Obesity and Diabetes Estimates, and the National Center for Health Statistics Compressed Mortality records from 1994 to 2006 to determine this result. The authors posit that because small business owners live in the communities where they operate, they develop a higher level of collective efficacy (the residents' ability to control outcomes and create a safe, productive community) and a

greater willingness to help the areas around them, which causes this increased health. They cite several studies, which demonstrate this, including Mills and Ulmer (1946), Blanchard and Matthews (2006), and Islam et al. (2006).

They connect this collective efficacy and connection to the community with both employee and small business owner entrepreneurial spirit, arguing that the small business entrepreneurial spirit and general interest in the success of the community, affects health outcomes. The businesses benefit when the community around them thrives, thus they support health infrastructure, promote community health programs, and support local farmers' markets, which then improves health outcomes. (Lynch, et al., 2011). Large retailers do the opposite; Blanchard, et al. (2011) find the presence of large retailers reduces health outcomes. This is likely because these businesses, such as Walmart, have less community efficacy or concern for employee welfare.

It must be noted, however, that these studies are correlational. Other factors could influence the relationship between small businesses and health outcomes; small businesses and wages; or small businesses and stable employment. For example, rural areas might contain both higher concentrations of small business and lower pollution, and rather than small businesses causing higher health outcomes, low pollution may cause them. Although an important concern in all studies, this is particularly relevant in the health analysis. Blanchard et al., however, control for several important variables, which strengthens the correlational argument. They control for the population health insurance status, income inequality, per capita income, racial make-up, physician concentration, the size and age of the population, and proximity of metro areas. Even after controlling for these factors, the regression results remain very robust; the correlation still proves highly statistically significant. Thus, small businesses have important non-income health benefits to communities (Blanchard, et al., 2011).

Health indicators align with a capability definition of poverty. Sen (1992) argues that one can have a higher income but still be deprived of valuable functionings or well-being. For example, if an individual with a high income must spend all of his money on a dialysis machine for his kidney, while someone with a lower income has few health problems or healthcare needs, then the one with higher income may actually suffer greater deprivation. Sen argues that poverty, in terms of income alone, ignores capabilities and functionings for individuals. In this sense, poverty is “the failure of basic capabilities to reach certain minimally acceptable levels” (Sen, 1992, 109). Being generally healthy is a valuable functioning for many (Sen, 1992), and if small businesses improve the health of the communities in which they operate, they contribute to human capability. In other words, evidence suggests that small businesses’ poverty reducing impact is not limited to job creation and increased wages, but it also enables other dimensions of well-being.

Small business’s community impact, however, includes more than just health or economic outcomes; business owners and community members report positive interaction. Besser and Miller (2001) find evidence of greater employer-employee goodwill and a greater desire to help the surrounding community in small business. They interview over 675 business owners and managers asking questions such as, how often has your business made “Financial donations to local schools,” how often is it the case that “If you do not look out for yourself, no one else in will,” and are you “as a business owner/manager, ... willing to expend resources to help the community?” (Besser and Miller, 2001, p. 229-230). From the surveys, they find that many small business leaders report civic engagement. Not all businesses convey this engagement, but civic leaders and those operating in communities with positive collective action express a commitment to improving the community around them. This includes about half of the businesses studied (Besser and Miller, 2001). Businesses indicate both investment in their employees and the communities where they

operate. This may support the positive community efficacy of small businesses discussed in Blanchard et al.'s (2011) study regarding health outcomes. These may be the same types of businesses. Surveys like this suggest that, these businesses contribute to the well-being and capabilities of their communities. However, survey data has limitations. For example, people will likely attempt to answer the above questions positively, and the manner in which surveyors ask questions may point respondents towards a certain response.

Small businesses' philanthropic participation in the community translates into trust and community support. Since 2011, a study conducted by The Garrity Group has found that New Mexico residents classify small businesses positively, indicating 80% favorability ("Garrity Perception Survey", 2015). Communities and small businesses report a mutually beneficial relationship. Similarly, in a questionnaire sent to community members of Excelsior Springs, Missouri in 2008, individuals identified small business retention as a top issue to address for further economic development. The community associated small business retention with economic growth and declared a need to support small businesses ("Excelsior Springs Community Report Card," 2008).

Overall, Americans assert significantly more confidence in small businesses than big businesses. According to a Gallup Poll, conducted since 1997, Americans consistently show three times as much confidence in small businesses than big businesses. They expressed 67% confidence in small businesses vs. 21% confidence in large businesses in 2015. Small business ranked second, trailing only the military in public opinion. Gallup also finds that people express confidence in small businesses because they know and trust the owners, who they consider friends and neighbors (Dugan, 2015). Overall, "83% of Americans wish that more of the products, services, and retailers they use would support causes" ("Cone Cause Evolution Study, 2010, p. 5), and the survey research indicates that small businesses may link this ideal with reality.

