MEMORANDUM *CONFIDENTIAL*

To: Matt Kibbe, President & CEO
Dick Armey, Chairman

From: Dean Clancy, Legislative Counsel and Vice President, Health Care Policy

Subject: **Health Care Strategy after the Court Rules**

Date: June 21, 2012

To help us communicate with the press and our members in response to the Supreme Court's ruling, I've prepared this memo outlining FreedomWorks' strategy for how we finish the job of repealing the government takeover of health care while replacing it with a patient-centered system.

This strategy comes out of many conversations with Hill staff and other groups in the repeal coalition, as well as my own sense of where we are, what we've achieved so far, and where we need to go next.

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Introduction

Although we're still winning this issue, the biggest danger for us right now is the possibility that congressional Republicans will snatch defeat from the jaws of victory by conceding the opposition's basic principles of government mandates and coercion, in order appear more "compassionate." One current example is the impulse among a few Republicans to embrace the Democrats' "slacker" mandate (which requires insurers to let adult dependents stay on their parents' health insurance until they turn 26). As I explain in the appendix, this "under-26" mandate is unprincipled, unnecessary, and actually harmful. But it sounds nice, and that's what makes it dangerous.

Republicans suffer a second vulnerability, in their long-standing hesitation to be too specific about what they'd do on the "replace" side of the "repeal and replace" agenda. I will grant that it's always prudent to avoid needless specificity. But under current conditions, excessive vagueness is also a danger. Members of Congress and repeal supporters need to be prepared to answer such inevitable questions as "What will the GOP do if the Court strikes down the mandate?" and "What is the GOP's idea for achieving universal coverage?" What they most need to understand is that these questions are traps. The premise of the questions—that the goal of health care reform must be to "get everyone covered" or "get a lot more people covered"—is wrong. Coverage expansion should not be our goal. Our goal should be to reduce costs and expand individual liberty without coercion. Coverage gains will follow as a natural and welcome by-product.

Since the only way to lower costs and enhance freedom—and, incidentally, the only way to increase quality and accelerate innovation—is to *reduce* government involvement in health care, it is paradoxically true that the only way to get more people *covered* is to reduce government involvement in health care!

If we try to "outflank" the Left by offering solutions to "achieve universal coverage by 'conservative' means," we are sure to lose the war. There's no way to turn coercion into an asset. It will always lead to disaster. RomneyCare and ObamaCare are great proofs of this; they both trace their pedigree back to "conservative, Republican" ideas offered in the late '80s and early '90s, and both have led directly to the current crisis.

Another thing I'm telling Republicans is that we shouldn't implicitly accept the premise that "Health care is now the Republicans' problem." Health care is America's problem, and everyone should be working to make it better in ways that are consistent with our inalienable rights to life, liberty, and the pursuit of happiness. But we can't fix it without first fully undoing the Democrats' costly, damaging handiwork. And, incidentally, if it *is* the Republicans' problem, then Republicans should be allowed to implement their own solution, which is to fully repeal the president's unpopular health care law and start over.

By the way, I wonder if it isn't time to retire the "repeal and replace" slogan in favor of something like "repeal and restart." We don't want to replace the Democrats' big-government solution with a Republican big-government solution. We want to do something far more fundamental. We want to replace government-centered care with patient-centered care. A term like "restart" captures that fundamental difference of visions more fully than does a term like "replace."

Speaker Boehner, as you know, has gone out of his way to reassure us publicly and privately that House Republicans are still firmly on board with a full repeal and will not try to preserve or re-enact the supposed "good" parts of ObamaCare (such as the under-26 mandate). Leader McConnell and the

Senate Republicans also seem generally solid, though a couple of them have made some disconcerting statements. As always, we will have to remain vigilant.

Regardless of what the Court does, we're counseling Republicans to avoid a vain pursuit of some imagined bipartisan "compromise" before the election. The Democrats cannot be expected to deal in good faith. Instead, Republicans should take their case for patient-centered care directly to the voters, and then, after the election, work to enact reforms in a thoughtful, transparent process. In other words, they should basically do the opposite of what the Democrats did three years ago.

In Sen. DeMint's strategy session last night, when discussing how to talk about the "replace" agenda in the wake of the Court's ruling, some Members seemed to take a pretty hard "Keep it at 100,000 feet" line, which struck me as a tad too defensive. I think we can take it down to 30,000 feet without crashing the plane. As we've been telling Republicans since November 2010, we *do* need to say what we'd replace ObamaCare with. Yes, we also need to avoid excessive minutiae and public disagreements over details. But if Republicans want the voters to entrust them with a governing majority, they have a duty to tell voters what they'd do with that majority. That's why they should openly run on issues like expanding Health Savings Accounts, allowing interstate purchase of health insurance, helping people with pre-existing conditions (without mandates), and making the tax treatment of health care expenses fairer. There's no need to get into more specific or potentially divisive issues.

I'm happy to report more and more Republicans have been taking a look at our favorite bills list, including Dr. Tom Price; who is in some ways the House GOP point man on health care issues, having the three-fold boast of being a doctor, a former head of the House conservative caucus, and a current leadership member.

With respect to tone, in the event that the Court strikes the mandate, I agree with the consultants who advise eschewing partisan chest-thumping and "spiking the ball." But it's always appropriate to celebrate when the Constitution is upheld, and indeed, in this particular case, *failing* to celebrate would be inappropriate. Think about it. If the Court strikes the mandate or the Medicaid expansion, or both, it will be a truly historic reversal of an 80-year trend toward ever-greater federal power. That's big. That's exciting. That's worth celebrating.

I also believe it will make full repeal of the Unaffordable Care Act# more or less inevitable, as I try to show below.

And, by the way, if the Court does strike down the mandate or the Medicaid expansion, I think we should remind people that this huge victory probably would not have happened without the Tea Party and the public's renewed interest in the idea of constitutionally limited government. It has been three years since the birth of the Tea Party, and that movement is still having an impact, even within the walls of the Supreme Court. How many other political movements can say that?

1. Where We Are

Supreme Court

I remain optimistic that the Court will at least strike down the individual mandate, and I'm more optimistic than most that they'll strike down the entire statute.

That said, the rumor mill is rife with hints that the Court has been wrestling internally over severability. If true, that tells us two things: (a) the mandate is history; and (b) at least one of the five "conservative" Justices is not on board with a full strikedown (alas).

Right now, it appears the Court will publish its decision on one of these three dates, in the following order of likelihood:

- Mon 6/25
- Thu 6/28
- Wed 6/27

Day of. SCOTUS decisions usually come out around 10:00 am, Eastern time. Chloe, Brian, and I will be at the Court each day at that time, ready to broadcast live online via our ustream page. Michael will also run the broadcast through our Facebook page and promote it via national email. Jackie and I have drafted press release language, based on the four most likely scenarios (strike-all, uphold-all, strike-mandate-only, and strike-mandate-plus).

First 24 hours. After the SCOTUS decision, the first 24 hours are critical. Our side should do absolutely nothing except comment on the decision, celebrate the Constitution, and work to keep the focus on what's wrong with ObamaCare. In these first hours, we must not go too deep into "what Republicans will do next," which, as I've noted, is where the Left wants to take the conversation in order to divide our side. On day one, let's keep the plane at 100,000 feet.

Next five months. From now until the election, we need to vigorously make the case for "repeal and replace" or "repeal and restart." As you know, this whole issue has always broken down along strictly partisan lines, with Republicans against ObamaCare and Democrats for it. If the Court's decision causes significant numbers of Democrats to switch sides and thus destroy their party's monolithic support for the government takeover, we should try to turn their retreat into a rout. We should force repeal votes in the House and Senate and give them no quarter except if they endorse full repeal. But if the Democrats' line holds, we should be extra-judicious, biding our time and making our case.

In the scenario where *only* the individual mandate is struck down by the Court, the House Republican leadership is currently saying they'll force a quick re-vote on full repeal. This might not change anyone's vote, but it will reinforce our message. Realistically, it will be hard to change many votes prior to the election, because many if not most of the Democrats who were vulnerable on ObamaCare were defeated in 2010; the remaining ones are mostly from relatively safe districts and thus less likely to feel the heat.

Four Questions for the Court

What's the Court likely to do? And what will it mean, politically and legislatively?

There are four basic issues before the Court:

1. *Tax Anti-Injunction Act:* Is the individual mandate a tax, for purposes of this judicial-process statute?
2. *Mandate:* Is the mandate constitutional under the Commerce Clause or the tax power?
3. *Medicaid expansion:* Is the Medicaid expansion unconstitutionally coercive of the states?
4. *Severability:* If any part of the law is struck, what other parts must also fall?

The lawyers on our side have done a superb job of making our case. Our main argument is that the mandate to purchase health insurance cannot be justified under the power to regulate interstate commerce, or under the power to lay and collect taxes for the general welfare, without also justifying Congress in exercising powers clearly never intended by the Founders, such as a power to make us all eat broccoli for our health.

The Administration's lawyers and supporters have scoffed at the very idea of a challenge to the mandate. To their way of thinking, it's a slam dunk—former Speaker Pelosi calls it "iron clad"—that Congress can regulate the way we pay for health care by making us all buy health insurance.

If the Court says the mandate isn't constitutional under the Commerce Clause, then the Left's fallback is to say, "Okay, but the mandate penalty is a tax; it's collected by the IRS. And Congress has broad power to lay and collect taxes for the general welfare. Ergo, it's constitutional."

This argument is ironic, because the very same people were determined to deny that it is a tax, when the bill was pending in Congress. President Obama denied it with special vehemence. So it's been more than amusing to watch the Democrats dance and weave during the post-enactment phase, to the point that Administration officials have simultaneously told the Court that the mandate is a tax and solemnly assured Congress that it is not a tax, on the same day.

If the tax power is the Left's fallback, what is ours? That's not clear from the lawyers' arguments, but we have tried to offer a fallback grounded in the Necessary and Proper Clause. Our FreedomWorks Foundation Constitution Defense Fund friend-of-the-court legal brief in the case is intended precisely to provide a kind of firewall, in the event the Court is tempted to uphold the mandate. Its reason for being is to help Justice Kennedy, especially, find a way to kill PPACA even if he thinks the mandate is constitutional.

The Left's hopes are tied to the Court's precedents in *Wickard* and *Raich*, the infamous decisions (from 1942 and 2005) that extended the commerce power to its current, extremely broad limit.# Our argument is that, even if that happens—even if the Court somehow finds that Congress has power under the Commerce Clause to require people to buy a private product—it should still find the mandate unconstitutional, because the statute as applied unduly burdens individual liberty.

How does it unduly burden individual liberty? By taking away choices that don't need to be taken away to achieve the law's claimed purpose of ending the problem of the uninsured “free-riding” on the rest of us.

