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Health Care Reform

Prepared by the Working Group on Repealing and Replacing Obamacare

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Introduction

Every promise President Barack Obama made to win enactment of Obamacare has now proven false.

He promised Obamacare would reduce health insurance costs for average families by $2,500 a year. But two years after the law went into effect, health insurance premiums for average families with job-based coverage have increased by $3,775 per year.[1] Total costs for employer-provided coverage have increased by $17,000 per year since Obamacare passed in 2010, primarily due to taxes and regulations imposed in the law.[2] Studies show Obamacare has already increased health insurance costs for younger adults by 44 percent.[3] The bottom line: The Affordable Care Act is not affordable.

Obama partisans argue that many families do not bear these cost increases, because of the subsidies paid by Obamacare. But that just means those costs are sent to the taxpayers, or to the Chinese with a higher national debt, which means your children or grandchildren are paying the bill. Those subsidies are not free money. Working people today bear the costs of higher taxes and national debt – with fewer jobs, slower wage growth, and slower economic growth.

Insurers are protecting themselves from all the new costs imposed by Obamacare by dramatically raising deductibles to $6,000 per year or more. As a result, workers and employers are paying these much higher costs and getting less in health insurance coverage. The typical American, who doesn't spend $6,000 on health care in a year, is getting nothing from this more expensive insurance and may even feel like he's uninsured. As for the insurance companies, they are losing money even with those high deductibles and are dropping out of Obamacare, leaving consumers with little or no choice among competing plans.

Obama promised if you like your health care plan, you can keep your health care plan. But that turned out to be if *he* liked your health care plan, you could keep your health care plan. Millions of Americans lost plans they were perfectly happy with because the plans failed to meet all of the requirements of the Obamacare mandates.[4]

Obama promised that if you like your doctor, you can keep your doctor. But millions of Americans lost their doctor when they lost their health care plan – and their only choices for replacement plans had very narrow networks that did not include their doctors.[5] Americans with life-threatening diseases, such as cancer and heart disease, lost doctors and hospitals that had been treating them for years.

The whole point of Obamacare was to provide universal coverage. But even the Congressional Budget Office projected Obamacare would leave 30 million Americans uninsured *10 years after full implementation*. Most Americans who did get coverage through Obamacare got it from Medicaid, at the expense of taxpayers.

Early in 2016, House Speaker Paul Ryan

appointed a Health Care Task Force composed of House Republicans. The Task Force report, released on June 22, 2016 now constitutes the House Republican plan to repeal and replace Obamacare.

This Obamacare replacement plan would make good on the failed promises of Obamacare, assuring health care for all – with no employer mandate, no individual mandate, and trillions of dollars in reduced taxes, regulatory burdens, and federal spending. That would liberate all working families to choose their own health insurance in a competitive national marketplace, including health savings accounts (HSAs), assisted by a universal health insurance tax credit. The plan would reduce health insurance costs, as Obamacare originally promised, which would effectively be another major tax cut, further promoting economic growth.

The Repeal of Obamacare

The House Republican Task Force report begins by stating Obamacare cannot be fixed and so must be repealed: "This law cannot be fixed. Its knot of regulations, taxes, and mandates cannot be untangled. We need a clean start in order to pursue the patient-centered reforms the American people deserve."

Obamacare brought America a trillion dollars in increased taxes – plus nearly a trillion dollars in Medicare cuts that Medicare's own government actuaries say will sharply reduce the quality of health care for seniors – to finance $2 trillion in increased federal spending.

The repeal of Obamacare would be a trillion-dollar tax cut. That would include a 16 percent reduction in the capital gains tax rate, a 16 percent reduction in the tax rate on corporate dividends, and a 38 percent reduction in the top Medicare payroll tax rate.

The Medicare payroll tax is a direct tax on employment. Reversing tax increases on capital gains and corporate dividends promotes capital investment, which is the economic foundation for increased jobs and higher wages. Other Obamacare tax increases – such as the medical device tax and the tax on health insurance – directly raise the cost of health care and health insurance. Repealing them would help reduce health care costs.