Small Businesses and the Affordable Care Act (ACA)

Although small businesses help reduce poverty, expand capabilities, and interact positively with communities, intense competition permeates the markets in which they operate. This presents a significant challenge; according to a poll conducted by the National Federation of Independent Businesses (NFIB) (2003), 81% of small business owners believe that they operate in a highly competitive or competitive climate. Similarly, 61% believe the current climate much more competitive than just three years ago and the competition continues to increase (Dennis Jr., 2003). These small firms also compete against larger firms with greater resources, which include, more streamlined supply chains, significantly more employees, and economies of scale. These resources allow them to absorb new costs more effectively than small businesses. Small firms lack scale and scope in the competitive environment against large firms (Armstrong, 2013). Overall, small businesses experience a heightened competitive environment. Because of this, they have less elasticity in assuming new costs, and when the government enacts new regulations small businesses can face significant challenges in attempting to comply.

Many of these policies come with new costs, which may negatively affect these businesses. For example, the Affordable Care Act (ACA) (officially signed into law on March 23, 2010 by President Barack Obama) affects individuals, companies, and groups across the nation. It intends to “expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising healthcare costs” (King, 2011, p. 1). The law includes many provisions, including requirements that all individuals obtain health insurance. Exemptions only apply to individuals that can site a religious reason or lack the economic means to pay for health insurance. The ACA states that those who earn less than 133% of the poverty line qualify for Medicaid, which exempts them from purchasing their own insurance.

This results in families of four making less than \$29,700 exempt. However, at this time, only 32 states have expanded Medicaid up to this number so some individuals lack this coverage. Both pre- and post-ACA many individuals receive health insurance through their employers. This paper focuses on the ACA in relation to small businesses.

The Affordable Care Act		
Individual	Employer	Health Insurer
Individual Mandate All Individuals must acquire health coverage, or must pay a penalty	Employer Mandate Companies employing 50 or more people must offer health insurance or pay a penalty	Guaranteed Issue Healthcare insurers are prohibited from denying coverage based on pre-existing conditions
Insurance Exchange An online marketplace for individuals to acquire health insurance, which is subsidized for those below 400% of the Federal Poverty Line	Insurance Exchange An online marketplace exists where small businesses can purchase group health insurance	Minimum Standards Insurance coverage must provide essential health benefits
	Employee Wellness New initiative to support and encourage employee wellness programs	Insurance Premiums The same premium applies to all applicants of the same age and from the same geographical area
	Small-Business Tax Credits Certain small business with fewer than 50 employers and an average employee wage of less than \$50,000 qualify for tax credits to offset health insurance	

Adapted from: Jain and Mohan, "The Affordable Care Act and Its Impact on Workers' Compensation," (2015).

In 2014, the National Center for Policy Analysis (NCPA) studied the effects of the ACA on small businesses. It found that the penalties mostly apply to companies with more than 50 full-time equivalent (FTE) employees, but costs still exist for businesses with fewer than 50 employees, such as tax credit limitations and potential intangible costs (such as decreased competitiveness). The key issues NCPA identifies include health insurance mandates for firms with more than 50 employees, the change in premium prices as a result of the ACA, limits on employee premiums, and strict requirements on tax credits.

The ACA mandates that firms with greater than 50 FTE employees provide health insurance options. If they fail to provide insurance, they face a tax penalty of \$2,000 (\$2,160 in 2016) for each uninsured person beyond the first 30 employees. The regulation also requires that businesses to pay for at least 60% of the health care expense of a minimum value plan (one that includes the Essential Health Benefits and nothing more). Not only must they provide at least one health insurance option, but they are also required to subsidize a significant portion of the premiums (The Henry J. Kaiser Family Foundation, 2015).

In addition to health insurance requirements the law now requires new Essential Health Benefits (EHBs). These increased benefits include: “ambulatory patient services; emergency services; hospitalization; 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; preventative and wellness services and chronic disease management; and pediatric services, including oral and vision care” (Herrick, 2014). The new EHBs mean that some low-cost plans, which employers offer employees prior to 2010, no longer comply. To reach these new standards, businesses may be required to pay more. A study conducted by the American Action Forum (AAF), found that premiums increased for businesses as a result of the ACA. According to their study, the rise in premiums for businesses sized 50-99 employees ranges by state, increasing from 8.2% in Michigan to 34% in Wyoming, with most states experiencing increases of over 15% (Gitis, et al., 2014). In addition to all of this, if the plan falls short of the EHBs, the employer incurs fines.

