APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

OPPORTUNITIES AND CHALLENGES IN THE AFFORDABLE CARE ACT FOR ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER SMALL BUSINESSES

JULY 2012

ADVOCATES FOR HEALTH JUSTICE

The Asian & Pacific Islander American Health Forum (APIAHF) is a health justice non-profit organization dedicated to improving the health and well-being of more than 18.2 million Asian Americans, Native Hawaiians, and Pacific Islanders living in the United States and its jurisdictions. We believe that all persons have the right to be healthy, the right to live in a thriving community, and the right to quality, affordable, and accessible health care.

For the past 26 years, APIAHF has worked with community advocates, public health leaders, and policymakers to generate policies, programs, and systems changes to improve the health of Asian American, Native Hawaiian, and Pacific Islander communities.

Through our policy and advocacy efforts, APIAHF was instrumental in the creation of the White House Initiative on Asian Americans and Pacific Islanders, fought for the passage of the Patient Protection and Affordable Care Act, and continues to demand the inclusion of Asian Americans, Native Hawaiians, and Pacific Islanders in the collection and reporting of local, state, and national health data.

Among our many successful partnerships, APIAHF is proud to direct the largest ever investment in Asian American, Native Hawaiian, and Pacific Islander communities through a $16.5 million grant by the W.K. Kellogg Foundation, the Health Through Action initiative.

Our work derives from three core values:

RESPECT because we affirm the identity, rights, and dignity of all people.

FAIRNESS in how people are treated by others and by institutions, including who participates in decision making processes.

EQUITY in power, opportunities, and resources to address obstacles hindering vulnerable communities and groups from living the healthiest lives.

MISSION

APIAHF influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders.

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EXECUTIVE SUMMARY

Enacted in 2010, the Patient Protection and Affordable Care Act provides avenues for Asian American, Native Hawaiian, and Pacific Islander small business owners to have access to affordable health insurance for themselves, their employees, and their families. Small business employers frequently have a difficult time providing coverage for themselves and their employees due to rising health insurance premiums. Asian American, Native Hawaiian, and Pacific Islander small business owners, and the self-employed in particular, need new options for purchasing affordable health care coverage as costs continue to rise. Asian Americans constitute over 1.5 million minority-owned businesses and have the second highest rate of self-employment next to non-Hispanic whites. Additionally, Asian Americans own 5.7% of businesses in the U.S. and employ 2.8 million people.

One of the ACA's main features is the establishment of new health insurance markets called "exchanges." Each state will offer two exchanges, the American Health Benefits Exchange for individuals and families (more commonly known as the "Individual Exchange") and the Small Business Health Options Program ("SHOP") Exchange for small business owners and their employees. These two initiatives will create a competitive marketplace that offers affordable, high-quality health insurance plans for the individuals, small businesses, and their employees and families.

CHALLENGES FOR AA AND NHPI SMALL BUSINESS OWNERS

To fulfill the promise of health care reform, federal and state governments must ensure that diverse communities such as Asian Americans, Native Hawaiians, and Pacific Islanders are able to overcome some of the many challenges they face in accessing health insurance. Among the most prominent of these challenges are immigration status, income, and afforability, as well as cultural and linguistic access. Exchange design, language barriers, limited health literacy, and a lack of awareness about the different coverage options can impact enrollment rates and diminish the effectiveness of both the Individual Exchange and the SHOP Exchange.

RECOMMENDATIONS FOR POLICY MAKERS

In order to ensure that Asian American, Native Hawaiian, and Pacific Islander small business owners maximize their options under the Patient Protection and Affordable Care Act, the following recommendations should be addressed by policy makers:

- Provide Culturally and Linguistically Appropriate Education and Technical Assistance for Enrollment
- Conduct Asian American, Native Hawaiian, and Pacific Islander Consumer Testing
- Develop Targeted Outreach Materials
- Establish Alternative Coverage Options for Low-income Self-Employed and Immigrant Business Owners, such as the Basic Health Plan

CONCLUSION

By addressing these key issues early on, states can increase the coverage rates of Asian American, Native Hawaiian, and Pacific Islander small businesses, their employees, and families and ensure that their Exchanges have a robust enrollment pool. Once fully implemented, the Patient Protection and Affordable Care Act will promote economic growth for local communities and further economic development.

