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## **Policy review: the US Affordable Care Act, community health centers, and economic development opportunities**

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Part of the Patient Protection and Affordable Care Act (ACA) was designed to extend public health care coverage to millions of Americans and will provide states with a fiscal cushion to help achieve that goal. What have largely gone unnoticed however, are the economic development benefits of the Act. The ACA provides substantial funding for the creation of new community health centers in medically underserved areas in order to serve this new patient population. Other provisions of the Act offer a host of economic benefits via a variety of related community economic development funding opportunities. The intent of this article is to provide a review of the literature regarding the importance of the ACA for community economic development. Subsequently, we provide two case studies as examples that illustrate the initial impacts of the ACA. We conclude that those states that choose not to expand public health care coverage to low-income populations will forego more than just Medicaid matching funds. State and local governments also stand to lose out on substantial economic development dollars.

**Keywords:** Affordable Care Act; Obamacare; community health centers; community development; economic development; Community Development Block Grants

### **Introduction**

All levels of government are struggling with how to provide access to public health care to the greatest number of eligible citizens, while at the same time cutting expenditures to cover fiscal shortfalls. One result of the prolonged economic downturn, worsened by the US federal government's application of semi-annual stop-gap budgeting and across-the-board spending cuts, is that almost two-thirds of all state governments continue to face budget deficits (Center for Budget and Policy Priorities, 2013). In efforts to bridge these gaps, many states have increasingly curtailed funding to public health care facilities and programs.

The Patient Protection and Affordable Care Act, also known as the ACA or "Obamacare," is designed to address disparities in access to quality health care services. In doing so, however, it adds to states' fiscal stress by extending the eligibility range for individuals who qualify for publicly funded medical care. Full implementation of the ACA anticipates expansion of health care insurance to an estimated 32 million additional Americans, with nearly half of these individuals covered through the extension of Medicaid, which provides public health care programs and services to low-income families, the elderly, and the disabled (Medicaid.gov, n.d.). To mitigate the fiscal impact to the states, the ACA provides funding to cover 100% of the cost for the increased

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Medicaid population through the year 2019. In addition, the Act provides \$9.5 billion for new community health centers (CHCs), designed specifically to provide public health provisions such as those offered by Medicaid, in medically underserved areas (The Kaiser Foundation, Kaiser Commission on Medicaid and the Uninsured, 2012). This suggests that CHCs have the potential to play an integral part in providing services to this new patient population. Beyond funds for expansion of existing CHCs and development of new centers, the Act also offers substantial economic benefits to state and local governments via a variety of economic development funding opportunities.

In this article, we assess the ways in which the Affordable Care Act serves as a new source of support for state and local economic development. This paper begins with a literature review of applicable economic development theory in order to provide a fundamental context in which to situate the community economic development aspects of the ACA. A snapshot of state and local fiscal issues including budget deficits, intergovernmental transfers, and economic development funding resources and a review of CHCs and their role in fostering economic development follows. Finally, we move to an in-depth examination of the ways in which the ACA's promotion of CHCs is designed to facilitate community economic development.

## **Methods**

A variety of US government sources were used during the comprehensive review for this study. These included: The Department of Health and Human Services (including the Health Resources and Services Administration Data Warehouse Office, the Centers for Medicare and Medicaid Services, and the Centers for Disease Control and Prevention), the Census Bureau, the Bureau of Economic Analysis, the Economic Development Administration, the Bureau of Labor Statistics, the White House Office of Management and Budget, and the Library of Congress' THOMAS database.

Projections of the fiscal effects of the ACA for the states that chose to implement the Act were sought out, resulting in two case studies that serve as illustrations. Maryland and Michigan were chosen for several reasons. First, they were the only states for which projected data were available, and even then estimated savings and revenues were aligned directly with insurance initiatives, such as Medicaid matching funds and savings from uninsured care costs. Second, they represent differing political ideologies among their governors. Maryland's governor is a Democrat, whereas, Michigan's governor is a Republican. And third, the states are facing very different fiscal issues. Maryland has a budget deficit to overcome, whereas, Michigan has resolved its budget shortfalls, but a number of cities within the state have been deemed insolvent and placed under the control of governor-appointed fiscal managers.