Before I explain how the Act does that, we need to understand the Administration's basic “cost-shifting” argument, and why it doesn't work. The Administration claims the mandate is necessary to eliminate cost-shifting and uninsurance in the health care market. The uninsured, this argument runs, are "free riders" who shift massive costs onto the rest of us. But this is a fallacious premise. The uninsured can and often do “self-pay,” that is, they don't rely exclusively on health insurance, as this argument implicitly assumes. And in fact, the uninsured as a group pay ***more*** than other people, not less. And finally, only a small fraction of the uninsured are affected by the mandate, suggesting that ending “cost-shifting” is not the Administration's real purpose.

The Administration claims “cost-shifting” amounts to $43 billion a year, which is about 1.8 percent of all health care spending. That's a pretty small figure, in the grand scheme. But a review of the data suggests actual cost-shifting by those to whom the mandate actually applies is much less even than that: only around $13 billion, or less than one-half of one percent of health care spending.
If the mandate is needed to end “cost-shifting,” why does the statute exempt 24 million Americans from the mandate?

- Those whose insurance exceeds 8 percent of their household income
- People who don't have to file a tax return
- Members of American Indian tribes
- Undocumented aliens
- Prisoners
- Certain religious groups
- People in health-care sharing ministries

And why does it exempt the following groups from having to pay the mandate penalty?

- All persons exempted from the mandate
- Persons living permanently outside the U.S.
- Residents of U.S.territories and possessions
- People who are uninsured fewer than 3 months out of a year
- "Hardship" cases, as defined by the Secretary of Health and Human Services

(Note that last point, and think: “vote-buying.”)

The Administration's second claim is that the mandate doesn't really make us buy insurance, it really only regulates "the means of paying for health care." The idea is that since we all get sick in our lives, it's “free-riding” and “cost-shifting” for us to go without insurance. But this argument, again, is built on the fallacious premise that insurance is the only way we pay for health care services. It's not. As we've noted, some people can and do self-pay. Therefore, the bill does not end “cost-shifting.” Instead what it does—and this is its real purpose—is redistribute income from young, healthy people

to others by making them buy government-controlled health insurance, from a government-regulated insurance company, for the entirety of their lives. Is *that* in the Constitution?

So now we come back to our legal brief and our argument that PPACA, even if "constitutional," is unconstitutional as applied. We make this argument because PPACA effectively outlaws the kinds of plans most affordable for young, healthy people: consumer-driven health plans (CDHPs) and Health Savings Accounts (HSAs). The combination of two requirements of the law will effectively eliminate CDHPs and HSAs; and that, we argue, goes too far beyond the simple desire to "end cost-shifting" to pass constitutional muster.

The two requirements I'm referring to are: (1) the rule that insurance plans cover no less than 60 percent of a person's health care costs (this is the definition of a "bronze plan," which is the least generous option the law permits) and (2) the rule that insurers spend no less than 85 percent of premium payments received on actual medical care, as opposed to administration or profit ("medical loss ratio" or MLR). By putting these two policies together, PPACA makes it impossible to obtain a plan with anything other than a low deductible. (A deductible is the portion of your medical costs you have to pay out of pocket before your insurance kicks in.) That means CDHPs and high-deductible plans paired with HSAs will disappear. This is tragic because, as I'll show in the section on patient-centered care below, building patient-centered care cannot proceed without people having free access to economical, high deductible insurance. (By the way, as I'll also try to show below, the patient-centered care revolution is already underway and producing wonderful benefits.)

In sum, PPACA unduly burdens our liberty by harmfully narrowing our health insurance options, and it violates the Constitution by doing this needlessly.

Seven Scenarios

Flowing from the four basic issues in the case, I can see seven possible outcomes.

To begin with, I predict the Court will answer "No" to questions number 1 and 3 above, which will effectively eliminate two of the seven scenarios. To wit:

1. Declare the mandate a tax. (Odds: 0%.) Based on the Justices' comments at oral argument, I think the Court won't find the individual mandate to be a tax for purposes of the Tax Anti-Injunction Act, and thus it won't be forced to postpone final resolution of this case until 2015 or 2016. (Whew!)

2. Strike Medicaid expansion. (Odds: 0%.) I think the Court won't find the Medicaid expansion to be unduly coercive of the states (although I think they *should* do so), because Medicaid is, strictly speaking, "voluntary" (i.e., states don't "have" to take the federal money). If the Court does strike down the expansion, as I've said, it will be a history-making victory for federalism and the Tenth Amendment, because it will likely entail or eventuate in a revival of the old (currently dormant) rule that says, "If Congress lacks a power to do something under some specific grant of power, then it cannot circumvent the Constitution by doing that same thing via the spending power." So, for example, if you cannot order the states to increase their legal drinking age, then you can't bribe them to do so with federal grant money (which, of course, the feds currently do, with highway funding). Striking down the Medicaid expansion on Tenth Amendment grounds is arguably as big a deal as striking down the individual mandate. But again, I don't see it happening (alas).

That leaves six other possible scenarios, which I'm willing to put odds on:

3. Uphold entire law. (Odds: 5%.) Possible but unlikely. The Administration has consistently failed to articulate a clear limiting principle that would explain why Congress can make us buy health insurance but not make us eat broccoli or anything else it feels like making us do. To uphold the Unaffordable Care Act would be to say Congress can do anything, which would mean that there are in fact no meaningful limits on federal power, which would represent a constitutional revolution. I can't believe Justice Kennedy and the four Justices to his right will go that far; so I think there are five votes for striking down at least the mandate.

Now, there is the danger of a scenario where four of the Justices vote for striking down the mandate, four vote for upholding it, and Kennedy tries to have it both ways. He goes with the leftists on upholding the mandate, but instead of agreeing with their reasoning pens a separate, solo opinion concurring in their judgment yet declaring that he simply finds the mandate "unique" and not a precedent for future cases. I can almost see him speaking "of existence, of meaning, of the universe, and of the mystery of human life." This would be a horrible outcome, and a terrible piece of judging. But it wouldn't be as devastating as the one in which he joins the left-leaning Justices outright, because a four-person opinion does not become the "opinion of the Court," binding on lower courts and in future cases; a five-person opinion does.

4. Strike mandate only. (Odds: 10%.) The conventional wisdom holds that this is the most likely outcome, and some commentators put the odds as high as 80 percent. I am not so sure. If the Court strikes down only the mandate, the linchpin of the entire statute, then it effectively writes a new law never intended by Congress. Plus, striking only the mandate would devastate the insurance industry, because of the law's insurance mandates (which require insurers to take all comers and basically charge everyone the same price, regardless of health risk—mandates known to wonks as "guaranteed issue and community rating"). I could see the five right-leaning Justices, including Kennedy, rejecting this option on severability grounds (the statute is too interconnected to surgically remove just the mandate) and the four left-leaning Justices rejecting it on practical grounds (it would be too disruptive of the insurance market to remove the mandate without also removing the insurance mandates). So I find it hard to see them ending up there, though again, I'm in the minority on that.

5. Strike mandate plus insurance mandates. (Odds: 5%.) This is quite possible, and it's the Administration's preferred fallback position, because it means the insurance industry won't be devastated by the loss of the mandate, which in turn means the Left will have a better chance of preserving the remainder of the law and coming back later to reinvent the mandates in some other guise. But my sense, based on Justice Kennedy's comments at oral argument, is that the Court won't go for this particular outcome because, although the individual and insurance mandates are indeed intimately connected, striking them while leaving everything else may not be much different from "legislating from the bench," which he seemed loath to do.

6. Strike all of Title 1. (Odds: 20%.) This is quite possible; in fact, I would regard it as more possible than other "partial strikedown" options. Title 1 is the "guts" of ObamaCare. It includes not only the individual and insurance mandates but also:

- the employer mandate;

- the benefits mandates, including the "free preventive services" mandate that gave rise to the notorious HHS anti-conscience mandate);
- the premium subsidies (to help people afford the government-controlled insurance they're required to purchase); and
- the exchanges (where they will have to go to obtain the subsidies).

Most of Title 1 doesn't take effect until 2014. The Court could reason that this title is inherently a "unity" but that it's also "detachable" from the other titles of the bill, even though those other titles probably wouldn't have become become law without it.

The other titles are:

- Title 2, Medicaid expansion;
- Title 3, Medicare cuts and changes, including the Independent Payment Advisory Board (IPAB) (a.k.a., the care-denial board, a.k.a., the "death panel");
- Title 4, public health provisions;
- Title 5, health care workforce provisions;
- Title 6, Medicare anti-fraud provisions;
- Title 7, the "bio-similars" approval-process bill;
- Title 8, the CLASS Act long-term-care entitlement; and
- Title 9, various new taxes.

7. Strike entire law. (Odds: 60%.) Many smart people think this is the least likely outcome. I continue to think it's the most likely outcome because of the inherent difficulty of cutting up this intricate statute without, in effect, writing a new law from the bench. Of course, striking out any part of any statute effectively rewrites that statute. But usually the part struck out is peripheral to the rest. In this case, the offending provision, the mandate, is the linchpin. Certainly, it's the linchpin of Title 1, which in turn would not have become law without the other titles; each of which was added either to help pay for Title 1 or to buy votes to help pass the whole package. The head-bone is connected to the foot-bone. So my money remains on a total strikedown.

Political Impacts: Win-Win for the Tea Party

Politically speaking, whether the Court says "yea" or "nay" to the mandate, this case is more likely to be a win for our side than for the Left.

Elections are won and lost based on differential turnout ("who shows up"), and turnout is determined mostly by intensity of feeling; and on this law, most of the intensity is on our side. Americans hate the mandate. Two-thirds oppose it, in fact, including a majority of independents. Seventy-two percent think it's unconstitutional. Among the 53 percent of likely voters who favor repealing the law, according to Rasmussen, 42 percent do so strongly; while among the 42 percent who oppose repeal, only 30 percent do so strongly. In short, the intensity disparity favors the law's opponents.

And that won't change as a result of this case. If the mandate is upheld as a valid exercise of Congress's power to regulate interstate commerce, and limits on federal power are effectively eliminated, our side will be even more galvanized than we already are to elect constitutional conservatives in November. It will be like waving a red flag in the face of the tea party.

If, however, the mandate is struck, Democrats will be thrown on the defensive—since they'll have spent three years trying to force an unconstitutional law on an unwilling public. (This would also be true if the Medicaid expansion is struck, though the immediate political reverberations of that might be less than with the mandate.)

If the Court goes further and scraps the whole enchilada, then the Republicans will really win the high ground politically, and it may even hand them the election. It will be a huge blow to President Obama, and a big boost to the Republicans, particularly to the tea party grassroots. I don't see any way the president can put a happy face on such an outcome.