INTRODUCTION

Small business employers have a difficult time providing coverage for themselves and their employees due to rising health insurance premiums. As a result, small businesses offering coverage declined from 68% in 2000 to 59% in 2007.[1] At the same time, a larger proportion of the population is heading towards self-employment as contractors, consultants, and independent agents. Thus, small business owners, and the self-employed in particular, will need new options for purchasing affordable health care coverage.

Enacted in 2010, the Patient Protection and Affordable Care Act (ACA) provides avenues for Asian American, Native Hawaiian, and Pacific Islander small business owners to have access to affordable health insurance for themselves, their employees and their families. One of the law's main features is the establishment of new health insurance markets called "Exchanges." Each state will offer two Exchanges, the American Health Benefits Exchange for individuals and families (more commonly known as the "Individual Exchange"), and the Small Business Health Options Program ("SHOP") Exchange for small business owners and their employees. These two initiatives will create a competitive marketplace that offers affordable, high-quality health insurance plans for individuals, small businesses, and their employees and families.

By 2017, an estimated 4 million small businesses could gain coverage through the SHOP Exchange, while an estimated 24 million individuals will be eligible for coverage under the Individual Exchange.[2,3] Because many of these small businesses and individuals will be Asian American, Native Hawaiian, and Pacific Islander, it is critical that the federal government and states consider the needs of these populations as they implement the ACA.

We would like to acknowledge the comments and guidance of Small Business Majority in the development of this issue brief.

PROFILE OF ASIAN AMERICAN, NATIVE HAWAIIAN AND PACIFIC ISLANDER SMALL BUSINESSES

Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) small businesses stand to greatly benefit from the establishment of the Exchanges. The federal government defines a "small business" as a business with no more than 500 employees for most manufacturing and mining industries, and no more than $7 million in average annual receipts for most nonmanufacturing industries.[4] Asian Americans constitute over 1.5 million minority-owned businesses and have the second highest rate of self-employment next to non-Hispanic whites.[5] Additionally, Asian Americans own 5.7% of businesses in the U.S. and employ 2.8 million people.[6] There were 2,135 Asian-owned businesses with 100 employees or more in 2007 and 1.2 million reported businesses with no paid employees.[7] Small business ownership varies by Asian American subgroup with Korean Americans having the highest rate of ownership. For the NHPI community, there were about 38,000 Native Hawaiian-and Pacific Islander-owned firms, of which 4,151 were firms with at least one employee.[8] Table 1 highlights the percentage of small business ownership among Asian Americans.

Table 1. Small Business Ownership Among Asian American Subgroups

Ethnicity	Small Business
Asian	11.0%
Asian Indian	9.4%
Bangladeshi	9.9%
Cambodian	9.7%
Chinese	11.2%
Filipino	4.8%
Hmong	6.7%
Indonesian	9.1%
Japanese	12.0%
Korean	22.0%
Laotian	4.0%
Malaysian	11.0%
Pakistani	13.0%
Sri Lankan	12.0%
Thai	12.0%
Vietnamese	14.0%
Other Asian	8.0%

Source: APIAHF analysis of 2009 American Community Survey Public Use Microdata Sample (PUMS) data

The states with the most Asian-owned businesses are California (509,097), followed by New York (196,852), and Texas (114,336). In 2007, the cities with the largest number of Asian-owned businesses were New York City (153,885) and Los Angeles (61,607). The states with the most NHPI-owned businesses are Hawaii (11,403 firms), California (9,174 firms), New York (1,852 firms), and Florida (1,772 firms).