## **The role of government in community economic development: developing the theoretical framework**

The importance of government participation in the economic development process has long been acknowledged. Liou (2001, p. 1006) notes that government is essential for several reasons, including:

[I]dentifying and formulating development policies and programs to promote economic growth and social change, ... assuring the successful institutional development and reform ... [of] ... identified development policies and programs, and supporting and maintaining

positive and stable political and social environments to provide the opportunity and time for the success of development policies and programs.

Aoki, Kim, and Okuno-Fujiwara (1997, as noted in Liou, 2001) contend that the belief that public and private development efforts are mutually exclusive is erroneous, arguing instead that there is an additional role for government: to coordinate the process in order to guard against failures of market coordination, inefficient credit allocations, and information asymmetry.

The trend toward support for public policy that provides for increased state autonomy, combined with the economic crises and recession of the past decade, has strengthened the role of state and local governments in economic development. In addition, this has given more credence to the market failure approach as an explanation of the importance of regional economic development policy. Traditional economic development theory focuses on job growth as the primary goal of economic development. The new wave approach, on the other hand, emphasizes innovation. Bartik (1990) maintains that both the traditional economic development theories and the market failure approach are too vague and lack a cost-benefit analysis of the social impacts. The market failure approach emphasizes economic efficiency and takes into consideration the importance of government in the provision of public goods and elimination of externalities and asymmetries. It encourages “expansion of benefits that private markets fail to recognize adequately.” Further, “regional economic development policies will be efficient if the value of these nonmarket benefits exceed program costs” (1990, p. 362).

There are several advantages to the market failure approach. It allows for “a wise use of government resources because it focuses on what private markets are unable to do and ... goals that are measurable in the common currency of dollar benefits” (Bartik, 1990, p. 368, as cited in Liou, 2001, p. 1016). Of course there are also limitations, including the inability to determine the extent of nonmarket benefits, distributional effects, or costs to adjacent regions – spillover effects. The net effect, however, is that “encouraging regional governments to pursue regional efficient policies is likely, on average, to increase the efficiency of the national economy” (Bartik, 1990, p. 368, as cited in Liou, 2001, p. 1016).

State and local governments use four primary strategies to incentivize economic development, and these strategies are dependent on the goals and the degree of progress of the economic plans. These strategies include: (1) subsidizing traditional inputs, such as loans and loan guarantees and tax-exempt bond financing; (2) reducing the political costs of business through tax incentives and abatements as well as regulatory limitations; (3) promoting entrepreneurial development by providing incubators, marketing, and other business services; and (4) providing and improving social amenities, such as arts and education and other public services (Liou, 2001). Bartik (2004) finds that economic development incentives would be more efficient and effective if the policy process were open to public participation and long-term analysis. He asserts that “a ‘bottom-up’ approach to reforming incentives ... is likely to be more effective, more durable and more democratic” than the top-down approach involving regulation and prohibition. “Federal policy can be more helpful in providing financial support for ‘bottom-up’ reform: subsidizing better benefit-cost analysis and information on incentives, encouraging stronger coordination of incentives at the metro level, and targeting assistance at creating jobs in economically distressed local areas” (p. 33).

### **Challenges to economic development for state and local governments**

States had barely recovered from the economic downturn that occurred earlier in the decade when the great recession struck in 2007 and 2008. State budgets hit annual record-setting deficits, and the nation's unemployment rate doubled from 5 to 10%, something not seen since the early 1980s (US Bureau of Labor Statistics, 2012).