Some Democrats will undoubtedly try to argue that, by having lost on the mandate, they'll benefit in the fall, because a political liability will have been "taken off the table" five months before the election. But this feels a bit like the person who is convicted of shoplifting saying the public prosecutor has a terrible problem because he now has no case to prosecute. While the health care issue will diminish in the sense that it has been "resolved" as a legal matter, the American people will have yet another chance to make a judgment about the stewardship of the president and the Democrats. It's hard to see how they avoid the shame of such a high-profile slap-down.

Of course, if either the mandate or expansion falls, then the Left might be galvanized to fight what they will decry as an "activist, Republican" court. They are already preparing the way for this by noting how many of the Justices were appointed by Reagan (2), Bush the elder (1), and Bush the younger (2). But it's hard to see this making much of a difference. More likely, the Democratic base will be depressed at having massively fumbled the health care issue for a second time in twenty years.

In the scenario where the Court strikes down the mandate and the insurance mandates, but nothing else, Democrats will have salvaged much of their bill. But they'll still be on the defensive on its remaining mandates and taxes, which are easier to fight than the main market "reforms" have been.

So call me a hopeless optimist, but I'm having trouble seeing any scenario that doesn't ultimately inure to the benefit of the Tea Party.

Public Opinion

Okay, enough of the Supreme Court. Let's look at the court of public opinion.

Three years after the bill first appeared in Congress, the Washington Post-ABC News Poll reports that the law has yet to score majority support in any of its polling. That's three solid years below 50 percent.

A February 2012 Gallup Poll shows support for repeal continuing to lead opposition, although by a narrow margin: 47 percent in support versus 44 percent opposed. In its March 2012 release, the Post-ABC poll found that 41 percent of Americans support ObamaCare, while 52 percent are opposed.

But look closer. The May 2012 Kaiser Tracking Poll shows the ratio of those who are unfavorable to the law at 44 percent versus only 37 percent who are favorable to it—a 7-point advantage for those who disfavor the law. (Interestingly, the percentage of people with a favorable view of the law

dropped 5 full percentage points in April, perhaps because of news coverage of the Supreme Court oral arguments.)

While the mainstream press likes to portray this data as showing that neither supporters nor opponents of the law have a clear majority of the public on their side, what jumps out at me from the Kaiser chart is that opposition has exceeded support with almost perfect consistency since the law's enactment in March 2010, and at a couple of points opposition has exceeded 50 percent, while support never has. Since numerous other polls have shown opposition figures as high as 59 percent, it's a fair assumption that a majority of the public does in fact oppose this controversial law.

And of course, as I noted earlier, there's a disparity of intensity. While the aforementioned Gallup poll finds Republicans overwhelmingly favor repeal (87 percent) and Democrats overwhelmingly oppose it (77 percent), Republicans hold their views much more intensely than do Democrats, with 56 percent of Republicans strongly favoring repeal but only 39 percent of Democrats strongly opposing it. Elections, again, are decided by relative turnout, so these numbers bode well for Republicans in November, *as long as their candidates continue to run on a strong full-repeal platform.*

According to the same Gallup poll, Americans overwhelmingly believe the individual mandate is unconstitutional—by an eye-popping 72 percent to 20 percent, which may be less a reflection of constitutional viewpoints than of the mandate's profound unpopularity. But still: *72 percent!* And the March 2012 Kaiser Tracking Poll finds that only 32 percent of Americans have a favorable view of the mandate.

This may help explain why more than two-thirds of Americans hope the Supreme Court will overturn some or all of the law, according to a new New York Times-CBS News poll. Just 24 percent said they hope the Court will keep the entire law in place, and 27 percent said the justices should overturn only the mandate; but 41 percent said the Court should strike down the entire law.

Perhaps the most encouraging sign is that we're winning the independents. More than 70 percent of independent voters say they want to see some or all of the law struck down. More than 50 percent say they hope to see the whole law overturned. A mere 22 percent say they hope the entire law survives.

In sum, we're winning in the court of public opinion. A favorable Supreme Court ruling should help solidify that advantage.

2. What We've Achieved So Far

Why We Fight

As Matt points out in his new book, back in 2007 Robert Reich, who had been Labor Secretary in the Clinton Administration, gave a speech at Berkeley in which he revealed what progressive academics like him actually think about patients' freedom. Reich presented an imaginary speech that he wished would be given by an "honest" politician. It included the following memorable "promises":

- "You young, healthy people—you're going to have to pay more." *Applause.*

- "[I]f you're very old . . . [we've decided i]t's too expensive, so we're going to let you die." *Applause.*

- "[We're] going to use the bargaining leverage of the federal government … to force drug companies and insurance companies and medical suppliers to reduce their costs. But that means less innovation, and that means less new products and less new drugs on the market, which means you are probably not going to live that much longer than your parents. Thank you." *Applause.*

Applause, applause, applause. Could anything be creepier?

"We're going to let you die." This, in five words, is what we're fighting against. *This* is why we fight.

Americans favor "health care reform," and rightly so. But what voters mean by "reform" and what folks in Washington mean by it tend to be very different things. Voters want lower costs, shorter wait times, less paperwork, more control, and more freedom. The political Left, by contrast, wants to centralize control of a "system" in Washington, partly in order to impose its view of justice and the good life on all of us, but also (whether it wants to admit this to itself or not) to increase its own power and patronage. The political Right seems pulled in two different directions. Sometimes it wants to give voters what they really want by putting patients first and reducing government involvement in the patient-doctor relationship. Sometimes, however—too often—Republicans slip into the bad habit of trying to please corporate interests like the drug and device makers and the health insurance lobby.

As I argued above, the only legitimate purpose for any health care reform should be to lower costs and expand individual liberty for patients. Period.

Why do we keep insisting on full repeal, when undoubtedly some Republicans silently discount our ability to achieve it? For two reasons. (1) Full repeal is necessary as a policy matter, in order to clear the legislative blackboard, so to speak, and to ensure that no piece of the Democrats' handiwork can rise up to cause unforeseen problems later. (2) It's essential for political reasons, so we can create a radioactive zone where intelligent politicians fear to tread. We don't just want to liberate health care, we want to liberate it permanently. Remember, we "won" against HillaryCare in 1994, but sixteen years later we found ourselves right back in the soup. Why? Because we hadn't bothered to solidify our advantage when we had the chance. Republicans and moderate Democrats could have fixed what was broken in our health care system back in the mid-'90s. Instead, they went to sleep, and the Left recovered the initiative. We must not let that happen again.

And full repeal is politically essential for another reason: It dramatically underscores the Left's unfitness to govern. If any part of this law is allowed to stand, the progressive coalition will use that fact to try to declare itself exonerated. We should not give them that escape route. This fight is a fundamental clash of visions regarding how health care should be delivered, and while we should certainly welcome bipartisan solutions, they must be bipartisan on the right terms. There's no need for needless or preemptive concessions. After all, just to remind ourselves:

- A majority of the public is with us.

- A majority of the states is with us. (Twenty-six have sued to overturn the law in court.)
- A majority of the current House is with us. (The House has passed a full repeal bill, 245 to 189.)
- A near-majority of the Senate is with us, including all 47 Republicans.
- A majority of voters have been with us in every election to date where ObamaCare has been on the ballot. Indeed, voters have approved every state-level repeal initiative, including in Arizona, Missouri, Ohio, and Oklahoma.

Voters simply aren't looking for moderation on this issue. They've made up their minds. They reject the government takeover. Could the Court's decision soften public antipathy to the law? Possibly. But rather than trying to swim with the ebbs and flows of public opinion, we should always be striving to inform and enlarge the public view, based on the true, unchanging principles of liberty and human nature. This fight is winnable.

We also need to remind ourselves that the historic 2010 wave election was, in many ways, a referendum on health care. ObamaCare was the top policy issue for voters, well ahead of others. Supporting the unpopular law played a big role in the defeats of scores of Democratic candidates, incumbents, and challengers alike. Seven of the eight House Democrats who switched their position on the bill from "no" to "yes" in March of 2010 were defeated by Republicans in November. Before the election, Democratic candidates were spending more money on advertisements *opposing* the health care bill than for it! Among that rarest of species, the incumbent who bravely defended his pro-Obamacare vote, two were especially vocal: Senator Russ Feingold of Wisconsin and Congressman Earl Pomeroy of North Dakota. Both lost.

Two years later, this issue shows no signs of abating in its ability to move the needle. We know from our own work that grassroots activists are more likely to take action on health care than almost any other issue.

- Witness the amazing speed and ease with which we gathered those first 120,000 petition signatures to "End ObamaCare Now!" (We're now up to 325,000.)
- Witness how "Repeal ObamaCare" scored No. 1 in our Tea Party Debt Commission online survey, with an amazing 98 percent preferability rating.
- Witness how "Repeal ObamaCare" is currently scoring No. 1 in our newly launched "My 2012 Freedom Platform" online survey.

I swear that "Repeal ObamaCare" has become the most potent idea in American politics.

Another sign that ObamaCare is potent politically is the Repeal Pledge—a comprehensive promise to repeal, defund, and replace PPACA—which has proved a powerful tool in Republican primaries. Candidates who fail to sign it hurt themselves politically, and failing to sign it almost certainly contributed to the demise of GOP Senate candidates in Indiana (Dick Lugar, defeated by Richard Mourdock) and Nebraska (John Bruning, defeated by Deb Fischer). In both races, the winner signed the pledge; the loser didn't.

According to Hadley Heath and Heather Higgins of the Independent Women's Voice, which did a post-election survey in the Nebraska contest, "[A]mong Nebraska primary voters, 'Obamacare' repeal ranked highest of any single issue as the determining factor in the respondent's vote. Roughly 57

percent of respondents said that [winning candidate Deb] Fischer signing the Repeal Pledge mattered to them." When asked which mattered more to their vote, Sarah Palin's endorsement of Fischer or Fischer's signing of the Repeal Pledge, 14 percent said the Palin endorsement while 35 percent said the Pledge.

What We've Accomplished Over the Past 18 Months

A. At the Federal Level

Summary of accomplishments. In 2011 and the first quarter of 2012, the repeal coalition, of which FreedomWorks is a leading member, accomplished a number of important things. Most importanly, we helped make "repeal and replace" an item of GOP orthodoxy and the term "patient-centered" central to GOP reform thinking. We helped put members of both houses of Congress on record regarding full repeal, as well as on defunding of the law (both the entire bill and key portions thereof). We helped secure repeal of the law's onerous "1099" tax reporting mandate, so hated by small business. We helped congressional investigators publicize the scandalous CLASS Act cover-up. We secured House passage of a bill to repeal IPAB, the Independent Payment Advisory Board (a.k.a. the care-denial board, a.k.a. the "death panel"). In these efforts, FreedomWorks alone sent more than 20,000 letters and calls to Congress, conducted dozens of Hill meetings, and circulated a series of confidential strategy memos.