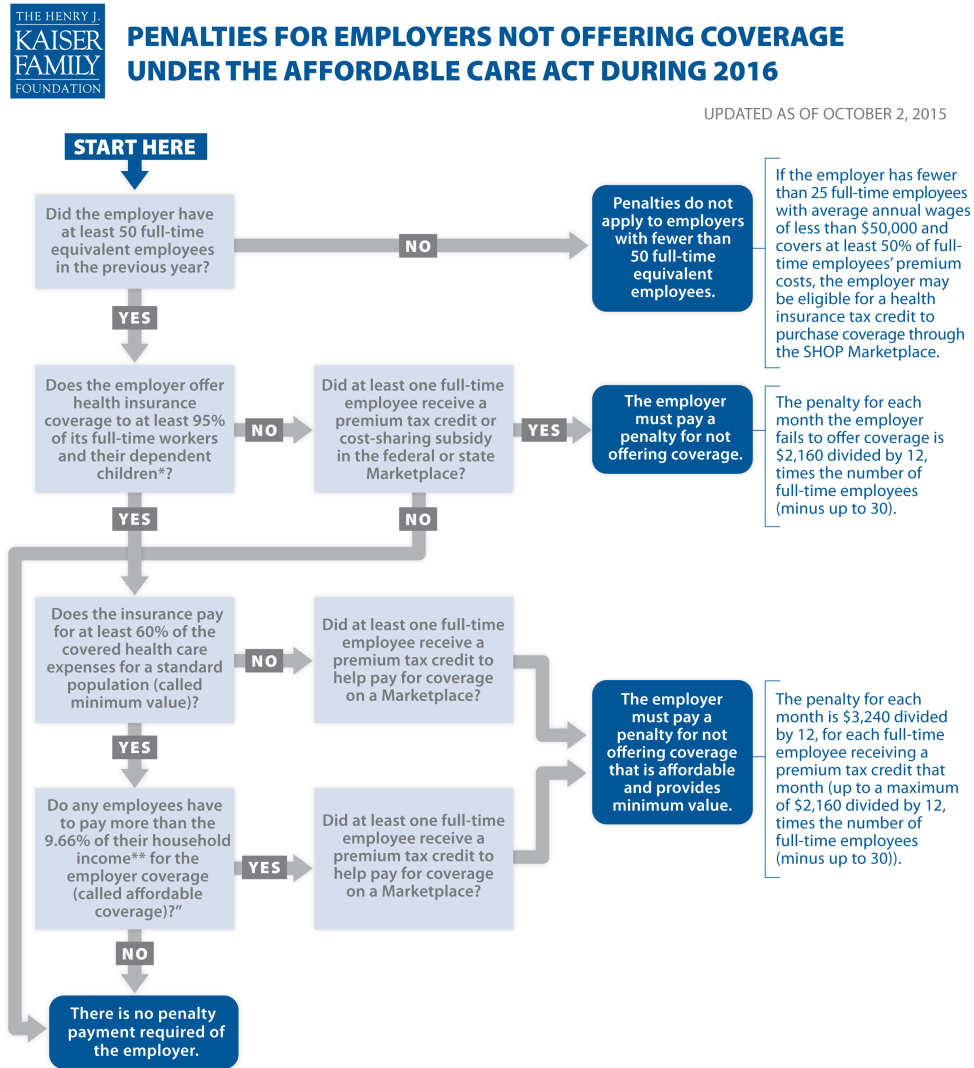
As part of this, the ACA eliminates limited benefit plans for employers. Previously, employers had the option to tailor plans, which lowered costs because it afforded businesses the flexibility to offer smaller plans or ones that best fit their employee’s needs. Insurers priced plans based on employees’ health status, history of claims, and other variables, thus

small businesses with healthy employees could potentially offer less expensive plans. The ACA prohibits this system, which limits flexibility. Now the small-group market can only vary prices based on where the applicant lives (or business operates), age, and tobacco use (CMS, 2014). The addition of EHBs also eliminates flexibility; small businesses with tight budgets (maybe those with fewer than 50 employees) had the option to provide health insurance, although a potentially more limited, tailored plan. The new EHB requirements, however, prevent this option, as plans must reach certain minimal standards. Although imperfect and some health insurers took advantage of the previous pricing system to increase profits, the new pricing system and EHBs eliminate flexibility for small businesses.

Companies, both large and small, offered health insurance plans as a way to attract talent, even if that meant providing tailored plans. Now the ACA requires coverage for most businesses, and because of changes in requirements businesses smaller than 50 employees, while not required to provide coverage, may have too few resources to provide it. A 2013 survey, found that 88% of workers considered health insurance as an extremely or very important workplace benefit, which affected in their decision to accept or reject the potential job (Fronstin, et al., 2013). If these new EHBs prevent businesses with fewer than 50 FTE and fewer resources from providing coverage, this could potentially put them at a competitive disadvantage.

The limit on employee premium payments also affects employer healthcare spending. If employees earn less than 400% of the federal poverty level, the law requires that they pay no more than 9.5% (9.66% in 2016) of their total income on health insurance. If employees have to pay greater than that amount to get coverage, employers must subsidize the difference between the health insurance costs and 9.5% of employee income. If employers fail to comply, they incur a \$3,000 (\$3,240 in 2016) fine per employee (ObamaCare Small Business Facts, 2016). As a result of these changes and many not listed, the Center for Medicare and

Medicaid Services (CMS) finds that the ACA increase premiums for two-thirds of employers offering complete employee health plans (CMS, 2014).



*A dependent child is defined as a child of an employee who is under the age of 26. Employers do not face a penalty under the Affordable Care Act if they do not offer coverage to the spouse of a full-time employee.

**Affordability is determined by reference to the taxpayer's household income (i.e., the employee's required contribution for self-only coverage should not exceed 9.66% in 2016). Since employers generally do not know the worker's household income, to determine if an employer may be subject to a penalty, the employer can measure 9.5% against three separate safe harbor amounts (the worker's Form W-2 wages, the worker's hourly rate of pay as of the first day of the coverage period, or the federal poverty line for a single individual). Note that a worker's and the worker's dependents' eligibility for premium tax credits or cost sharing subsidies are based on family income; not the safe harbor amounts.