Correspondingly, state revenues dropped 21% between fiscal years (FY) 2007 and 2008, and then almost a third (31%) again in 2009. In FY 2010, revenues rose almost 80% over the previous year, but general revenues accounted for only 12% of that increase (US Census, 2011a, 2011b). Spending cuts were the hallmark of the period, with education and Medicaid taking the biggest hits (California Primary Care Association (CPCA), 2012; McNichol, Oliff, & Johnson, 2012). A number of states are finally seeing improvements in their financial condition, yet more than half (58%) projected deficits totaling \$49 billion for FY 2013. This is in addition to the over \$530 billion cumulative shortfall for the previous four years (CPCA, 2012). To add to this precarious position, the federal budget sequestration initiated in 2013 is expected to reduce transfers to states by a total of \$6 billion, with a second round of additional spending cuts planned for 2014 (Center for Budget and Policy Priorities, 2013).

### ***Changes in health care spending***

One of the primary strategies that states have used to cope with declining revenues and federal transfers has been to reduce spending for public health care programs and services. Even though Medicaid enrollment rose 46% between FY 2000 and 2010, 30% of that growth in Medicaid enrollment occurred during the first half of the decade. During the same period state Medicaid spending rose as well but at a considerably higher rate of 71%. Like enrollment, the greatest increase, 46%, occurred between FY 2000 and 2005. Because of the economic crises, however, expenditures rose at a much slower rate (25%) during the second half of the decade (Smith et al., 2009). Federal Medicaid spending growth also rose during the first few years of the decade, but began to wane in 2005 and 2006. Not surprisingly, funding from the American Recovery and Reinvestment Act (ARRA) accounted for the growth in federal spending thereafter (Smith et al., 2009).

While Medicaid programs and services vary wildly across the states, one thing they all have in common is that the cost of service delivery has increased considerably. Governments spent approximately \$335.1 billion on the provision of Medicaid services in FY 2009, and the program's costs are expected to rise considerably in the future (Vestal, 2010). Facing ongoing revenue shortfalls, increased federal spending mandates, and the absence of other sources of fiscal support, state governments question their ability to pay their share of Medicaid costs. As states work to meet budget stabilization requirements, giving up federal matching funds needed to provide services for state residents is a double-edged sword. In many cases, Medicaid spending cuts have been touted as essential to bridge budget gaps.

### ***Community challenges: declining revenues on all fronts***

As the country slowly moves out of the 2008 financial crisis, "county and municipal governments are still looking for additional state aid to offset declines in property taxes, a trend ... [that] will continue as the housing market recovers" (Celock, 2011, p. 1). As recovery remains to be seen in many states, local leaders are examining all possible

ways to mitigate Medicaid costs. “Federal statute allows as much as 60% of the state share [of Medicaid matching funds] to come from local government funding” (Mitchel, 2012, p. 4). For already cash-strapped municipalities, this translates to reductions – instead of the increases needed to offset insufficient tax revenue – in intergovernmental transfers. Consequently, municipalities are also reducing public health benefits and services to bridge budget gaps. “Local governments are also cutting reimbursements to Medicaid providers and instituting small co-pays to reduce unnecessary emergency room visits” (Celock, 2011, p. 1).

Cities and towns face limited revenue options and increasing service demands in today’s challenging economic environment. In order to realize prioritized economic development projects and spending needs, they are increasingly reliant on the local government fund (LGF), which transfers a percentage of states’ general revenues to municipalities. But as states’ general revenues decline, so do LGF transfers.

### ***Fewer federal economic development dollars***

Federal funds from a variety of sources are available to assist low- and moderate-income communities with infrastructure and housing development needs as well as the business support necessary to recruit and retain high-quality business and health care professionals. For local governments, some sources have been more accessible than others. Community development block grants (CDBGs) are available to municipalities with populations under 50,000 to fund infrastructure projects, “eliminate or prevent slums and/or blight, and address health and/or safety problems” (Tennessee Department of Economic & Community Development, 2012). However, as seen in Table 1, CDBG funding has consistently declined, falling over 40% in just 15 years from \$6 billion in 1997 to only \$3.5 billion in 2011.