The SHOP and Individual Exchanges have the potential to increase health coverage for AAs and NHPIs. Presently, there are 2.3 million AAs and 162,000 NHPIs who are uninsured. While AAs and NHPIs have comparable rates of private health insurance compared to Whites, they are more likely to be uninsured. In addition, there is wide variation in health coverage among AA and NHPI ethnic subgroups. For example, uninsurance rates range from 8% among Japanese to 23% among Pakistanis.[9]

Table 2. Health Insurance Coverage Status

Race/ethnicity (alone & in combination with other races)	Uninsured
Asian	14.1%
Asian Indian	11.8%
Bangladeshi	22.5%
Cambodian	21.3%
Chinese, except Taiwanese	12.3%
Filipino	10.6%
Hmong	15.9%
Indonesian	15.0%
Japanese	7.9%
Korean	22.3%
Laotian	18.5%
Pakistani	22.9%
Taiwanese	13.8%
Thai	19.3%
Vietnamese	18.7%
Other Asian	24.6%
Native Hawaiian/Pacific Islander	13.5%
Guamanian/Chamorro	13.1%
Native Hawaiian	10.2%
Samoan	16.5%

Source: 2007-2009 American Community Survey 3-Year Estimates

It is unknown how many of AA and NHPI business owners are uninsured, however existing data suggests that there is a correlation between small business ownership and uninsurance. For example, more than two in five Korean Americans are uninsured, and an estimated 1/3 of Korean families own or work in a small business. Many of them are also immigrant and low-income. According to a 2009 survey conducted of Korean owned small businesses in Koreatown, Los Angeles, 52% of the respondents were uninsured and 30% replied that their dependents were also uninsured.[10] Only 10% reported that all of their dependents had health care coverage.[11]

REQUIREMENTS TO ACCESS THE SHOP AND INDIVIDUAL EXCHANGES

Starting in 2014, qualified Asian American, Native Hawaiian, and Pacific Islander small business owners and qualified employees can begin to shop for and enroll in affordable health insurance plans offered through the SHOP Exchanges. The SHOP Exchanges will be run by a state entity or the federal government and will permit AA and NHPI small businesses who meet certain employment criteria to purchase qualified coverage. A unique feature of the SHOP Exchange is that it will include an affordability screening tool to help employees determine if they can afford to purchase the plan selected by their employer and will connect employees who cannot afford their employer's plan to the Individual Exchange. In addition, employees will also be able to determine if they are eligible for Medicaid or eligible to receive subsidies to help pay for insurance premiums for plans offered through the Individual Exchange.

Small Business Health Options Program (SHOP) Exchange

- Who: Beginning in 2014, states can permit **small businesses** with 1 - 50 or 100 employees (depending on the state) to purchase health insurance through SHOP Exchanges.
- Starting in 2017, states may permit small businesses with over 100 employees to shop for and enroll in plans offered through the SHOP Exchanges.

American Health Benefits Exchange (Individual Exchange)

- Who: Beginning in 2014, **individuals and families** without employer-sponsored coverage can shop for and enroll in affordable health insurance plans.
- Individuals and families with incomes between 133 and 400 percent of the Federal Poverty Level will be eligible for subsidies to buy health insurance in the Exchange.

Currently, the U.S. Department of Health and Human Services has given states the flexibility to determine whether to combine their Individual Exchange with their SHOP Exchange.[12] Regardless of what a state decides, insurance plans in the SHOP Exchange must meet the same criteria for plans offered in the Individual Exchanges.

Tax credits

Since 2010, small businesses have been eligible for a small business tax credit of up to 35% of the employer's contribution toward insurance premiums. The credit is based on a sliding scale for private employers who meet certain criteria and will increase to 50% in 2014. A credit of up to 25% of the employer's contribution is available for small tax-exempt employers, with an increase to 35% in 2014.

The small business tax credit differs from the premium tax credit that will be offered to individuals with incomes of up to 400% of the federal poverty level (FPL) to purchase plans through the Individual Exchange. The amount of the premium tax credits will be determined by the Internal Revenue Service and will be tied to an individual's annual tax return. According to an estimate by the non-partisan Congressional Budget Office, the average eligible household will receive an average subsidy amount of $5,000 a year beginning in 2014. An estimated 20 million individuals and their families will benefit from this credit.[13]

How the Small Business Tax Credit Works (SHOP Exchange)

Small business employers must:

- Have between 1 - 25 employees
- Pay an average annual wages below $50,000
- Pay at least half of their employees' health coverage

In order to claim the tax credit:

- Private employers must complete Form 8941 with the Internal Revenue Service
- Small tax exempt businesses must complete 990-T with the Internal Revenue Service (even if you don't normally do so)

How the Premium Tax Credit Works (Individual Exchange)

The individual or family must be:

- Between 100% - 400% FPL($22,350 – $89,400 for a family of four in 2011)
- A citizen or lawfully present in the U.S. and not be incarcerated
- Ineligible for any other qualifying coverage (Medicare, Medicaid, or Employer-sponsored)

In order to claim the tax credit:

- For most, the credit will be included as part of your tax return.
- The tax credit is also advanceable and refundable.