<http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/>

As mentioned previously, however, companies with fewer than 50 employees face fines for opting out of health insurance coverage. That being said, the ACA encourages these firms to provide coverage by offering a temporary tax cut to certain employers that offer qualified

health insurance plans. To be eligible for the credit, these businesses must have fewer than 25 full-time employees, pay an average wage of less than \$50,000 a year, and pay at least half of their employees' insurance premiums. This credit was originally from 2010 – 2013, and the maximum credit for employers was 35% of premiums paid. It changed in the years from 2014 to 2016, and the maximum credit increased to “50% of premiums paid for small business employers,” expiring in 2016 (IRS.gov, 2016). This increase in credit was positive, but it also adds new restrictions. Compliance requires that companies offer employee healthcare plans on the Small Business Health Options Program (SHOP) marketplace (IRS.gov, 2016). Although theoretically benefiting small businesses that offer health insurance services, the NFIB (2011) found that in 2010, only 170,300 businesses claimed the tax credit, while the White House estimated 4.4 million businesses eligible. The NFIB reported that both taxpayers and practitioners made mistakes in calculating the credit, which resulted in so few employers claiming it (NFIB, 2011).

Even those businesses, which know they can claim the credit, do not claim it. According to the Kaiser Family Foundation, among firms both eligible to purchase and considered purchasing plans on the SHOP exchanges, 64% do not purchase because they still deemed it too expensive, 15% deemed it too big of a hassle, and 15% believed it too complicated. Although a potentially positive benefit, few businesses utilize the credit (Claxton, et al., 2015). It takes time and resources to claim the credit, so even businesses knowledgeable about the credit might not claim it. Meant to help small businesses, the credit has been underutilized and if legislators do not extend this credit it will expire this year.

Although many argue that the ACA hurts small businesses, some argue that the ACA benefits most small businesses. Small business owners historically had a harder time providing health insurance to their employees. Rising health insurance costs, not being able to spread risk across many employees, and other reasons caused this, but the ACA makes

plans much more affordable (ObamaCare Small Business Facts, 2016). For example in 2006 businesses with 1-9 employees experienced premium prices 18% higher, businesses with 10-24 employees experienced prices 10% higher, and businesses with 25-99 employees experienced prices 7% higher than firms with 1,000 or more workers (Gabel, et al., 2006). Some argue that the ACA decreases this gap, or diminishes it altogether. The ACA achieves this through several means, one of which is the Small Business Health Options Program (SHOP), where businesses with 100 or less FTE employees (as of November 15th, 2015) shop for group health plans. The SHOP plans simulate purchasing a large group plan but with a small group, decreasing overall premiums. According to the ObamaCare website, small employers may experience up to a 50% reduction in their share of the employee premium cost (ObamaCare Small Business Facts, 2016).

Although the ACA has caused some positive outcomes for small businesses, the current literature finds significantly more negative than positive effects. Some may argue that the research predominantly comes from those highly motivated to find faults with and repeal the legislation; many of the costs and requirements for small businesses are simply new legislation requirements and burden small businesses regardless of their political leaning.

These new requirements prove particularly burdensome for those small businesses with just over 50 employees. The ACA considers small businesses large enough to bear significant burden (almost as much burden as very large businesses) when they employ greater than 50 individuals. Conversely, the SBA considers most businesses with fewer than 500 or even 1,000 employees as small enough to need support. These two definitions and the amount of resources a 50-person business and a 500-person business contains differ greatly. While a 500-person business may contain the resources to comply with these new requirements without significant economic harm, a 50-person business may face serious challenges. These employers, which Acs et al. (2008) find as those with the greatest positive net employment

effects, face fines for noncompliance just like large businesses. They face fines if they do not provide health insurance options for employees and if the insurance they provide is deemed too expensive. Similarly, for businesses with 50-99 employees, insurance premiums increased on average 19.99% since ACA implementation (Gitis et al., 2014). The ACA places significant costs on small businesses, which they must then consider and determine how to both manage costs and provide for their employees.

Employer's Actions as a Result of the ACA

The ACA's new rules cause employers to react and change their business strategies, to both remain profitable and comply with requirements. Three key ways they adapt are through cutting employee hours, not hiring, and increasing the amount of premiums employees pay, all of which can affect wages. The International Foundation of Employee Benefit Plans (IFEBP) surveyed over 600 small business owners about their thoughts on the ACA and found that more than 40% delayed hiring because of uncertainty and concerns surrounding the ACA. In general, 60% of employers believed the ACA detrimental to their organization. In fact, from 2010 to 2015 employers' views of the ACA became more negative. (2015 Employer-Sponsored Healthcare: ACA's Impact, 2015).

Employers simultaneously consider reducing employee hours and decreasing hiring, when determining how to respond to the ACA. Mercer (2015), a consulting firm, also conducted a survey about employment, employers' actions, and enrollment in health insurance plans 5 years into the ACA. This included both big and small businesses, but it found that 2% of employers reduced the number of workers; 7% reduced the number of hours for employees who worked 30 or more hours per week (so as to make sure they are considered part-time employees under the ACA and prevent the need to pay healthcare benefits); and 12% reduced the number of hours for employees who occasionally worked 30

or more hours per week (Mercer, 2015). Four percent of firms with greater than 50 FTE employees reported reducing the number of employees it intended to hire because of new health insurance costs, according to the Kaiser Family Foundation (Claxton, et al., 2015). When considering reduction in hours, employees may experience both a decrease in wages and a loss of health insurance. Those that now work less than 30 hours per week lose full time employee status. They are thus ineligible for benefits, including health insurance.