Table 1. Summary of national economic conditions and federal spending, 1997–2011.

	GDP (Trillion) <sup>^</sup>	Surplus/deficit (% of GDP) <sup>#</sup>	Unemployment rate	CDBG (Billion) <sup>^</sup>	EDA (Billion) <sup>^</sup>	CHC (Billion) <sup>^</sup>
2011**	\$15.09	−8.7	8.9	\$3.51	\$9.61	\$2.58
2010**	\$14.76	−9.0	9.6	\$4.01	\$10.06	\$2.22
2009*	\$14.12	−10.1	9.3	\$3.69	\$7.82	\$4.24
2008	\$15.03	−3.2	5.8	\$3.78	\$10.73	\$2.17
2007	\$15.17	−1.2	4.6	\$4.02	\$12.80	\$2.15
2006	\$14.94	−1.9	4.6	\$4.15	\$6.53	\$1.99
2005	\$14.57	−2.6	5.1	\$4.76	\$6.77	\$2.00
2004	\$14.05	−3.5	5.5	\$5.15	\$7.31	\$1.92
2003	\$13.51	−3.4	6.0	\$5.28	\$7.69	\$1.77
2002	\$13.10	−1.5	5.8	\$5.35	\$7.39	\$1.66
2001	\$13.03	1.3	4.7	\$5.58	\$6.73	\$1.49
2000	\$13.03	2.4	4.0	\$5.55	\$7.17	\$1.33
1999	\$12.51	1.4	4.2	\$5.66	\$6.84	\$1.24
1998	\$11.95	.8	4.5	\$5.71	\$6.95	\$1.12
1997	\$11.58	−.3	4.9	\$6.00	\$6.90	−

\*ARRA.

\*\*ACA.

<sup>^</sup>Adjusted for inflation (in 2011 dollars).

<sup>#</sup>Both on and off budget items.

Source: Bureau of Economic Analysis (n.d.), Bureau of Labor Statistics (n.d.), US Department of Health and Human Services (n.d.), and Office of Management and Budget (n.d.).

Until recently, federal earmarks were also a viable resource for community economic development. Awards totaled, on average, just over \$1 billion annually between FY 2000 and 2009. That averages out to allocations of approximately \$20 million per state per year throughout the decade. Earmarks had become an increasingly important source of funding during the period for a broad range of community needs, including drinking and wastewater systems; buildings and programs for educational, social, and cultural needs; local transportation; and corrections and emergency needs (Kunz & O’Leary, 2012). These options for local governments have virtually been eliminated due to Congress’s failure to pass appropriations legislation and its moratorium on earmarks.

The US Economic Development Administration (EDA) also provides substantial funding for community economic development and revitalization. Table 1 shows that, in contrast to CDBG and earmarked funds, EDA funding has been relatively stable overall. Federal spending averaged \$7 billion annually between 1997 and 2006; the dramatic increases in FYs 2007–2008 and 2010–2011 represent extraordinary commitments from Presidents George W. Bush (2007, 2008) and Barack Obama (through the ARRA of 2009), respectively. The EDA recently announced a \$15 million initiative to foster job creation in rural areas of the country. The agency has also committed to providing disaster relief and planning assistance for local communities (US Economic Development Administration, 2012). These commitments will likely shift annual funding away from direct local economic development needs such as infrastructure and emergency services (i.e. police, fire, and medical).

Table 1 also shows annual Congressional appropriations for CHCs. Apart from the funding spike in 2009, in which allocations doubled as a result of ARRA initiatives, appropriations for CHCs more than doubled between 1997 and 2011, indicating increasing Congressional support for CHCs and supporting projects. In contrast to waning CDBG allocations and shifts in funding priorities for EDA allocations, this indicates a positive source of support for local economic development.