On May 17th, the House GOP leadership helpfully published its own summary of health care accomplishments, which I will quote here in full, without change, for reference:

[Begin House GOP summary] "Our economy continues to struggle, and the president's health care law is making things worse," Speaker John Boehner said today. Whether the Supreme Court strikes down all or part, or upholds the law as it is, Boehner says Republicans are committed to "repealing ObamaCare in its entirety":

> *"Our economy continues to struggle, and the president's health care law is making things worse—raising health costs and making it harder for small businesses to hire workers. The only way to change this is by repealing ObamaCare in its entirety. We voted to fully repeal the president's health care law as one of our first acts as a new House majority, and our plan remains to repeal the law in its entirety. Anything short of that is unacceptable."*
>
> -- Speaker John Boehner

The House Republican majority has voted 29 times so far to repeal, defund, and dismantle President Obama's health care law. Here's an update to a previous post looking at these efforts:

- REPEALING THE LAW: One of the first actions taken by the House in 2011 was to adopt H.R. 2, a bill repealing the health care law in its entirety.
- DEFUNDING THE LAW: The jobs-focused budgets passed by the House this year (H.Con.Res. 112) and last (H.Con.Res. 34) fully repeal and defund the government takeover of health care. Several amendments to H.R. 1 would prohibit funding from being used to implement or enforce provisions of the law.
- REPEALING THE SMALL BUSINESS PAPERWORK MANDATE: The House passed and the president signed H.R. 4, *Pledge to America* legislation that repealed the health care law's job-crushing paperwork mandate.

- FREEZING THE IRS BUDGET: Another provision in the spending cut agreement prevented the IRS from hiring 16,500 new agents to help impose the health care law's tax hikes and mandates.
- ELIMINATING SLUSH FUNDS: Several ObamaCare slush funds were eliminated in last year's spending cut agreement signed by President Obama. The House approved H.R. 1213 and H.R. 1214 to repeal other slush funds and save taxpayers billions of dollars. And the House recently cut an ObamaCare slush fund to pay for a bill that stops student loan rates from doubling.
- SCRAPPING THE RATIONING BOARD: The House passed legislation (H.R. 5) repealing the Independent Payment Advisory Board (IPAB), a panel of 15 unelected and unaccountable government bureaucrats tasked with rationing care for America's seniors.
- EXPOSING TRUE COST OF THE LAW: The House voted to repeal the *CLASS Act* (H.R. 1173) whose phantom "savings" were "crucial to garnering support for passage" of Obamacare, according to a bicameral Congressional investigation.
- BACKING STATES & SMALL BUSINESSES: Speaker John Boehner filed a brief in federal court backing the effort by states and small businesses challenging the constitutionality of the law.
- HOLDING THE ADMINISTRATION ACCOUNTABLE: House committees held roughly three dozen hearings in 2011 examining the impact of ObamaCare on job growth, the costs imposed on families and small businesses, the administration's use of waivers to exempt select groups from the law's mandates, the constitutionality of the law, and much more.

The president's health care law makes it harder for small businesses to hire new workers, jeopardizes seniors' access to care, and adds to the debt that threatens job growth. It needs to go."There's only one way to truly fix ObamaCare," Speaker Boehner has said, "and that's by fully repealing it."

Republicans made a *Pledge to America* to repeal ObamaCare and create a better environment for private-sector job growth. And the House is going to continue working to keep that pledge to repeal the law and then work on step-by-step, common-sense legislation that will help lower health care costs for families and small businesses, and protect American jobs. **[End House GOP summary]**

Full repeal vote. As the foregoing summary makes clear, the most critical vote was also one of the earliest. In January 2011, soon after the new "tea party" class of freshmen was sworn in, the House passed H.R. 2, a bill to repeal ObamaCare in its entirety. This was, of course, a key plank in the Contract from America, the unofficial platform of the tea party movement. All 242 House Republicans voted yes on H.R. 2, and all 47 Senate Republicans voted yes on its Senate companion. Only three out of nearly two hundred House Democrats joined with the Republicans to vote for it; no Senate Democrats voted for it.

Budgetary cost estimates. In addition to protecting the Constitution and individual liberty, H.R. 2 would eliminate the law's spending burden on taxpayers, which is at least $1.4 trillion over the ten-year period of 2010-2019 (and significantly more, as you move the ten-year window out into the future).

Contrary to the claim by the Congressional Budget Office in January 2011 that repealing ObamaCare would increase the deficit by $230 billion (over the ten-year period of 2012-2021), full repeal will most assuredly be a big help to Uncle Sam's financial position, because the law contains at least $700

billion worth of budget gimmicks and double-counting that CBO is required by law to "follow out the window."

But set that issue aside. Over the past year and a half, the case for the Democrats' "repeal will increase the deficit" argument has fallen apart.

At the time of its enactment in March 2010, PPACA was clearly a budget-buster, but Democrats were able to deny this by pointing to CBO estimates showing the bill to be, in fact, a deficit reducer. After Republicans retook the House majority in 2010 and moved to repeal the law in January 2011, CBO estimated that repeal would increase the ten-year deficit by about $200 billion. A year and a half later, CBO is no longer saying that.

1) CBO budgetary cost estimates have become more realistic:

CBO in 2010	+$200 billion net deficit reduction
CBO in 2012	$0 billion net deficit reduction

2) Why have CBO's estimates changed?

CLASS Act not implementable	-$90 billion
Premium subsidy costs up	-$110 billion
	-$200 billion

The Administration's decision to pull the plug on CLASS Act implementation effectively eliminated about $90 billion in anticipated receipts that helped make ObamaCare look cheaper than it really is.

3) Why did CBO's estimate of premium subsidy costs go up?
Because their employer dumping estimate went up:

CBO in 2010	6 million workers dumped into exchanges
CBO in 2012	20 million workers dumped into exchanges

"Employer dumping" is shorthand for employers deciding to stop offering health benefits to their employees, and instead pay a fine while leaving their employees to seek out health coverage in the exchange. The law's subsidies and penalties are clearly structured in such a way that they will tilt the playing field in favor of massive employer dumping. For many employers, it is simply cheaper to dump and pay a fine than to offer coverage. CBO, however, downplayed the likelihood of dumping while the legislation was pending. Now it appears to be coming around.

Congressional oversight. House Republicans on the Energy and Commerce Committee have been doing a great job of investigating the law. For example, they've uncovered internal administration emails that show that the political leadership of HHS knew that the CLASS Act poses a massive bailout risk and simply lied to Congress in order to use CLASS as a budget gimmick to help pass the bill. (A key question, as yet unanswered, is "Did HHS also lie to the White House about this? Or, as seems more likely, did the White House direct HHS to lie to Congress?") We've worked to get the word out about the CLASS Act coverup, and our efforts seem to have paid off with the House vote last September to repeal the unsustainable program by a vote of 267 to 159. (I urged House Republican leadership staff to hold off on scheduling that vote until the White House's role was

clearly established, or at least until the Court's decision was published; but they chose to go ahead, and to my knowledge have done no oversight of the issue since.)

Other internal emails reveal that the White House and the pharmaceutical lobby cut backroom deals beneficial to them but extremely costly to taxpayers—despite the president's 2008 promises to do just the opposite.

Executive branch implementation. The Administration has been working overtime to implement as much of the law as they can before the Court or Congress can stop them. Although the main provisions of the, bill don't take effect for another year and a half, numerous less important provisions have taken effect and the Administration has already issued 12,000 pages of regulations to implement the Act, with its 159 new boards, agencies, and commissions, 16,500 new IRS agents, etc. A $1 billion-dollar implementation fund established by the Act has already been spent; but that won't stop them. The law gives the Administration other, virtually open-ended pots of money to draw from to be used for implementation.

ObamaCare Taxes. If the Court leaves Title 9 of PPACA standing (the tax title), and Congress fails to repeal the law this year, we will see a series of new taxes come on line on January 1, 2013, including:

- A new 3.8 percent payroll tax on certain investment income
- A new excise tax on the sales of medical device manufacturers and importers
- A reduction of the income tax deduction for medical expenses (only people whose medical expenses exceed 10 percent of their adjusted gross income will be able to access the tax, up from the current level of 7.5 percent of AGI)

These new taxes are projected to generate $23 billion in federal receipts in 2013 alone, and all of the tax hikes in ObamaCare are projected to raise $500 billion over ten years.

B. In the States

We've been fighting in the states on two main fronts: (a) passing Health Care Freedom Acts and (2) stopping state implementation of PPACA exchanges.

Health Care Freedom Acts. Health Care Freedom Acts are state laws that protect two rights: 1) The right to choose not to participate in any health care system or plan without a penalty, fine, or tax. 2) The right to spend your own money to get access to any lawful health care service. These acts have been the subject of a nationwide grassroots movement encouraged and supported by groups like FreedomWorks, the Cato Institute, the Heartland Institute, and the American Legislative Exchange Council (ALEC).

At a FreedomWorks-hosted liveblog session last month on How to Stop ObamaCare in the States, ALEC's Christie Herrera explained that "The Health Care Freedom Act is a state law or constitutional amendment that bars an individual mandate." A HCFA, importantly, also effectively bars state officials from helping to enforce a *federal* individual mandate. So a HCFA could be likened to an act of "state nullification." Now, under our Constitution, state law can't really trump federal law, so the passage of a HCFA is to that extent symbolic. But it does send a powerful signal

to Washington and state capitals. And that's why tea party activists have worked to pass it in as many states as possible.

Herrera notes that "Fourteen states have passed it#—many with bipartisan support. Virginia passed HCFA with the support of 55% of House Democrats. . . . 71% of Missouri primary voters passed HCFA, including 1 in 6 Democrats. . . . Ohio's Issue 3 won with 66% of the vote last November, including all of OH's 88 counties, and 58% of Cuyahoga County (where there are 12% registered Republicans). Health care freedom is a bipartisan issue."

Simple grassroots tactics, by the way, can make a huge difference in this kind of effort. For example, in Missouri, when the Health Care Freedom Act was being considered, local activists came into a committee hearing with cameras. When the legislators, who had been unsympathetic, realized they were being taped, they decided the better part of valor was to pass the Act!

Stopping PPACA Exchanges. Under PPACA, states are required to set up exchanges, those pseudo-marketplaces where individuals will go to obtain government-controlled health insurance with federal premium subsidies. If a state fails to set up an exchange, the federal Department of Health and Human Services will set up a federal exchange in that state. If HHS doesn't like the way a state has set up an exchange, it can use its leverage to impose its own policy preferences. So the exchanges are going to be federally dominated, even in those states where the exchange is nominally state-run.

But here's a critical fact: Due to a drafting glitch in the statute, which wasn't detected until recently, in those states that fail to set up a state exchange (i.e., where the feds set up an exchange instead), the federal premium subsidies cannot flow and the employer mandate cannot operate. This means PPACA's "market reforms" will be largely inoperable in those states that simply decline to set up an exchange! Think of that. We can nullify ObamaCare by having our state representatives and governors do absolutely nothing.