With regard to reduced hiring, although 2% or 4% of employers may seem small, if only 2% of small businesses reduced their workforce by only 1 employee, this results in over 100,000 lost jobs. Larger firms in particular likely decrease their workforce by more than 1 employee, increasing this number. The American Action Forum (AAF) finds that the ACA decreases small business jobs by 350,000 across the nation. Using labor market data from the Bureau of Labor Statistics (BLS) and health insurance premium data from the Medical Expenditure Panel Survey (MEPS), they find that a 1% increase in employer health insurance contributions is associated with a 0.06% decrease in jobs for companies sized 20-49 (Gitis, et al., 2014).

Premium increases have resulted in increased cost sharing by employers and reduction in take home wages for employees. Both large and small businesses have raised the amount that employees pay into health insurance plans. Although this takes burdens off of employers, maximum requirements on employee contributions and the 9.5% of employee income payment ceiling limit the amount employers pass onto employees (Mercer, 2015). The increased cost sharing hurts employees by requiring that they allocate larger portion of their incomes to healthcare. The AAF finds that the ACA decreases total aggregate employee pay by over \$22.6 billion annually (Gitis et al., 2014). That being said small businesses attempt to provide for their employees. According to the Kaiser Family Foundation, companies with

less than 200 employees paid a greater portion of health insurance premiums every year from 1999-2015 (Claxton, 2015).

Analyzing employee pay further, for company sizes 20-49 and 50-99, a 1% increase in employer health insurance contributions results in a decrease in wages. In 68% of states annual wages decreased between \$750 and \$1,750 per year. Thirty-eight percent of states experienced decreases greater than \$1,000. Across the nation, the AAF finds that employees lose on average \$827.50 annually as a result of the ACA. In Wyoming, employees lose \$1609.58 a year; in Connecticut, they lose \$1641.60; and in Colorado, they lose \$1,270.69, all three of the higher states. Although some might consider this a small amount of money, the difference between a \$24,000 a year income and \$25,000 a year can result in significantly different opportunities for low-income workers (Gitis, et al., 2014). Particularly for those living at the poverty line, a marginal change in discretionary income could significantly impact capabilities. According to Mercer, 28% of companies have already implemented some form of this, cost sharing, hour's reduction, or employee reduction, and another 48% are considering implementation (Mercer, 2015).

A conversation with Tom Turlington, the Vice-President at Turlington Lumber Company, a small business with 40 employees, helps demonstrate this effect. Before the ACA, the company offered to pay 100% of premiums for employees, and helped to subsidize health insurance premiums for employee family members. As a result of changing premium prices, the company now only pays 80% of premiums for employees and discontinued family plans, attempting to balance providing for employees while maintaining costs. To further this, although premium prices increased for the past two years, the company has maintained the commitment to pay 80% of premiums, but it is likely that, if premium prices increase next year, the company will increase cost sharing. Although only one example, this helps to

illustrate the effect on both employers and employees (Turlington, personal communication, March, 31 2016).

These increases in premiums decrease take home wages, but the ACA's potential positive health benefits must also be considered. The social gradient of health helps address the intersection between wages and access to health. Which proves more beneficial? According to the social gradient of health, the evidence indicates that "the lower an individual's socioeconomic position, the worse their health" (WHO, 2008). For example, if using under-5 mortality rates to measure health, the lowest income bracket has the highest mortality rate, and the highest income bracket has the lowest mortality rate. The evidence indicates that this occurs on the country level, i.e. the lowest income countries have the worst health, and on the individual, intercountry level, i.e. the poorest people, within each country, have the worst health (WHO, 2008). Therefore one can posit, that a decrease in people's annual wages, as a result of the ACA, may decrease their overall health, even with new access to healthcare. People may now have health insurance but that does not guarantee increased health.

The ACA curtails many of the ways that these businesses enhance employee well-being and decrease poverty. Recall that Gebremariam, et al. find that small business growth increases incomes; Langan finds that small businesses decrease the unemployment rate and increase hourly wages; and Blanchard, et al. find that small businesses improve the health of their communities. However, many studies of the ACA show that it limits small businesses' ability to achieve these exact things. Small businesses are reducing the number of hours employees work, so that they are not considered full time and thus do not receive benefits (Mercer, 2015). They have postponed hiring or even cut jobs as a result of the ACA. Owners also report decreasing wages slightly to account for the costs associated with the ACA (Gitis, et al., 2014). All of these impacts neutralize the positive contributions small businesses ordinarily provide for communities.