### **Community health centers**

For more than 40 years, CHCs have served as the nation’s largest primary care system, providing health care in underserved areas. CHCs were developed as part of Lyndon Johnson’s war on poverty and designed to provide access to health care to those subject to extreme poverty, racial segregation, and high unemployment. CHCs serve more than 23 million people today. In many instances, they are the only source of health care for millions of low-wage, part-time, and seasonal workers in industries such as agriculture, manufacturing, and hospitality (Adashi, Geiger, & Fine, 2010; Altarum Institute, 2011; Levine, 2011; National Association of Community Health Centers, 2011a, 2011b).

CHCs are required to be located in or serve federally designated, medically underserved areas or populations. Governmental resources are best allocated to these areas, because of the inability of the private market to adequately meet the needs of those communities. The market failure approach explains this governmental utilization of resources because it allows for “a wise use of government resources because it focuses on what private markets are unable to do and ... goals that are measurable in the common currency of dollar benefits” (Bartik, 1990, p. 368; Liou, 2001, p. 1016). Of course there are also limitations, including the inability to determine the extent of nonmarket benefits, distributional effects, or costs to adjacent regions. The net effect, however, is that “encouraging regional governments to pursue regional efficient policies is likely, on



average, to increase the efficiency of the national economy” (Bartik, 1990, p. 368, as cited in Liou, 2001, p. 1016).

CHCs across the country “expect to see patient rolls skyrocket from the 23 million now treated to more than 40 million in the next five years” (Levine, 2011, p. 1), in part because prolonged unemployment, underemployment, and mortgage defaults serve to increase the pool of eligible participants. In 2012, state funding for CHCs declined to the lowest level since 2005. The National Association of Community Health Centers’ (2011b) annual funding survey indicates that 33 states and the District of Columbia (DC) appropriated a total of \$335 million in State Fiscal Year (SFY) 2012. This is almost \$300 million less than SFY 2008 when funding was at its peak. The reductions in state funding have caused some states to close clinics, reduce hours of operation, or restrict or eliminate disease management or preventative care programs (The National Association of Community Health Centers, 2011c).

### CHCs as local economic development drivers

CHCs “were originally created as part of the Office of Economic Opportunity in the 1960s War on Poverty, at the same time that community development corporations (CDCs) were formed” (Sporte & Donovan, n.d., p. 66). They were intended as, and continue to be, a significant part of municipalities’ economic development endeavors. The Robert Graham Center (2007) and Sporte and Donovan (n.d.) noted the far-reaching economic benefits of CHCs by using their IMPLAN model to calculate the activity generated by federally funded CHCs in 2005. In this model, illustrated in Table 2, direct effects represent the total operating expenditures of health centers. Indirect and induced effects represent the multiplier effect. The indirect effects represent “the response by local industries caused by ‘the iteration of industries purchasing,’” and the induced effects represent the “response by all local industries to the expenditures of new household income generated by the direct and indirect effects” (Sporte & Donovan, n.d., p. 69). In that year alone, federally funded CHCs generated 143,073 jobs and accounted for \$12.5 billion in economic activity. More recently, the National Association of Community Health Centers (2011c) determined that in 2009, CHCs “generated approximately \$20 billion in economic activity for their local communities” (italics in original) (Sporte & Donovan, n.d., p. 69).

### The Affordable Care Act: a significant new funding source for local economic development

The Affordable Care Act aims to extend coverage to an additional 32 million people, about half of which will be eligible for Medicaid if all states adopt the Act’s expansion

Table 2. Total economic activity stimulated by federally funded CHCs’ operations, 2005.