HHS has said it will simply ignore the drafting error. To which we say: "See you in court."

Therefore:

- States that have begun to set up PPACA health exchanges should stop.
- States that have already approved legislation or funding for exchanges should rescind it.
- States that have been offered federal money for exchange implementation should refuse it.
- States that have received such money should return it.

As the Cato Institute's Michael Cannon told us at the aforementioned liveblog session, "ObamaCare is likely to collapse of its own weight even if it 'works' as intended. Without the mandate, it collapses faster—thus the lawsuits. Without the tax credits/subsidies, it collapses faster—thus the need to block exchanges at the state level."

Our efforts to block them are working. As of now, it appears only 5 to 10 states will meet current deadlines, according to a GOP-leaning consulting group that has been helping states set up PPACA exchanges.# The Administration never expected this kind of resistance. As Benjamin Domenech of the Heartland Institute told our liveblog audience, "Thus far, the vast majority of states have chosen to play the waiting game to various degrees—and even those states with Democrat majorities which

are emphatically in favor of implementation have not yet been able to meet the goals in terms of timing set down by PPACA."

Domenech added: "HHS was never prepared for the eventuality that more than a few states would refuse to implement. They are now stuck with a problem they never expected to have, in part thanks to efforts of people like [Michael Cannon] to inform state legislators of the negative costs of implementation."

A number of governors have been heroes in the effort to stop exchanges, most recently New Jersey's Chris Christie, a Republican, who vetoed that state's exchange legislation, and New Hampshire's John Lynch, a Democrat, who signed a bill halting all work on exchanges.

Supporters of exchanges argue they're needed to help individuals and small businesses obtain coverage at affordable rates without being priced out of the market to due pre-existing medical conditions. But there are at least three reasons why this argument fails:

1) The purpose of exchanges is to eliminate medical risk as a factor in pricing health insurance, replacing it with guaranteed issue and community rating, which really means eliminating true insurance in favor of government-regulated group benefits. We should be preserving and strengthening true insurance not destroying it. This should be a "line in the sand" issue for advocates of patient-centered care.#

2) There are alternative, acceptable ways to address the problem of pre-existing conditions. Specifically, states can (and 38 states currently do) operate pre-existing conditions pools, which are basically subsidies that help people with pre-existing conditions afford good private health insurance. That approach lets the market work with minimal government intervention.

3) If exchanges were such a good idea, the free-market would have invented them by now. Wait a minute: the free market already has invented them! They're called online comparison sites, the most famous of which is ehealthinsurance.com.

So government exchanges are either harmful (as in Massachusetts) or unnecessary (as in Utah), but in any event, stopping PPACA exchanges has become essential to stopping the government takeover of health care.

3. Where We Need to Go Next

What We Need to Do Over the Next 18 Months

As I mentioned, the health care fight remains winnable, and we are currently winning it. The next eighteen months will decide how we win it (and the next five months, whether we can win it). Now is the time to be planning.

Remember: Our *vision* is a patient-centered health care system. Our *goal* is to repeal and replace ObamaCare with patient-centered reforms *in 2013.* Here are what we have spelled out as the basic principles of a patient-centered system#:

Basic Principles of a Patient-Centered System

1. Every intelligent, adult human being has a right to make his or her own health care choices.
2. Patients are customers and have a right to shop around and take their business elsewhere.
3. Health care professionals have a right to be paid for their services, at market rates.
4. Doctors and patients should have the right to freely enter into contracts with each other.
5. People should bear the consequences of their own free choices.
6. People should be free to opt out of public insurance programs.
7. In a free society, the moral way to help those who are less fortunate is through voluntary charity, not mandates and regulations.

In striving to make those principles a reality, our political strategies are to:

Repealing ObamaCare: Political Strategies

1. Keep working to make full repeal politically inevitable.
2. Keep educating the public on the law's harms (costs, mandates, care denials, constitutional violations).
3. Keep ObamaCare's supporters on the defensive, without falling into political traps.
4. Keep rallying support for achievable "replace" ideas that reduce costs and expand individual liberty.

This leads to our policy strategies on the "replace" side of the agenda:

Replacing ObamaCare : Policy Strategies

1. Focus on reducing costs and expanding freedom, not on expanding coverage.
2. Make federal health care programs voluntary.
3. Defend true insurance and expand the individual market.
4. Reduce reliance on third-party payment.
5. Stay on offense.

Which leads us to a more specific policy agenda:

Replacing ObamaCare: A Concise Agenda

1. Make participation in tax-subsidized health coverage more voluntary and portable.
2. Ensure full funding for state pre-existing conditions pools and reinsurance programs.
3. Lower prices through greater transparency and competition.
4. Increase consumer choice in federal health programs.
5. End Medicare price controls and prevent rationing.
6. Give individuals greater control and security through strengthened HSAs.
7. Encourage states to lower costs and increase competition.

Possible Fallbacks to the Mandate

Before we get to the replace agenda, of course, we have to repeal ObamaCare in its entirety. Our actions won't take place in a vacuum. The Left will be trying to protect and preserve the law. And if the Supreme Court should strike down the mandate, progressives will almost certainly move to replace it with some other, equally coercive but more constitutionally permissible policy. So we are forced to stop and consider what the Left's fallback might be, and how we can counter it. Based on what I've seen, the four leading "fallback" ideas for the mandate appear to be:

1. Payroll tax
2. Late penalty
3. "Irrevocable" Opt-out
4. Auto-enrollment

According to health professor Jonathan Gruber of MIT, a supporter and drafter of PPACA, if the mandate falls, then the next best policy, from the perspective of those who seek universal coverage, is auto-enrollment. The reason becomes apparent when you look at Professor Gruber's list of coverage impacts:

- Mandate: Covers 32 million people
- Auto-enrollment: Covers 24 million people
- Late penalty: Covers 12 million people
- No mandate with no fallback: Covers 08 million people

Source: Gruber 2011

If you were a progressive, "universal coverage" type, wouldn't you choose auto-enrollment as your fallback to the mandate?

Let's look a little more closely at each of these fallback ideas.

Payroll tax. We already have payroll (FICA) taxes for Medicare and Social Security. These add up to 15.3 percent of our compensation (I'm folding both the employer and employee shares into one number here). My guess is the ObamaCare payroll tax, if they create it, would equal about 8 to 10 percent of our wages. We know the Supreme Court is going to find that constitutional—because it already has in the case of Social Security and Medicare. So this approach would be very straightforward. But it would also be hard to get through Congress. After all, who wants new payroll taxes?

Late penalty. This would say that if you decide not to buy insurance, but later you change your mind, you can come in and buy it, but for every year you've tarried, you're going to be charged an extra 10 percent each month for the rest of your life. This is how they do it in Medicare Part B, a program that is nominally optional, but that is in reality basically mandatory because of this policy; 98 percent of seniors sign up for Part B because of the stiff late penalty. Democrats might try this one, but I think they're more likely to go with auto-enrollment, because it gets more people covered.

Irrevocable opt-out. What that means is you sign a piece of paper saying, "I don't want to participate in this government health care system. I want to be completely out of the system, thank you very much." That's irrevocable. You're out, forever. More likely, the law would give you a chance, say, every five years, if you change your mind, to come in without penalty. My guess is

they'd also allow special times to come in, if you have a serious hardship or something. But otherwise, you would be on your own. I doubt the idea will work, because of politicians' natural proclivity to keep adding "compassionate" loopholes and exceptions.

Auto-enrollment. Here your employer (or the government) will automatically enroll you in an insurance plan, but you can opt-out if you really want out. If you combine this with tax credits, you've got a pretty powerful incentive for people to take up the "voluntary" coverage. I call that combination a "soft mandate." Why? Because if the tax credit is, let's say, $5,000, then if you didn't take the credit, you would in effect be paying a $5,000 tax penalty. It's a carrot rather than a stick, but the effect is similar. This is perhaps tolerable, because it is, strictly speaking, optional. But auto-enrollment plus tax credits creates a lot of pressure on people to get covered. This idea has unfortunately been championed by some conservatives, most prominently Stuart Butler of the Heritage Foundation. I think we should eschew it for the same reason the Left likes it: It's fundamentally coercive.

By the way, these four options are not mutually exclusive. In fact, you could combine all of them, if you wanted. You could have auto-enrollment, plus a five-year irrevocable opt-out, plus a 10 percent-a-year late penalty, plus a new 10 percent payroll tax. You could do all of that. (And don't you just know the Democrats will go for "all of the above"?)

What Patient-Centered Care Looks Like

One question I often get from reporters is, "What do you mean exactly by 'patient-centered care'?"

For the Left and some business interests, the answer to this question is "patient-*focused*" care, meaning third parties coordinate to help the patient. But when I answer this question, I define it as "patient-directed" and "patient-controlled." And that ultimately means *financially* controlled by the patient. To be truly free, you, the patient, must control the dollars spent for your health needs. You must own your own health care. Period.

The problem with today's over-reliance on third parties—whether it's your employer limiting your choice of health care plans or your insurer (or your government) limiting your access to treatment—is that the decision-making power is centralized and managed by someone who isn't you and naturally cares more about obeying a system than about helping you.

A "patient-centered" approach means the customer is always right. And you are the customer. Shouldn't that be the way, after all? Shouldn't health care decisions *always* ultimately be made by the person who undergoes the treatment? Whose life is it, anyway?

Third-party payment means you've lost a piece of your freedom. That's why true insurance is ultimately a better approach than group health benefits. Unlike group benefits, true insurance is personal, portable, and individually owned and controlled.

Additionally, not everyone needs insurance. Not everyone needs the same kind of insurance. Some people prefer to pay out of pocket. Freedom means not having to have insurance at all. That's why the individual mandate is so wrong-headed. It runs counter to all three prongs of "life, liberty, and the pursuit of happiness."

Happily, and not a moment too soon, comes evidence that patient-centered care is already happening out there in the real world. Patients are doing what no bureaucracy ever can: "bending the cost curve downward," while improving the quality of care. That's right. Patients are already solving the "health care problem," all by themselves—from the bottom up—in the very shadow of the impending government takeover.

This is big. It's a revolution, in fact. And it's another reason why ObamaCare has to go in toto.

This new revolution is happening because of a recent, significant rise in consumer-driven health plans (CDHPs) and Health Savings Accounts (HSAs). A CDHP is a health insurance policy that has a high deductible, the amount you pay before your insurance kicks in. The higher your deductible, the more incentive you have to be a careful consumer. CDHPs cost less than traditional insurance plans. An HSA is a tax-advantaged account that helps you cover your deductibles and other out-of-pocket health costs.