Information is available at: http://www.irs.gov/newsroom/article/0,,id=223666,00.html

CHALLENGES FOR ASIAN AMERICAN, NATIVE HAWAIIAN AND PACIFIC ISLANDER SMALL BUSINESSES AND THE EXCHANGES

To fulfill the promise of health care reform, federal and st,ate governments need to ensure diverse communities such as Asian Americans, Native Hawaiians and Pacific Islanders are able to overcome some of the challenges these communities face in accessing health insurance. For example, Exchange design, language barriers, limited health literacy, and a lack of awareness about the different coverage options can impact enrollment rates and diminish the effectiveness of both the Individual Exchange and the SHOP Exchange. Addressing these key issues early on can increase the coverage rates of AA and NHPI small businesses, and their employees and families and ensure Exchanges have a robust enrollment pool.

LIMITATIONS TO THE SMALL BUSINESS TAX CREDIT AND SHOP ELIGIBILITY

Not all small businesses are subject to the ACA and its regulations. Businesses with no paid employees, such as sole proprietorships, are excluded from the small business benefits offered in the ACA. According to the U.S. Census Bureau's 2007 Survey of Business Owners, there were 1.5 million Asian-owned businesses; however 1.2 million reported that they had no paid employees. Among the 38,000 NHPI-owned businesses in the U.S., approximately 33,850 had no paid employees. As such, these small business owners will not be eligible for the small business tax credit or be able to purchase private health insurance in the SHOP Exchange in 2014. Since a majority of AA and NHPI businesses do not qualify for coverage through the SHOP Exchange, there must be a strategy for enrolling self-employed AA and NHPI small business owners with no paid employees through the Individual Exchange.

EMPLOYER PENALTIES

While the ACA does not require employers to provide health insurance benefits to their workers, larger employers will face penalties starting in 2014 if they do not make affordable coverage available. These penalties vary depending on a number of factors including business size; those employing more than 50 full time employees may pay around $2,000 per employee, per year.[14] For small businesses with less than 50 employees, there is no penalty.[15] These penalties increase each year based on the growth of premium costs. Based on the 2007 Survey of Business Owners conducted by the U.S. Census, these penalties may affect an estimated 6,000 Asian-owned small businesses. States will need to help these affected businesses understand the potential impact of these penalties.

LIMITED ENGLISH PROFICIENT POPULATIONS

Limited English proficient (LEP) populations constitute a significant percentage of the 24 million individuals expected to participate in both the Individual Exchange and the SHOP Exchange. More than 1 and 3 AAs are LEP, many of whom are small business owners and workers. Language barriers can reduce the rates of enrollment and lower the quality and effectiveness of prevention, treatment and patient education programs. It is essential that important written documents, such as eligibility and enrollment forms and instructions, be translated. In addition, oral interpretation services must be made available—either in person or over the phone—to individuals seeking to enroll or understand their coverage through both the Individual Exchange and the SHOP Exchange.

MIXED STATUS FAMILIES AND THE EXCHANGES

Based on the 2010 Census, the Asian American community has the highest proportion of foreign-born individuals among all racial groups.[16] Many Asian Americans and some Pacific Islanders live in "mixed status" households where one or more family members have an immigration status that differs from other members of the family. This mixed status complicates the process for enrolling in family coverage due to immigration-based restrictions to accessing health care coverage. As a result, parents may be qualified for one type of coverage, while their children are eligible for other types of coverage. For example, a citizen child may be qualified for Medicaid or the Children's Health Insurance Program, while her immigrant mother who has been in the U.S. for less than five years—is only eligible to receive subsidies to purchase insurance in the Individual Exchange and her undocumented father is ineligible for any of these programs. These differences in coverage rules will only add confusion and delay, and even erroneous denials of enrollment for those who need it the most.