	Total economic impact	Employment (full time equivalents)
Direct	\$7,261,975,096	89,922
Indirect	\$1,124,387,922	10,223
Induced	\$4,172,328,893	42,918
Total	\$12,558,691,911	143,073

Source: The Robert Graham Center (2007), and Sporte, & Donovan (n.d.).



provisions. Approximately nine states, however, have opted out of the ACA's Medicaid expansion provision on constitutional and ideological bases, arguing that it represents an overreach of government power "that threatens the basic liberties that all Americans enjoy and must retain" (Hudak, 2012, p. 1). Of the top 10 states with the greatest populations of uninsured (25–19%), four of those states – Texas, Georgia, South Carolina, and Mississippi – have refused the additional funding, whereas California, Arkansas, and Nevada, also in that list, plan to expand enrollment. Lawmakers' rejection of the ACA's provisions for Medicaid enrollment will eliminate their access to the related matching funds, possibly making them ineligible for the myriad of grant funds, discussed below, that would provide municipalities within their states with additional federal funds for economic development.

While the states will be responsible for some costs related to expanding Medicaid-eligible populations, it amounts to little more than the 5% percent match for federal outlays. ACA expenditures to the states, on the other hand, will increase significantly. As Table 3 illustrates, between 2013 and 2022, federal Medicaid spending for newly eligible populations will distribute almost \$1 billion to the states.

### *ACA support for CHCs*

To help facilitate access, the ACA established an \$11 billion Health Center Trust Fund (HCTF) to be spent between FY 2011 and FY 2015. Of that, \$1.5 billion is allotted for capital expenditures, while \$9.5 billion is allocated to support expanded operations. The ACA also created a \$1.5 billion fund to expand the National Health Service Corps (NHSC), which provides scholarships and student loan repayments to professionals who serve at CHCs in communities with limited access to care (US Department of Health and Human Services, 2011). These commitments were designed to help CHCs attract and retain high-quality health care professionals. It is anticipated that because of the Medicaid and private insurance coverage expansion and the HCTF and NHSC funding, CHCs will serve approximately 40 million patients between 2010 and 2019 (The Kaiser Foundation, Kaiser Commission on Medicaid and the Uninsured, 2012). In an initial demonstration of support, shortly after the Act was signed the Department of Health and Human Services (2011) announced \$700 million in grants to local governments, provided by the HCTF, to build, refurbish, or expand CHCs in underserved areas.

Table 3. Total federal and state Medicaid expenditures<sup>a</sup> under the ACA, 2013–2022 (in \$billions).

	Expenditure under NO ACA (baseline)			Expenditure under ACA with NO states expanding Medicaid			Expenditure under ACA with ALL states expanding Medicaid <sup>b</sup>		
	Federal	State	Total	Federal	State	Total	Federal	State	Total
U.S. total	\$3.66	\$2.68	\$6.34	\$3.81	\$2.75	\$6.56	\$4.61	\$2.76	\$7.37

<sup>a</sup>Includes all Medicaid spending in baseline including aged, long term care, DSH, etc.

<sup>b</sup>Also includes expenditure increases that would have occurred under the ACA without the Medicaid expansion.

Source: Kaiser Commission on Medicaid and the Uninsured (2012).

### ***ACA support for other community economic development***

The ACA's focus on ensuring improved access to care in many instances also creates community economic development opportunities. The Prevention and Public Health Fund, initiated by the ACA, appropriates funding to states and communities for preventative services, public health infrastructure and training, and research. In FY 2010, an initial allocation of \$500 million was distributed to states and communities to boost prevention and public health efforts. Additional funds are dedicated in each subsequent year to help states and communities expand on these critical priorities.

Within this fund, over \$298 million in community prevention grant funds are targeted for public health wellness and education. Community and state prevention grants, comprising \$222 million, fund state and community initiatives that use evidence-based interventions to prevent major illness and obesity, reduce health disparities, and launch a consolidated chronic disease prevention program. The clinical prevention fund allocates \$182 million for access to Critical Wellness and Preventive Health Services grants (\$112 million), which fund initiatives that increase awareness of new preventive benefits, expand immunization services and activities, and strengthen employer participation in wellness programs. Behavioral health screening and integration with primary health grants totaling \$70 million are targeted to assist communities with the coordination and integration of primary care services into publicly funded community mental health and other community-based behavioral health settings.