These businesses weigh the costs and benefits of increasing jobs and keeping high wages, with the need to remain profitable or a going concern. Eighty point four percent of employers sized 0-50 believe that the ACA increases costs, and 82.8% of employers sized 51-599 believe that the ACA increases costs (2015 Employer-Sponsored Healthcare: ACA's Impact, 2015). If they cannot operate profitably, this presents even greater trouble for employees and management; as a result, small decreases in wages or postponing hiring seem necessary costs in the big picture. In fact, the firms with 20-499 employees, which according to Acs, Parsons, and Tracy (2014), have the largest effect on increasing jobs and decreasing poverty, are the companies which have implemented the greatest decrease in wages (Gitis, et al., 2014) and have reduced hiring (2015 Employer-Sponsored Healthcare: ACA's Impact, 2015) as a result of the new ACA regulations. The burdensome ACA regulation may negate many of the benefits these companies provide. While the ACA creates opportunities for individuals to more easily access healthcare, the new costs to both employee jobs and income may outweigh the overall benefits.

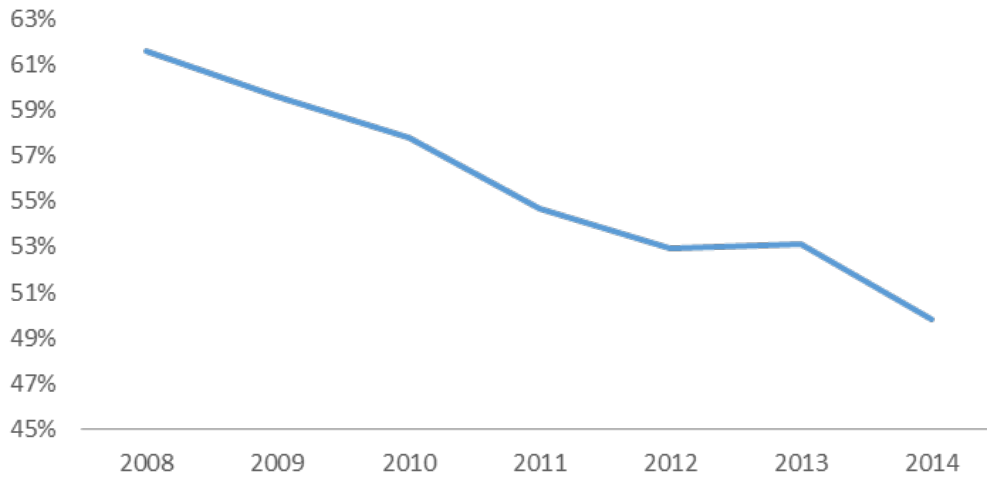
Many small employers have stopped offering health insurance plans to their employees, deciding that the new restrictions and costs too expensive. According to the MEPS data, employers with fewer than 50 employees offering health insurance, decreased from 61.6% to 49.8% from 2008 – 2010 (MEPS, 2008-2015). Of the firms sized 3-199 that did not offer health insurance 41% cited high costs associated with health insurance as the reason that they did not offer it (Claxton, et al. 2015). In some ways, this allows employees to purchase their own health insurance plan and decide what is best for them, but it also demonstrates the size of the health insurance burden for small businesses as many owners choose to discontinue providing insurance options.

Percent of Private-sector employees in establishments that offer health insurance

Year	Less than 10 employees	10-24 employees	25-99 employees	100-999 employees	1000 or more employees	less than 50 employees	50 or more employees
2008	45.00%	69.50%	85.30%	95.90%	99.00%	61.60%	97.40%
2009	42.50%	66.60%	85.00%	96.30%	99.70%	59.60%	97.90%
2010	40.50%	64.70%	83.30%	95.40%	99.60%	57.80%	97.40%
2011	36.00%	62.70%	80.60%	94.40%	99.50%	54.70%	96.80%
2012	35.30%	61.70%	78.90%	94.60%	99.60%	52.90%	96.80%
2013	36.20%	59.30%	81.20%	95.20%	99.10%	53.10%	96.90%
2014	32.90%	55.50%	77.20%	92.70%	99.10%	49.80%	95.80%

Author Analysis of Medical Expenditure Panel Survey Data

Companies with less than 50 employees offering Health Insurance



Despite these costs, the ACA as a whole may still improve health outcomes for individuals. Do the potential benefits then outweigh the costs? In 2015, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) estimated that 17.6 million people uninsured before the ACA gained health insurance coverage. The number continues to grow. Both Medicaid expansion and non-expansion states experienced a decline in their uninsured rate. Expansion states experienced an 8.1% decline in their uninsured rate, while the non-expansion states experienced a 7.3% decline (ASPE, 2015). According to the U.S. Department of Health and Human Services, both access to and quality of care are improving. Since, 2011 hospital-acquired conditions, such as ulcers or central line infections, have fallen

by 17%. Similarly, the “Medicare 30-day readmission rate fell by 12.5% in 2013” (“The Affordable Care Act is Working,” 2015). This translates into over 150,000 fewer hospital readmissions.

Although the ACA appears to be improving access and quality, it may not actually improve individuals’ health. Access and quality are only two determinants of health; other factors include the environment, age, genetics, diet, physical activity, and more. For example, even if one had improved access and quality, if genetics caused him to have diabetes or living in a polluted area gave him lung cancer, he would still face serious health concerns. The ACA is too new to study the health effects on individuals. However, researchers have studied the Massachusetts’ healthcare reform, which was a model for the ACA. After enactment, low-income households in particular saw improved health status, including greater use of preventative services and a decreased mortality rate (Van Der Wees, et al., 2013). The ACA may potentially have similar effects. But even with this, one must consider the current adverse effects, such as a decrease in wages, a reduction of worker hours, a reduction in hiring, and more.