A decade ago, almost nobody had either of these things. Today, a remarkable 28 million Americans, or roughly 9 percent of us, have a CDHP; and 13.5 million Americans, or about 5 percent of us, have an HSA (which under current law must be paired with a CDHP). Together, these options are turning millions of patients into consumers, helping them take control of their own health care destinies.

New government data shows that this shift is measurably slowing the growth of health care spending. In 2007, national health expenditures rose by 6 percent. In 2008, they grew by a more moderate 4.4 percent. In 2009, by 3.9 percent. In 2010, by 3.8 percent.

Incentives work. Thanks to the rise of "patient power," more and more people are asking their doctors critical questions about costs and affordable alternatives. And that, in turn, is putting downward pressure on prices—and upward pressure on quality.

We've long known that cosmetic surgery and laser eye surgery are the only two areas in health care where prices continually fall while quality continually rises. They're also the only two areas not covered by insurance. That, of course, is no coincidence.

Now we're starting to see patient-centered care at work throughout the health care sector:

1) Many doctors' offices—5,000 of them, by one recent count—have switched to a "direct-care" or "highly attentive physician" model. Subscription-based rather than insurance-based, this model enables a doctor to take the time he used to spend on insurance paperwork and instead spend it caring for patients.

2) At a growing number of wellness centers like Personal Edge and Executive Health Exams International, doctors spend as much time with patients as they need, instead of the typical 25 minutes, and in settings that are "more day-spa than doctor's office."

3) A new generation of hospitals and clinics have appeared that specialize in treating just one ailment: cancer. Often boasting four-star service in settings that are "more home than hospital," these facilities offer state-of-the-art technology and better outcomes than can be obtained in traditional full-service hospitals.

4) In most industries, prices are posted; but that's not true in health care, where patients are not the real customers, their insurers are. Now that's changing, as more patients pay cash. CareSpot, a chain of 30 walk-in urgent-care clinics in Florida, posts its prices to help it compete directly with overpriced doctor's offices and overcrowded emergency rooms. CareSpot is booming, with plans to open another 15 clinics by the end of this year.

These signs are glimpses of the patient-centered health care system of tomorrow, a system marked by less waste, lower costs, shorter wait times, more comfort and convenience, and greater access to new therapies.

Unfortunately, this revolution is doomed under ObamaCare, which basically outlaws CDHPs and HSAs, starting in 2014. As I explained in the Supreme Court section above, the law's definition of "bronze" plans, combined with HHS's "medical loss ratio" (MLR) regulations, effectively make affordable forms of insurance with higher-deductibles untenable. They won't be available in the exchanges. The Left wants to eliminate high-deductible coverage as an option. That would be a disaster. And it's another critical reason for full repeal.

To accelerate and ensconce the patient-centered care revolution, we should also at a minimum: (1) expand Health Savings Accounts, (2) remove barriers to the interstate purchase of health insurance, (3) repeal Medicare's individual mandate, and (4) make medical expenses fully tax-deductible (that is, lower the hurdle for accessing the existing medical expense deduction from 10 percent of Adjusted Gross Income to zero percent).

A key way to measure progress in this effort is by how many millions of people move from centralized to decentralized sources of health coverage—how many Americans obtain true insurance, as compared to the number who rely on "government-based" or publicly subsidized coverage.

A second key measure of success is how much of our health care spending comes out of our pocket, under our own control, rather than being controlled by third parties like employers and insurers.

If we can reverse the direction of the trend lines in this chart—especially the descending red line (out of pocket spending)—we will be moving toward the patient-centered system of tomorrow.

How to Build Patient-Centered Care

So how do we expand on the ongoing patient-centered care revolution?

First, get the goal right. Focus on costs and expanding freedom, not on expanding coverage.

Second, accept that "doing nothing" is not an option. I sometimes meet grassroots tea party activists who say, "Replace ObamaCare with NOTHING!" I think what they're really trying to say is "Don't let the government screw it up!" But what this view misses is that the government has already screwed it up to a great extent. So "doing nothing" is not really an option, if we want a better system.

Some of my fellow conservative and libertarian health policy wonks will grant this, but then say, "Yes, we need to do something. But not yet. After ObamaCare is gone, let's all stop for a while and take a 'deep breath'." I'm not sure we have the luxury of much time.

Now, to be clear, as I've said, I think Republicans don't need to enact any reforms before the election, although they do need to be able to talk about what they would do, if given a chance to govern.

But the problem with "taking a deep breath" is that it assumes the other side will also take a deep breath. History suggests just the opposite. The Left gets by on very little sleep. During the 16-year-long "deep breath" after HillaryCare, Republicans managed to enact HSAs and make a lot of speeches about medical malpractice reform. During that same period, the Left accomplished HIPAA, S-CHIP, the Patient's Bill of Rights, Medicare Part D, RomneyCare, ObamaCare, CLASS, IPAB, PCORI, CCIIO, the HHS anti-conscience mandate, etc., etc., etc. Health care is like a video game in which the zombies never let you take a deep breath.

Assume for a moment we succeed in blowing up ObamaCare, like we blew up HillaryCare. Do we really think the Left won't try to build a third Death Star, if an opportunity presents itself? Why take a chance? Why not be proactive? Why not victory?

Third, avoid replicating ObamaCare inadvertently. If you analyze ObamaCare, and also, unfortunately, RomneyCare (as well as some other Republican health care reform proposals), you find they all have three things in common: (1) coercion (such as a mandate to purchase insurance), (2) a government exchange, and (3) risk adjustment (or, as I sometimes call it, "bureaucratic price controls"). Any approach to health reform that includes all three of these elements will *not* lead to patient-centered care. Any reform that includes even one of these ideas should be scrutinized very, very closely.

Specific Reform Ideas

Democrats like to say, "Republicans have no ideas for reforming health care." That's not true. Republicans have a ton of ideas for fixing what ails our health care system. In fact, I once compiled a spreadsheet list of GOP health reform ideas and finally had to stop after identifying more than 125 distinct proposals.

Of course, some ideas are better than others, and some are more popular than others. Let me list just a few of the more popular GOP health reform ideas:

- Reform state medical malpractice laws.
- Let people purchase insurance across state lines.
- Let small businesses band together to obtain insurance for their workers at group rates.
- Expand Health Savings Accounts and flex benefits.
- Incentivize hospitals and doctors to publish their prices, to promote comparison shopping.
- Ease federal mandates (i.e., EMTALA) that contribute to emergency-room over-crowding.
- Let seniors join their Member of Congress's health plan.
- Eliminate Medicare's individual mandate (make Medicare voluntary for individuals).
- Let Medicare patients and doctors privately contract with each other (circumvent Medicare's price controls).

Legislation We Support

Clearly, there are many good, or at least debate-worthy, bills here. We have some favorites. Each of the following bills would move us toward a more patient-centered health care system.

1. Rep. Paul Broun's Patient OPTION Act (H.R. 4224) is a compendium of simple, positive ideas that are consistent with the Patient-Centered Care Principles we listed above. Specifically, the bill:

- Repeals ObamaCare in its entirety.
- Makes all health care expenditures, including health insurance, fully tax deductible.
- Expands and strengthens patient-friendly Health Savings Accounts (HSAs).
- Allows consumers to purchase health insurance across state lines.
- Allows small businesses to band together to obtain lower health insurance rates through Association Health Plans (AHPs).
- Converts Medicare from an old-fashioned "socialized medicine" system into a simple, modern, high-quality "premium support" system.
- Permits individuals to opt out of Medicare if they wish.
- Reforms the EMTALA mandate burden on overcrowded hospital emergency rooms.
- Creates tax incentives for physicians who provide free care to patients in need.

The Patient OPTION Act offers a potent remedy for what ails American health care.

2. Rep. Todd Rokita's State Health Flexibility Act (H.R. 4160) would block-grant Medicaid to the states. Importantly, it would not build escalators into the grants for inflation or population. The grants will be a fixed amount that stays fixed until Congress agrees to revisit them. The states will have maximum flexibility to use the funds as they think best. This lack of escalators may seem restrictive, but it's the same model we used successfully in the 1996 welfare reform. That block grant, fixed at about $16 billion a year, hasn't grown over the past 16 years. We should follow the same model with Medicaid.

3. Sen. Rand Paul's Congressional Health Care for Seniors Act (S. 2196) would allow seniors to join the Federal Employees Health Benefit Program (FEHBP). This is a superior form of "premium support," compared to the Ryan-Rivlin and Wyden-Ryan approaches, which would leave the Medicare bureaucracy in place, serving as both a competitor and the referee. Instead, Sen. Paul's bill would fire the Medicare bureaucracy and let the Office of Personnel Management (OPM) administer the program for Medicare beneficiaries, just as it does today for federal employees and Members of Congress. The Congressional health care program is highly popular. Ryan's approach is comparable to the Congressional health care plan. Paul's approach is the Congressional plan. (To protect non-seniors in FEHBP from premium increases, Medicare beneficiaries would be segregated into a separate risk pool.) (Note: Ryan-Rivlin and Wyden-Ryan have all three of the essential elements of ObamaCare I mentioned earlier, making them akin to "ObamaCare for seniors." By contrast, Paul's approach has only one of the three elements: an exchange. And it's a very mild form of exchange at that.)

4. Sen. Jim DeMint's Retirement Freedom Act (S. 1317) would end Medicare's individual mandate, which is much tougher than ObamaCare's. Enrollment in Medicare Part A is automatic, if you successfully apply to receive Social Security retirement benefits. Under a policy implemented by the Clinton Administration in the early '90s and continued since, anyone who tries to to *dis*enroll from

Medicare must forfeit his monthly Social Security checks and pay back any money he has already received. Last year, Senator DeMint and 12 of his colleagues introduced the Retirement Freedom Act (S. 1317), which has also been introduced in the House by Congressman Sam Johnson (R-TX) (H.R. 2435).

5. Rep. Bill Huizenga's Health Freedom for Seniors Act (H.R. 3819) would create Medicare HSAs and permit tax-favored account rollovers from IRAs into HSAs.

Let's talk about these ideas, and enact the best ones, through a thoughtful, transparent process. We have nothing to be afraid of, because our principles are sound, and good policy is good politics.

Process Advice: Regular Order

Not all health policy ideas are created equal. Let them compete against one another in the marketplace of ideas. Congress should proceed via a thoughtful and transparent process. Instead of voting on massive, 2,800-page bills no one has read, it should move single-topic bills according to "regular order" (hearings, subcommittee, committee, floor, conference committee). And be sure to give Members plenty of time to read the bill before voting on it! See which ideas can garner the most votes in a free and open debate. Isn't that what the Founders would have wanted?