The employer mandate is another effective tax on jobs. Even for employers who already provide health insurance, the employer mandate requires most employers to buy more expensive health insurance, raising the cost of employment. For employers who do not currently provide health insurance, the employer mandate is a costly tax on jobs.

That jobs tax burden has forced millions of workers out of full-time employment into part-time, 29-hour-a-week jobs to avoid triggering the mandate, which applies to full-time workers. The Bureau of Labor Statistics (BLS) reports there are six million Americans still stuck in involuntary part-time employment. "These individuals, who would have preferred full-time employment, were working part-time because their hours had been cut back or because they were unable to find a full time job," BLS reports.[6] This is the direct result of the Obamacare employer mandate tax.

Repealing the employer mandate's effective tax on employment will increase job creation. That increased labor supply to the economy, in turn, will increase economic growth and prosperity. The return of the standard, middle-class, 40-hour work week will mean the return of rising wages and incomes for the middle class and working people.

The individual mandate is an effective tax on working people, forcing workers to pay the high cost of Obamacare-required insurance. This tax violates Obama's pledge not to increase taxes on the middle class. Repealing this effective tax would free workers to choose the health insurance they prefer in the marketplace.

Restoring A Trillion Dollars in Medicare Cuts

In a *Wall Street Journal* op-ed, Obama's chief economist, Jason Furman, praised Obamacare's Medicare cuts, saying they involve reducing "overpayments" to health care "providers" (doctors and hospitals). However, Medicare actuaries say Obamacare's Medicare cuts will ultimately decrease Medicare payment rates to doctors and hospitals to one-third of what is paid by private insurance and only half of what is paid by Medicaid, where the poor cannot get timely and adequate health care.[7] As the Medicare actuaries further explain, "The large reductions in Medicare payment rates to physicians would likely have serious implications for beneficiary access to care; utilization, intensity, and quality of services; and other factors."[8]

The actuaries further observe Obamacare's Medicare cuts would result in "negative total facility margins" for approximately 40 percent of the nation's hospitals, skilled nursing facilities, and home health agencies by 2050.[9] The actuaries explain, "In practice, providers could not sustain continuing negative margins [total losses] and, absent legislative changes, would have to withdraw from providing services to Medicare beneficiaries."[10] Timothy Jost, a law professor at Washington and Lee University, wrote in the *New England Journal of Medicine*, "If the gap between private and Medicare rates continues to grow, health care providers may well abandon Medicare."[11]

In fact, Medicare actuaries conclude these Medicare cuts will have such severely negative effects on health care for seniors that Congress will be forced to reverse the cuts, increasing the federal budget deficit. The actuaries write, "It is reasonable to expect that Congress will legislatively override or otherwise modify the reductions in the future to ensure that Medicare beneficiaries continue to have access to health care services."[12] That is what repealing Obamacare would do.

The Universal Health Insurance Tax Credit

The House Republican Health Care Task Force Plan proposes as the centerpiece of its Obamacare replacement plan a universal health insurance tax credit for all workers without employer-provided health insurance. Leading free-market health economist John Goodman has advocated such a tax credit roughly equal to $2,500 per person or $8,000 per family. That would effectively extend to everyone the same tax preference as employer-provided health insurance receives.

Workers would be free to use the tax credit to help buy any health insurance in the market of their choice, including health savings accounts (HSAs). The credit would be refundable and payable monthly so that even those with little or no tax liability would receive the full amount of the credit, which they can use to help pay their insurance premiums. That $2,500 would not be meant to pay the entire cost of such insurance, but only to help pay for it, just as the tax preference for employer-provided insurance does not pay the entire cost of such insurance, but only helps pay for it.

The capped credit would provide an incentive to purchase health insurance, but not an incentive to buy more and more expensive health insurance without limit, as would happen with an open-ended deduction or tax exclusion for health insurance. Moreover, the capped credit provides everyone with the same equal tax benefit for health insurance, rather than the widely varying, arbitrary tax benefits under Obamacare.