As implementation completes in 2022, the long-term health effects of the ACA are still uncertain. That being said, even if it improved health, it would not settle the ethical questions about the law. Amartya Sen’s (1992) capability approach to poverty helps analyze this concern. According to Sen people need both capabilities and functioning’s. Being healthy is a general functioning that most people value. Other valuable functionings include literacy, employment, housing, positive relationships, and more; they permeate all aspects of life. The concept of capabilities and functionings, however, includes freedom of choice. Capabilities are people’s freedoms to enjoy or even reject functionings. Forcing or coercing people to use capabilities to achieve unwanted functionings limits their freedoms. With regard to health, an individual may purposefully deprive himself of food if participating in a hunger strike, which

decreases his health, but this is a conscious choice that he makes, even though detrimental to health. Forcing him to eat, so that he could achieve health, would limit his capabilities and freedom to choose his own functionings. Applying this to healthcare, being healthy is a functioning but choosing to purchase health insurance (so that one can hopefully be healthy) is a capability, and if people prefer not to purchase it, the government should not force it (Alkire and Deneulin, 2009). Although useful, having health insurance does not guarantee one the functioning of being healthy.

The ACA decreases peoples' capabilities even further by constraining individual choice in two distinct ways. First, with individual health insurance mandates and second, with the types of plans offered, and in the process, it may not necessarily address poverty. These individuals should have the opportunity to use their income to buy health insurance that fits their needs. For example, those who consider purchasing health insurance unnecessary to fulfill the functioning should not be forced to buy coverage or punished for noncompliance. Though in this situation, individuals may choose to take the tax penalty if they do not purchase health insurance. However, if people indirectly take a pay cut as a result of employer requirements to purchase health insurance, this eliminates choice. Individuals not only pay for an unwanted health insurance plan, but they also lose some income, which, may have been spent better elsewhere. The lack of choice decreases individuals' capabilities.

The type of plans offered also eliminates choice. Previously both individuals and companies could tailor plans to specific needs, potentially lowering costs. Now the new EHB requirements decrease choice for both groups. These EHBs include specific needs, such as mental health services, chronic disease treatment, and pediatric services, which may not apply to everyone. Not only must individuals and businesses purchase health insurance, but the ACA also limits and eliminates many of their plan options. Imposing health insurance on

individuals and employers, potentially decreasing their overall capabilities in the process, is a negative ACA result and contradicts Sen's capability approach.

Health, Fairness, and Responsibility

Considering this, whose ethical responsibility is it to ensure health capability? Regardless of overall decisions and choices, health is an important aspect of maintaining a complete and adequate life. The responsibility is thus shared; individuals and social institutions, including governments and businesses shoulder this responsibility.

Individuals have the responsibility to be as healthy as possible. In some ways, the ACA currently encourages this, but it only does so after individuals have subscribed to a health insurance plan (which they may not want to do). It promotes this by eliminating cost sharing for some preventive services and by offering rebates for wellness programs. When individuals attempt to achieve optimal health, they "govern their own lives in a social responsible manner" (Baker, 2011, p. 1606). Not everyone will be equally healthy. Genetics, environment, and many other factors impact a person's overall health, but individuals bear a responsibility to be as healthy as possible. If an individual, however, ignores his responsibility, then other institutions have a lesser responsibility or no responsibility towards that individual.

Social institutions also bear the responsibility to ensure health capability. Daniels suggests that Rawlsian principles of justice require a "universal, mandatory national insurance system (but details of organization and financing can vary considerably)" (Daniels, 2006, p. 258). This would make the worst off as well off as possible, arranging the injustices that exist in favor of the disadvantaged. The healthcare system implemented under the ACA is far from this fairness. Instead of creating a national insurance system, it combines individual, government, and business responsibility, unnecessarily burdening individuals,

small businesses, and employees of small business. Small businesses face greater costs to continue providing for employees, and the government fines if they do not purchase health insurance along or with their employer. If one applies Rawls' theories about justice to the question of health capability and responsibility, then the current ACA policy proves inadequate (Daniels, 2006).

Although the government is lacking, both individuals and government have responsibilities to ensure health capability, with businesses supporting both to achieve this. By paying their ordinary taxes and supporting individual capability choices surrounding health insurance, businesses fulfill their responsibility to the two groups. However, as mentioned previously, the ACA places a significant and unnecessary portion of the responsibility on small businesses. Applying Young's (2004) theory of responsibility and justice, large and small businesses have a differential responsibility to support individuals and governments in ensuring health capability. Large businesses' resources afford them the ability to adapt to new and changed circumstances without suffering serious deprivation or consequences (Young, 2004).