AFFORDABILITY CHALLENGES

Even with the availability of the premium tax credit offered to help individuals and families purchase health plans through the Individual Exchange, the cost of purchasing coverage may still be too high for low-income business owners and immigrant business owners in particular. Two examples are highlighted below:

> **Example One:** A self-employed immigrant business owner with an income of less than 133% FPL would not be eligible for the small business tax credit if she has no employees and would not be eligible for Medicaid if she has been lawfully present in the U.S. for less than five years.
>
> **Example Two:** A self-employed immigrant business owner with an income of 150% FPL would not be eligible for the small business tax credit if he has no employees and would not qualify for Medicaid because his income is too high.

In addition, while both business owners would be eligible for a premium tax credit, the cost of purchasing a private plan in the Exchange exceeds the cost of paying the penalty for being uninsured. Table 3 provides estimates of the monthly and yearly premium costs based on an individual's income as a percentage of FPL. Table 4 illustrates the penalties an uninsured individual (and their dependents) would have to pay for remaining uninsured based on the formulas outlined in the ACA.

Table 3. Annual Premium Costs for a Qualified Individual Under the ACA[17]

Percentage of FPL (2010)	Monthly Pre-Tax Income	Minimum Monthly Premium	Annual Costs
150	$1,354	$54.15	$649.80
175	$1,579	$81.34	$976.08
200	$1,805	$113.72	$1364.64
225	$2,031	$145.70	$1748.40
250	$2,256	$181.63	$2179.56

Table 4. Annual Costs of Penalty for Not Having Minimum Essential Coverage for an Individual[18]

Year	Individual	Family
2014	$95 or 1% of income, whichever is greater	$285 or 1% of income, whichever is greater
2015	$325 or 2% of income, whichever is greater	$975 or 2% of income, whichever is greater
2016 and beyond	$695 or 2.5% of income, whichever is greater	$2,085 or 2.5% of income, whichever is greater

Note: The penalty is pro-rated by the number of months without coverage, though there is no penalty for a single gap in coverage of less than 3 months in a year. After 2016, the penalty amounts increase annually by the cost of living.

To illustrate this affordability challenge, let's return to the self-employed immigrant small business owner in example 2. Because this small business owner has an income of $1,354 a month (150% FPL), he would have to pay $649.80 a year in premium payments for an insurance plan or pay $162 (approximately 1% of his annual income) in 2014 for going without insurance coverage. By 2016, however, the penalty will increase to at least $695, which is roughly equivalent to the estimated annual cost of purchasing health insurance ($649.80).

RECOMMENDATIONS FOR POLICYMAKERS AND ADVOCATES

Creating information and enrollment features and processes sensitive to small businesses, immigrants, limited English proficient persons and other vulnerable populations will increase the Exchanges' effectiveness in assisting AA and NHPI communities. Given the flexibility afforded by the federal government and the variety of implementation approaches across the states, the following issues are important considerations for policymakers involved at the state level and for advocates working on AA and NHPI health.

PROVIDE CULTURALLY AND LINGUISTICALLY APPROPRIATE EDUCATION AND TECHNICAL ASSISTANCE FOR ENROLLMENT

Organizations that work directly with AA and NHPI populations are crucial to providing technical assistance and education to Asian American-, Native Hawaiian-, and Pacific Islander-owned small businesses regarding their options for health insurance coverage. Because the majority of these small business owners will need to purchase health coverage in the same manner as individuals and families—through the Individual Exchange—and receive tax credits if they are income eligible, states should partner with AA and NHPI Chambers of Commerce, community development groups and other allied organizations to design both their Individual Exchange and the SHOP Exchange and develop navigator training programs. AA and NHPI Chambers of Commerce continue to serve as valuable networking and skills-building opportunities for small business owners, which is why it is important to include these organizations in crafting outreach strategies.