Conclusion

The Left's vision for health care is diametrically opposed to ours. Their vision is one of centralized government control; ours, of decentralized patient control. Their vision entails the stagnation of medical progress, because it is a zero-sum game of "global budgets" and bureaucratic rationing. Our vision, being open and evolving, entails ever-improving quality, driven by patient preferences and scientific and entrepreneurial innovation. Theirs, because it is essentially political, requires political favoritism, waivers, and payoffs to keep it creaking along; ours, a thorough de-politicization of health care decisions. Theirs generates social and political conflict between grasping interests; ours, social peace among harmoniously aligned interests. Theirs is a vision premised upon shared misery; ours, upon general prosperity. Our vision, in short, is quintessentially American, while theirs is like something out of Prussia circa 1880 or (perhaps more aptly) Britain circa 1775. They—to quote our friend Robert Reich—would "let you die." We want you to have every chance to live the longest, happiest, freest life you can.

This is why we fight.

Appendix A

Talking Points on ObamaCare's Supposed "Good" Parts

Democrats are claiming that ObamaCare has many "good" parts that are already helping millions. Unfortunately, some powerful Republicans have been making noises about trying to keep some of these supposed "good" parts.

This document is intended to help us respond to the Democrats' claims, as well as to help persuade undecided Republicans why ObamaCare has no "good" parts and should be repealed in its entirety.

Contents

General Message

Claim: "Repealing the 'Affordable Care Act' would be a disaster for millions of Americans who are already being helped by this important law."

Response:

- There are no "good" parts of this harmful and unconstitutional law, which should really be called the "Unaffordable Care Act."
- Mandates merely drive up costs and increase bureaucratic control.
- Patients don't need a massive increase in government mandates and bureaucracy; they need more freedom to make their own health care choices.
- Any "protection" or "benefit" that's popular will tend to occur naturally in a free market.

- Leaving any part of ObamaCare on the books would be a huge mistake, because every part of it is based on flawed premises and, if left in place, will tend to drive up costs and increase government control at the expense of patients and doctors.
- Anyone who is upset with the law being repealed should talk to the Democrats.
- We need to fully repeal this unnecessary, budget-busting law, so we can start over and build a patient-centered system where individuals have maximum choice and control.
- Liberating patients and doctors to make their own choices is the only approach that can truly reduce costs and improve quality.
- ObamaCare is Exhibit A for the case that "Freedom always works better than government."

Specific Issues

1. Under-26 mandate

Claim: "7 million uninsured adults have received coverage as a result of the under-26 mandate."

Response:

- No young adult will lose coverage immediately following the Court's decision. The under-26 mandate is included in existing insurance contracts, and will therefore run through the end of the plan year (for most plans, this means through the end of 2012 or into early 2013).
- 37 states have extended adult-dependent coverage mandates of their own. New Jersey's mandate goes up to age 30.
- Many insurers offered this kind of coverage before ObamaCare, and many are likely to continue offering it after it's repealed. For example, Aetna, Humana, and UnitedHealth Group, three of the nation's largest insurers, have announced they will continue to offer extended adult dependent coverage up to age 26, regardless of what happens.

- Mandates like this simply drive up the costs of insurance for everyone. The under-26 mandate is already doing so. (Kaiser) By one credible estimate, the mandate has increased costs for the average family between $150 and $450 (New York Times, assuming an average premium of $15,073)

- The mandate has already caused some employers to drop all types of dependent coverage, to avoid these additional costs. (Wall Street Journal)
- Additionally, as pointed out in a recent FreedomWorks blog post, the mandate will:
    - Make it harder for young adults to get employer-provided insurance as employers face financial incentives to drop coverage. (House Ways and Means Committee)
    - Cause colleges to shut down their low-cost student insurance programs, or raise premiums significantly. (Wall Street Journal)
    - Increase insurance costs for young adults who must buy their own insurance by 19-30%. (Forbes)
- Since when did 25-year-olds start being defined as "children"?

- Why stop at 26? Why not 36? Or 66? (One GOP Congressman has a bill to raise the age to 31!)

- What young adults need is a job, not a mandate to stay on their parents' health insurance.

Background: ObamaCare requires all insurers that offer coverage for adult dependents (on their parents' policy) to continue doing so up to age 26. The left-leaning Commonwealth Fund has estimated that 7 million adults have obtained coverage thanks to the mandate. Realistically, at most 2.5 million of these adults were actually uninsured; the remainder probably already had coverage but switched to their parents' policies because it was financially advantageous for them to do so. Prior to ObamaCare, most insurers who offered extended adult dependent coverage only did so for dependents up to age 21 or college graduation, although some insurers went beyond that age. The federal under-26 mandate took effect for policies whose plan year began on or after September 23, 2010. Under political pressure from the Administration and congressional Democrats, the nation's largest insurers and many large employer plans came into compliance even before the mandate took effect.

2. Pre-existing conditions ban (for children)

Claim: "As many as 17 million children can no longer be denied coverage because of pre-existing health conditions."

Response:

- No child will lose coverage immediately following the Supreme Court's decision. This mandate is included in existing insurance contracts, and will therefore run through the end of the plan year (for most plans, this means through the end of 2012 or into early 2013).
- Mandates are the wrong way to address pre-existing conditions. A better way to go is to drive down costs through market-oriented, patient-centered reforms, including state-level pre-existing condition pools, which 38 states already have up and running.

- Pre-existing conditions are a problem for only about 1 percent of the U.S. population—ObamaCare is an example of massive overkill.

Background: ObamaCare bars health insurance companies from imposing pre-existing condition exclusions on children's coverage. This mandate took effect for policies whose plan year began on or after September 23, 2010. It will be extended to apply to adults beginning in 2014. Democrats decided to take a "kids first" approach in order to provide themselves with a politically powerful talking point as quickly as possible after this unpopular law's enactment.

3. Lifetime limits ban

Claim: "105 million Americans no longer face a cap on lifetime benefits."

Response:

- No one will lose this "protection" immediately following the Supreme Court's decision. The ban on lifetime limits is included in existing insurance contracts, and therefore runs through

the end of the plan year (for most plans, this means through the end of 2012 or into early 2013).
- Mandates like this simply drive up the costs of insurance for everyone.
- This mandate is unnecessary. Some insurers voluntarily offer unlimited lifetime coverage, and should be left free to do so.

Background: ObamaCare bans insurers from imposing overall or "lifetime" limits on coverage (e.g., a $1 million lifetime maximum). This ban took effect for all insurance policies whose plan year began on or after September 23, 2010.

4. Annual limits ban

Claim: "3.4 million extremely sick patients are being protected by the ban on annual limits."

Response:

- No one will lose this "protection" immediately following the Supreme Court's decision. The ban on annual limits is included in existing insurance contracts, and therefore runs through the end of the plan year (for most plans, this means through the end of 2012 or into early 2013).
- Mandates like this simply drive up the costs of insurance for everyone.
- This mandate is unnecessary. Many insurers voluntarily offer generous annual coverage, and should be left free to do so.
- It's hard to take an Administration seriously that claims to oppose annual limits and then issues thousands of waivers allowing such limits for millions of people who happen to work at politically well-connected companies and labor unions.

Background: Beginning in 2014, ObamaCare will bar insurers from imposing annual limits on coverage (e.g., $500,000 in a year). Prior to 2014, the Secretary of HHS is authorized to define the acceptable annual limits for all new plans in the individual market and all employer plans. For plan years beginning on or after September 23, 2011, the Secretary set the acceptable annual limit at $750,000. For 2012, she raised the acceptable limit to $1.25 million. For 2013, she will raise it again, to $2 million. For 2014 and thereafter, annual limits are banned. The Secretary can also issue waivers for specific health plans when she determines that "compliance would result in a significant decrease in access to benefits or a significant increase in premiums." As of January 6, 2012, a total of 1,625 groups representing 3,914,356 individuals had received a waiver from the annual limits ban. Recipients include large, politically well-connected corporations and health insurance companies, and even certain Administration-friendly states. By far the biggest beneficiaries of thise "waivers for favors"? Labor unions, representing 543,812 workers.

5. Recissions ban

Claim: "The ACA ended the unfair practice of insurance companies rescinding coverage when people get sick."

Response:

- Rescissions were already banned before ObamaCare and will continue to be banned after ObamaCare is repealed.
- This needless provision is just one more example of the shameless cynicism of the law's drafters.

Background: A "rescission" occurs when a health insurance company drops a person's coverage after the person has filed a claim. This practice has long been forbidden under state and federal laws and will continue even after the law is repealed. Democrats included the ban in ObamaCare simply to give themselves a politically powerful talking point. The ObamaCare rescissions ban took effect for policies whose plan year began on or after September 23, 2010, and applies to all new and existing health plans.

6. Free preventive services mandate

Claim: "86 million Americans have received free preventive care under the law."

Response:

- There is no free lunch, and no "free" mandate.
- Everyone's health insurance premiums are going up as a result of this open-ended mandate.
- Mandated benefits merely drive up costs.
- This mandate is unnecessary. Insurers have a natural incentive to provide preventive benefits at low-cost, when it saves them money to do so. This is why many insurers were already offering low-cost preventive coverage before ObamaCare, and why many will doubtless continue to do so after the law is repealed.
- Some mandates, like the HHS contraceptive coverage regulation, violate the consciences and religious liberty of some Americans and thus remind us of why "compassion" must never be allowed to supersede individual liberty and our basic constitutional freedoms.

Background: ObamaCare mandates that health insurance cover a wide array of services deemed "preventive" from the "first dollar," i.e., free of charge. The Secretary of HHS is authorized to define which services are "preventive." The recent HHS contraceptive mandate is one (notorious) example of how this open-ended mandate is being implemented in practice. The free preventive services mandate took effect for all policies whose plan year began on or after September 23, 2010. (ObamaCare also eliminates cost-sharing for preventive services for Medicare beneficiaries and provides seniors with a free, annual wellness visit and personalized prevention plan services. These new Medicare benefits began on January 1, 2011.)

7. Federal Pre-existing Conditions Pool (PCIP)

Claim: "Many thousands of Americans have obtained insurance coverage, thanks to the new [temporary] federal Pre-existing Conditions Pool (PCIP) program."

Response:

- Pre-existing conditions pools are a reasonable way to help people with pre-existing medical conditions afford good private health insurance.

- We don't need a federal pre-ex pool program because states can offer these pools, and in fact 38 states already have pre-ex pools up and running.
- Only about 50,000 people have signed up for the temporary ObamaCare pre-ex pool, far less than the 250,000 to 375,000 predicted by the law's supporters.
- Many, perhaps most, of the small number of people who signed up for the temporary federal pool can be covered by their state's pool.
- Persons dropped from PCIP should contact their state's pre-ex pool program, or their state representatives, urging them to get a pool program started.

- Pre-existing conditions are a problem for only about 1 percent of the U.S. population—ObamaCare is an example of massive overkill.