They benefit from structural inequalities and have moral responsibilities to try and correct them (Young, 2004). Large businesses employ lobbyists to influence political figures and legislative decisions. They benefit from favorable tax policies such as the "bonus depreciation" tax break, allowing businesses to depreciate capital investments quickly and the "research and experimentation tax credit," intended to spark investment. They also use their resources to hire tax experts to find other ways to decrease their tax burdens, such as tax inversions or international subsidiaries. Although available to all businesses, large firms disproportionately take advantage of these tax policies (Mider and Drucker, 2016). Large businesses disproportionately utilize these tax breaks. Small business owners noticed this dichotomy. In a survey conducted by Good Jobs First, 87% of small business owners and

managers reported that their economic development interests were “not effectively represented in their state’s capital” and 92% said that “the spending balance on incentives between small and large businesses is biased toward big businesses” (Fryberger et al. 2015, p. 6-7). Large businesses also benefited from the previous healthcare structure. They benefited from larger pools of employees, which spread the risk across a greater body of individuals, thus decreasing premiums relative to small businesses. On average, small businesses paid 18% more than big businesses for health insurance (Gabel, et al., 2006).

Not only have large businesses benefited from inequalities, but they also have the resources to bear these responsibilities more effectively than small businesses. The inequalities help them to amass resources, which they can then use to adapt to new and changed circumstances without experiencing serious deprivation (Young, 2004). Their size helps them develop economies of scale, which decrease their costs of services and inputs; they can also manage their supply chain more effectively than small businesses, again decreasing costs. Small businesses cannot decrease their costs of inputs as effectively, benefit from economies of scale, or influence policy makers on a large scale. Although the Small Business Administration exists to advocate for small businesses and tries to influence legislation on their behalf, this group proves such a large and diverse group that the SBA cannot realistically address each individual need.

With health insurance, small businesses are justified in doing less as they provide for their employees in other ways. Besser and Miller (2001) find that many small businesses actively participate philanthropically in the community, promoting a variety of organizations, including healthcare. Similarly, Blanchard, Tolbert, and Mencken (2011) find that small businesses help improve their communities’ health, thus improving health outcomes. Small businesses feel a responsibility not only towards their employees, but the areas in which they operate. Within their limited means, most of these businesses provide for their communities.

The even pay for a greater portion of individual employee health insurance premiums than large businesses (Claxton, et al., 2015). Those with the means (large businesses) should provide health insurance but small businesses fulfill their responsibility in other ways.

Policy Considerations

Public policy should consider the burdens the ACA places on small businesses and individuals. One potential avenue to move burdens more in line with responsibility is through a single payer system or universal healthcare system. The government provides healthcare and funds it through tax revenue, and individuals and businesses, which are both responsible for ensuring health capability, pay taxes. Individuals and businesses still have burdens to ensure health capability, but they achieve it in part through paying taxes, which the government then distributes in the form of healthcare. As with the current system, if the tax burden proves too great for individuals it can be subsidized. The redistribution of wealth benefits the least well off, which aligns with Rawls's theory (2001). Overall, the single payer system would distribute the health responsibility more fairly. Proportional taxes could qualify the single payer system: the greater the business size, the larger the tax burden. This places a greater responsibility on businesses with the resources and abilities to handle it. Having fewer resources justifies small businesses in doing less for employees' health insurance concerns. Although potentially difficult to implement, considering the current polarization surrounding healthcare and health insurance, this is a strong policy option.

If unable to implement a single payer system legislators could implement several other policy considerations to decrease this small business burden. For example, the government could decrease small firms' responsibility on health insurance plan requirements and provisions. Large businesses must continue to offer health insurance in compliance with essential health benefits, but small businesses could return to the tailored plan options.

Although small businesses still support both individuals and social institutions in their responsibility to provide health capabilities, this returns flexibility and choice to their decisions.

Increasing the health insurance mandates and requirements from 50 to 100 employees provides another potential option. Only businesses with greater than 100 employees would be required to provide health insurance for employees. The MEPS data shows that the number of firms in the private sector that offered health insurance with 100-999 employees only decreased from 95.4% to 92.7% (or 2.7%), while those with 25-99 employees decreased from 83.3% to 77.2% (or 6.1%). A significant number of firms with less than 100 employees thought health insurance too expensive and stopped providing it. Like those with fewer than 50 employees, the companies with fewer than 100 employees find provide health insurance to all employees difficult. Increasing the health insurance mandate requirements to businesses with fewer than 100 employees would positively address this concern. With any cut-off however, the burden proves greatest for those businesses just over 100 employees. This would present challenges for those businesses, but is a potential policy consideration. Implementation of these policy considerations could create more just and equitable health and health insurance outcomes.

Conclusion

The ACA presents small businesses and individuals with significant costs, which likely outweigh the benefits people receive. Businesses experience health insurance mandates, increased premium prices, and fines for noncompliance. Individuals still pay premiums, experience decreased wages, may not be hired initially, and can suffer in other ways, although they do received increased access to health. Many ways small businesses help address the poverty concern are also adversely affected by the new burdens of the ACA.

From an ethical viewpoint, the ACA places significant burden on small businesses and individuals; with greater resources and pricing elasticity, larger businesses should bear a greater responsibility to provide services than small businesses. Although well founded, specific components of the ACA prove lacking in relation to small businesses and poverty reduction. When developing social policies moving forward, U.S. policymakers should carefully consider the costs and benefits to both individuals and small businesses. This will help balance employer contributions and burdens with the attempt to address poverty.

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