Navigator programs established by the ACA will assist consumers in making choices about their health care options and accessing health care coverage and premium tax credits through the Individual Exchange. HHS' final rule on establishing state Exchanges requires that at least one of the state's navigator entities must be a community-based or consumer-focused non-profit, which is an opportunity for engagement with AA & NHPI communities.[19] Early collaboration with these partners will help AA and NHPI small business owners understand important issues related to tax credits, insurance plan concepts and plan value. These partnerships should include insurance brokers, who many times are important and trusted contacts for AA and NHPI small business owners. Brokers can help small businesses consider the variability that occurs in employment and staffing patterns and recommend different approaches to providing coverage. The state entities responsible for running both the Individual Exchange and the SHOP Exchanges should also partner with community-based organizations and leaders who have significant knowledge about their populations' members and have existing communication networks within their communities to serve as navigators. Insurance brokers must also understand the needs of AA and NHPI communities and provide translated written materials and oral interpretation for LEP consumers trying to access the Individual and SHOP Exchanges.

CONDUCT AA AND NHPI CONSUMER TESTING

To test the usability and level of health literacy needed to understand the information provided in both the Individual Exchange and the SHOP Exchange, states should conduct consumer focus group testing with limited English proficient populations prior to implementation in 2014. Consumers Union conducted some effective consumer testing to try to develop some "common language" for consumers to understand and use health insurance. Although the study included only a very small number of Asians and Pacific Islanders, their methods for cognitive interviewing—a technique where researchers encourage participants to voice their reactions while selecting a health plan—could be a good model to use.[20] This will provide insight on the merits and feasible improvements for one of the popular components of the ACA.

DEVELOP TARGETED OUTREACH MATERIALS

Each state should collect demographic data such race, ethnicity, primary language, and income level of enrollees entering both the Individual and SHOP Exchanges. Collecting demographic data will help states identify which populations are under-enrolling and allow states to tailor their outreach efforts such as through translated outreach materials that can effectively enroll the AA and NHPI population in the Exchanges. If translated materials are unavailable for the AA and NHPI population, there should be in-language taglines that direct state residents to appropriate language service resources provided by the state at no charge. These would be consistent with the statutory requirements in the ACA found in Section 1311.

Both the Individual and SHOP Exchanges should also utilize ethnic media to reach AA and NHPI communities. A recent study found that almost 3 in 4 Asian Americans are ethnic media consumers, with 57% reached by ethnic television and 43% by ethnic newspapers. Additionally, 1 in 4 Asian Americans are reached by ethnic radio.[21]

ESTABLISH ALTERNATIVE COVERAGE OPTIONS FOR LOW-INCOME SELF-EMPLOYED AND IMMIGRANT BUSINESS OWNERS

Policymakers must address the affordability challenges faced by low-income and immigrant small businesses. The ACA provides states with alternative models for developing innovative and affordable health insurance options such as Consumer Operated and Oriented Plans (CO-OPs) and Basic Health Plans (BHPs). CO-OPs are nonprofit, consumer-controlled entities designed to serve individuals and small businesses in noncompetitive markets.[22] Once implemented and operationalized, CO-OPs have the potential to improve the delivery of health care and provide more affordable coverage options for certain hard to reach populations such as independent workers, sole proprietorships, individuals living in rural or migrant communities, undocumented immigrants and others.

States should also consider creating a Basic Health Plan, a Medicaid-like insurance plan aimed at providing lower-income individuals with a more affordable alternative to plans sold in the Individual Exchange. BHPs would cover those with incomes between 133% and 250% FPL, an income amount that is high for Medicaid and often too low to afford plans offered through the Exchange even with a subsidy.[23] BHPs also present a promising option for lawfully present immigrants with incomes below 133% FPL and are ineligible for Medicaid due to immigration restrictions.

CONCLUSION

Once fully implemented, the Affordable Care Act will promote economic growth for local communities, and further economic development. Increasing the availability of affordable health insurance options will help overcome "job-lock," which prevents individuals from starting businesses due to the fear of losing health insurance coverage. Policymakers at the state and federal level must be mindful of the unique needs of Asian American, Native Hawaiian and Pacific Islander business owners to ensure the ACA improves health care access and provides affordable, quality health insurance options for diverse communities.

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HEADQUARTERS

450 Sutter Street, Suite 600
San Francisco, CA 94108
(P) (415) 954-9988
(F) (415) 954-9999

NATIONAL POLICY OFFICE

1828 L Street, NW, Suite 802
Washington, DC20036
(P) (202) 466-7772
(F) (202) 466-6444

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