Background: The PCIP program was added to ObamaCare as a temporary federal program that will end in 2014, when ObamaCare takes full effect. This program legally began on July 1, 2010. The PCIP's performance has been underwhelming: enrollment remains far below expectations even as the $5 billion set aside for the program has been spent, far faster than predicted. Through the end of February, 2012, a total of 56,257 people were enrolled in PCIP, a fraction of the 200,000 to 375,000 that the law's supporters had predicted. Moreover, each PCIP enrollee is costing almost $29,000 a year, more than twice what proponents projected. PCIP was added to the bill as a temporary "bridge" measure, when the bill's authors decided, for budgetary reasons, to postpone until 2014 the effective date of the law's general ban on pre-existing condition exclusions. Pre-existing conditions are a barrier to insurance coverage for at most 1 percent of the U.S. population (between 2 and 4 million people).

8. Medicare donut hole

Claim: "Millions of seniors are benefiting from the closing of the Medicare donut hole."

Response:

- The donut hole affects very few people and is being filled in very slowly, so there will be no significant disruption when ObamaCare is repealed.
- The donut hole is yet another sign of what happens when politicians devise an "insurance" program.
- Instead of filling in the donut hole, we need fundamental, market-oriented Medicare reform.
- In every current Republican Medicare reform proposal, all seniors would have drug coverage with no donut hole.
- Part D was a costly and unnecessary mistake.

Background: The so-called Medicare Part D prescription drug "donut hole" is being filled in slowly under ObamaCare, with the goal of completely filling it by 2020. The "donut hole" is a coverage gap in the Part D prescription drug benefit—and an artifact of the political deal-making that gave us Part D. Because the politicians in Congress could not afford to provide full drug coverage down to a very small-dollar level, they decided to provide generous coverage at the very low end of the cost range and also at the very high end, leaving patients on the hook for everything in the middle. Specifically, seniors are required to pay for 25 percent of their drug spending below a certain level ($2,830 in

2010) and only 5 percent of drug spending above the high-end cutoff ($4,550). In between, seniors pay 100 percent—that's the donut hole.

In 2010, under ObamaCare, seniors who reached the donut hole became eligible for a $250 rebate check. Since the beginning of 2011—under the "donut hole" agreement between the Democrats and the brand-name pharmaceutical manufacturers—the same Medicare beneficiaries have been receiving a 50 percent discount on brand-name drugs and biologics purchased in the donut hole. Gradually, the donut hole will be eliminated, such that, by 2020, seniors will only be liable for 25 percent of their drug spending until they hit the upper threshold, above which they'll be liable for 5 percent. But note—and this is important—most seniors do not face the donut hole, because insurers have flexibility to structure the benefit differently from the "standard" plan design (i.e., competing drug plans can can cover the donut hole voluntarily, without a mandate from Congress; and most plans do so). Only about 2.8 million seniors actually reach the donut hole in a given year and only about 470,000 reach its upper limit. (Incidentally, Part D was unnecessary: 75 percent of seniors had some form of drug coverage prior to the Act, which has displaced 80 percent of that already existing drug coverage. Part D was also terribly costly, adding $9 trillion to Medicare's long-term unfunded liability. It was, in short, a costly and unnecessary mistake.)

9. Small business tax credit

Claim: "Nearly a million small business employees are being helped by the small business health insurance tax credit."

Response:

- The ObamaCare small business tax credit is a dud.
- Almost no small businesses have bothered to take advantage of this overly complicated new subsidy, which requires a small business owner to spend many hours undertaking dozens of separate calculations just to determine whether he's even eligible for it.

Background: ObamaCare creates a new tax credit for qualified small employers for contributions to purchase health insurance for employees. Tax credits of up to 35 percent of premiums are available to firms that choose to offer coverage. Beginning in 2014, the tax credits will be increased to 50 percent of premiums. The credits are subject to a phase-out, with the full credit available to firms with 10 or fewer employees and average annual wages of up to $25,000, while firms with up to 25 or fewer employees and average annual wages of up to $50,000 are eligible for a reduced credit. There is also up to a 25 percent credit for small nonprofit organizations. This subsidy scheme became available in calendar year 2010. Very few small businesses have made use of it. Only 170,300 employers claimed the credit in 2010, a fraction of the 1.4 million to 4 million small businesses that were eligible. Just 770,000 workers were covered by the businesses claiming the credit in 2010.

10. Early retiree subsidy

Claim: "13 million early retirees aged 55-64 are enjoying lower premiums, thanks to new subsidies provided by the Early Retiree Reinsurance Program (ERRP)."

Response:

- The early-retiree subsidy is a payoff to big business and big labor, allowing them to offload some of their health care costs onto the taxpayer.
- This subsidy should go away, with the rest of ObamaCare.

Background: ObamaCare creates a new temporary (until 2014) reinsurance program to help offset the cost of health care coverage at companies that provide early retiree health benefits for those ages 55-64. The subsidy began to be offered on June 22, 2010. To date, the program has provided $4.73 billion in reinsurance payments to more than 2,800 employers and other sponsors of retiree plans, with an average cumulative reimbursement per plan sponsor of approximately $189,700. HHS estimates that 13 million people are enjoying reduced premiums thanks to the subsidy.

Appendix B

Thoughts on Pre-Existing Conditions Pools

The only real policy vulnerability on health care for advocates of patient-centered care is the problem of insurers excluding people who have pre-existing medical conditions. Strictly speaking, this is only a "problem" if you are trying to eliminate medical risk as a factor in pricing health insurance—that is, if you are trying to eliminate true insurance in favor of group benefits.

But if you are simply trying to make the true insurance market work better, as we recommend, then it is best to view pre-existing conditions as a discrete challenge to be dealt with judiciously. Pre-existing conditions affect just 1 percent of the U.S. population. Rather than remake 100 percent of the system trying to deal with it, as the Left has done, Congress should pursue targeted changes, starting with two things: (1) permitting the full deductibility of medical expenses and (2) fully funding state-run pre-ex pools (a.k.a. "high risk" pools).

There are three three basic issues in making pre-ex pools work:

(1) Price. What should be the level that the person with a pre-existing condition should be required to pay toward his or her insurance? In some state pre-ex pools, this level is set rather high, such that the pre-ex subsidy doesn't make the insurance affordable for the individual. Perhaps a more appropriate level is 25 or 35 percent above market rates, rather than the 100 percent found in some states. This question is best left to the states. But in the event that Congress insists on helping fund states' pre-ex pools, it *could* make the aid contingent on the state adopting a certain level.#

(2) Benefits. What does the insurance have to cover? Should plans cover everything that, for example, the state public employees' basic health benefit covers? Should they be permitted to have a limit on lifetime coverage? Again, these questions are best left to the states, but if Congress gets involved it could create a minimum floor.

(3) Subsidy. Who should pay for it? Again, ideally the states will provide full funding for their pre-ex pools. But if Congress also funds the pools, then it will have to decide where to get the money. Possible sources include (a) a reduction in federal "disproportionate share hospital," a.k.a. DSH, payments and (b) a small excise on federally regulated (ERISA) health plans.

Appendix C

Thoughts on Tax Equity

The root of most of our current health care problems is found in section 106 of the Internal Revenue Code. That section of the tax code heavily subsidizes employers for sponsoring group health benefits for their employees. It also encourages over-insurance and discriminates against people (a) who would rather buy their insurance in the true insurance market (more commonly called the "individual" or "non-group" market) or (b) who would prefer for whatever reason to purchase medical goods and services out of pocket rather than through insurance.

This problem needs to be addressed. It's the root of the other problems in our system. But we should tread warily. Many conservatives have proposed eliminating the section 106 subsidy (more commonly known as the "exclusion") and converting it into voucher-like tax credits (refundable or non-refundable). The upside of this reform is that it would be more individual and portable. The downside is that it would disrupt or eliminate the employer-based system. That system has its problems, to be sure. But half the U.S. population currently relies on the employer-based system, and despite its genuine flaws most Americans don't see much of a problem with it. In my view, trying to eliminate the employer-based system is a political nonstarter.

Additionally, in health care, any voucher-like approach could easily lead to the eventual imposition of guaranteed issue and community rating (and thus probably also an individual mandate) in the true insurance market. This runs directly counter to our vision of patient-centered care, which depends in part on enabling people to freely access the true insurance market without penalty or discrimination. At a minimum, supporters of a voucher-like approach need to show how it would not lead to guaranteed issue and community rating in the true insurance market.

That's why FreedomWorks tends to prefer a different and, we think, more prudent approach: full deductibility. Currently, people can deduct their medical expenses only if those expenses exceed 7.5 percent of their adjusted gross income (a very high threshold for most people, and one that will increase to 10 percent on January 1, 2013, if PPACA remains on the books). We would reduce that threshold to zero percent.

Relative to universal health insurance tax credits, full deductibility doesn't imprudently eliminate the employer-based system. In addition, it moves us in the direction of a more level playing field between insurance and out-of-pocket expenditures, provides relief to those with chronic health conditions, and doesn't create any new bureaucracy. It's also relatively easy to explain.

Appendix D

Replacing ObamaCare: Legislative Do's & Don'ts

Strategy

- Don't make "universal coverage" or even "expanding" coverage the goal.
- Do focus on lowering costs and expanding individual freedom. (Coverage gains will eventually follow, naturally.)
- Don't create new mandates and distortions; eliminate existing ones.

Policy

Public programs

- Don't try to salvage the "good parts" of ObamaCare—any of them. Repeal the whole law and start over. (Even if the Court leaves parts of the law in place.)
- Don't expand Medicare, Medicaid, or CHIP—reform them.

Patient-centered care

- Do take socialized medicine off the political table by smartly addressing pre-existing conditions.
- Do address pre-existing conditions through state-run pre-existing-condition pools (and possibly HIPAA reforms—but tread warily).
- Do move clearly toward tax equity—without launching a futile frontal assault on the employer-based system.
- Do remove obstacles to the adoption of consumer-driven, high-deductible health plans (including HSAs).
- Do help more people find a home in the individual market.
- Do help the individual market grow up, gradually, alongside the employer-based system.
- Do dismantle the individual *mandate* wherever it occurs—give patients freedom to opt out of all insurance programs, including Medicare.

Procedure

- Don't pass massive, "comprehensive" packages—no more 2,800-page bills.
- Do pass a series of separate, single-topic bills.
- Do proceed via regular order (hearings, subcommittee, full committee, floor; give members' ample time to read the bill; etc.).

(This is just a better way to legislate, and communicate—and will be a refreshing contrast to what happened with the Unaffordable Care Act. If reforms wind up all bundled into a big Reconciliation bill, that's OK, so long as they are either non-controversial or went through regular order first.)

Politics

- Don't fall into the trap of "defensive thinking."
- Do act like we believe our own rhetoric.
- Don't concede the Left's principles.
- Don't cater to K Street.
- Do keep reminding people who got us into this mess.
- Don't rush to make health care reform "our" side's problem (that will happen soon enough).