The Act also appropriates \$137 million for Public Health Infrastructure and Training. Of that, Public Health Infrastructure grants of \$40 million will fund state, local, and tribal public health infrastructure projects primarily by improving information technology, workforce training, and policy development. Over \$45 million in Public Health Workforce grants will support training of public health providers to improve access and quality of health services in medically underserved communities. Public Health Capacity grants, totaling \$52 million, are intended to fund state and local capacity to prevent, detect, and respond to infectious disease outbreaks through improved epidemiology and laboratory capacity and increase investments in programs that prevent health care-associated infections.

Another source of community economic support is the \$133 million research and tracking initiative, whose purpose is to increase resources for assistance and evaluation of preventive services. Health Care Surveillance and Planning grants totaling \$84 million are intended to fund data collection and analysis to monitor the impact of the Affordable Care Act and increase the collection and analysis of environmental hazards data. Prevention research grants totaling \$49 million will fund efforts to identify and disseminate evidence-based recommendations on public health issues to inform practitioners, educators, and other decision-makers, expand the development of recommendations for clinical preventive services, and interdisciplinary public health research studies (The Kaiser Foundation, Kaiser Commission on Medicaid and the Uninsured, 2012). This will also increase local employment opportunities.

### **Reaping the benefits of ACA funding: Maryland and Michigan**

Maryland stands to reap considerable economic benefits from the ACA's Medicaid expansion as well as its support for additional CHCs in underserved areas and commitment to workforce recruitment, retention, and education. This was the finding of the

detailed analysis of a dynamic health care simulation developed by the University of Maryland's Hilltop Institute that included population change, economic impact, employment, and health care expenditures. The simulation was designed so that it can be updated as new projections and data become available, conditions and factors change over time, and policy-makers, employers, and consumers make decisions. The model focuses on the new enrollments, expenditures, and economic activity resulting from the ACA health care reform (Fakhraei, 2012; Maryland.gov, 2012).

The study estimates that

the Medicaid expansion alone will add about \$2.5 billion in federal funds through the end of 2020 ... In addition, the advance tax credits, worth an estimated \$3.3 billion to Maryland's economy from 2014–2020 – and worth \$840 in 2020 alone – will pulse through Maryland's economy. (Milligan, 2012, p. 1)

The ACA's support for additional health care facilities and professional education and training is estimated to generate an increase in approximately 27,000 new jobs for the state – resulting in an unemployment rate of just 3.7% by 2020. New jobs will be found in all sectors of the economy “as the surge of new health care financing helps to grow industries ranging from construction firms building new medical office buildings to service sector workers running convenience stores, restaurants, and other small businesses” (Milligan, 2012, p. 1).

The impact to the state's budget from taking advantage of all the provisions of the ACA will result in savings of \$672 million, in large part from replacement of the state's Primary Adult Care program with the ACA's Medicaid expansion funding options. Further, the ACA is expected to save the state \$3.1 billion between 2014 and 2020 in uncompensated hospital care. The state also anticipates receipt of \$10.5 billion in new funds for hospital services, pharmacy, and other health services between 2012 and 2020 (Milligan, 2012). In addition, the Hilltop report estimates that ACA reforms and resultant economic development will generate approximately \$237 million in new state and local tax revenues each year (Maryland.gov, 2012) for a total of over \$1 billion between 2014 and 2020 (Fakhraei, 2012).

Similarly, Michigan anticipates substantial economic benefits from embracing the ACA's reforms. The state started FY 2013–2014 having eliminated its prior budget deficit and looking ahead to a slowly improving economy. However, the state has a unique financial problem: six cities, including Detroit, were deemed fiscal failures and placed under the auspices of Governor-appointed emergency managers (Abbey-Lambretz, 2013).

The ACA's Medicaid provisions alone could go a long way in making up for Michigan's budget cuts implemented to close the prior year's \$1.17 billion shortfall (Sunshine Review, 2012). Expanding Medicaid coverage to the expanded ACA eligibility parameters will save Michigan an estimated \$3.2 billion between 2014 and 2020. It is also estimated that the state could save \$17.1 billion between 2014 and 2020 in payments to hospitals for uninsured patients' health care. In addition, “10-year aggregate savings in the range of \$640–\$985 million could accrue to employers and individuals who purchase private health insurance as a result of the expansion of the state's Medicaid program” (Center for Healthcare Research and Transformation, 2012, p. 1), which, in turn, could result in increases in business and consumer spending, job creation, and state tax revenues.

### **Limitations of the ACA**

While the benefits are substantial, the ACA comes with several drawbacks, predominantly pertaining to sustained funding. Congressional reliance on six-month continuing resolutions, rather than passage of annual federal budgets, to fund government activities could negatively impact any appropriations necessary to support specific ACA initiatives funded through discretionary spending. In addition, the sequestration of mandatory spending programs is anticipated to take effect in 2014; it is unclear how that will impact public health care entitlement spending. Also, the Act authorizes funding for programs through FY 2019; it is possible that CHCs will then have to rely on Section 330 operating grants and revenues from public and private health insurance payments to maintain their expanded operations, which could curtail plans for future development and services. Finally, the depth and scope of the ACA have presented challenges to the departments charged with implementing the various aspects of the bill. Setting up the federal insurance exchanges and coordinating state exchanges as well as state participation in the federal exchanges, for example, has been a complicated, challenging endeavor (Brand, 2010; Government Accountability Office (GAO), 2013; Jost, 2009; Kingsdale & Bertko, 2010).

### **Limitations of the review**

The obvious weakness of this review is that the effects of the ACA will not be measured for years to come. Therefore, we had to rely on state projections based on the language of the law and the unique characteristics of each state. In short, detailed analysis of the ACA's impact on local economic development at this time is incomplete. This review serves to initiate discussion of the ACA's economic impact on local communities through the use of CHCs. Future research should revisit this discussion in order to quantitatively measure the ways in which ACA program funds have been used to expand CHCs and facilitate state and local economic development.

### **Conclusion**

Market failure theory (Bartik, 1990; Liou, 2001) tells us that one of the rudimentary roles for government is to identify and to implement policies and programs that meet the needs of the public but would not be effectively or efficiently delivered by private enterprise and whose nonmarket benefits would exceed costs. Private and public cooperative endeavors are lauded as ways to provide such services while guarding against failures of market coordination. CHCs are an exemplary illustration of this theory; they are government-sponsored, public/private collaborations created to provide public health care to millions of rural, disabled, low-income, disabled, and underserved participants. The ACA was designed to broaden eligibility standards and fund additional CHCs, as well the professional workforce necessary to accommodate the expanded population and the needs of the communities to support and sustain this growth.

Public funding for CHCs directly connects to neighborhood economic development theory through establishment of new institutions; investment in human capital through education, training, employment training, transportation, job readiness, antidiscrimination efforts, job linkages, and ongoing on-the-job supports; and employment of the skills of the neighborhood by incentivizing industries that require those skills. Studies show that inclusion of a CHC corresponds to increased community economic development.

CHCs play a vital role in community life, particularly in rural and underserved areas of the country as they generate economic activity in the communities they serve (The California Endowment, n.d.; Center for Disease Control and Prevention, n.d.).

Discussions of the ACA have been myopically limited to issues of insurance coverage and enrollment concerns. What is largely ignored is the comprehensive and substantive impact of ACA funding as an economic development driver. This paper draws attention to that feature of the Act so as to make local leaders aware of these potential new funding opportunities and also to encourage future studies on the impact of this aspect of the bill. As the focus on the ACA shifts from the insurance issues of the Act to the budgetary savings and revenue generation directly attributable to provisions of the Act, the economic development impacts of the ACA can be identified and measured. At a time when state and local governments are seeing revenue reductions from so many other sources, the ACA's impact on local development might be a municipal life-saver.

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