The insurance purchased with the tax credit would belong to the worker, not to any employer, and so it would be fully portable, following the worker to any job he or she may choose. Once a health insurance plan is purchased, renewability would be guaranteed as long as the premiums continued to be paid. No one's premiums could be increased higher than the premiums paid by those in the same initial risk class. That guaranteed renewability has long been required by law, even before Obamacare, indeed going back to the common law, because guaranteed renewability protecting against the costs of getting sick is what health insurance contracts promise to do. That requirement became federal law in the Kennedy-Kassebaum legislation of 1996.

The universal health insurance tax credit takes control over health care and health insurance away from politicians and bureaucrats in Washington, returning it to working people all across America. "Patient Power" is the central policy of the House Republican replacement plan for Obamacare.

Devolve Control Over Medicaid to the States through Block Grants or Per-Capita Allotments

The second component of Patient Power reforms to replace Obamacare under the House Republican Health Care Task Force Plan would be to transfer control over Medicaid to the states. That would be done through either block grants to each state, as under the enormously successful 1996 welfare reforms, or reforming the federal financing of Medicaid with per-capita allotments to each state. Under the Republican Obamacare replacement plan, the choice between those two alternatives would be at the discretion of each state. Either way, the change would enormously benefit to the poor.

Currently, the federal financing for Medicaid is provided under a matching federal financing formula, paying more to each state the more the state

spends on Medicaid. That amounts to the federal government paying the states to spend more on Medicaid, which raises costs to the states and to federal taxpayers.

Those counterproductive incentives would be reversed by replacing federal financing for Medicaid with fixed, finite block grants. With fixed block grants, each state would know that if it chooses to change its Medicaid program in ways that increase the program's overall costs, the state itself would pay 100 percent of the difference. If the state chooses to change its Medicaid program in ways that lower the program's overall costs, the state would keep 100 percent of the savings. These are ideal incentives for each state to weigh the costs against the benefits for Medicaid spending, and pursue only the spending deemed worthwhile.

Each state would be free to use its power under the Medicaid block grants to provide assistance to the poor through premium support payments or health insurance vouchers. The beneficiaries could use these to supplement the universal health insurance tax credit to help them obtain the private health insurance of their choice, from HSAs to managed care alternatives. The voters of each state would be free to determine how much assistance at what income levels would be necessary to ensure the state's poor could buy essential health insurance. Those levels would be very different for Mississippi and Louisiana than for New York and California, given their widely varying health care cost structures and income levels.

Such Medicaid reforms would be enormously beneficial for the poor. The program currently pays so little to doctors and hospitals that the poor often suffer grave difficulties in finding timely, essential health care under Medicaid. Scott Gottlieb of the New York University School of Medicine noted in a March 10, 2011 commentary in *The Wall Street Journal* ("Medicaid Is Worse Than No Coverage at All"): "In some states, they've cut reimbursements to providers so low that beneficiaries can't find doctors willing to accept Medicaid."[13]

As a result, Gottlieb added, "Dozens of recent medical studies show that Medicaid patients suffer for it. In some cases, they'd do just as well without health insurance."[14] Gottlieb reports a 2010 study of throat cancer "found that Medicaid patients and people lacking any health insurance were both 50 percent more likely to die when compared with privately insured patients."[15] A 2011 study of heart patients "found that people with Medicaid who underwent coronary angioplasty were 59 percent more likely to have … strokes and heart attacks, compared with privately insured patients. Medicaid patients were also more than twice as likely to have a major, subsequent heart attack after angioplasty as were patients who didn't have any health insurance at all."[16] A 2010 study of major surgical procedures "found that being on Medicaid was associated with the longest length of stay, the most total hospital costs, and the highest risk of death."[17]

This deadly problem was illustrated by the case of 12-year-old Deamonte Driver, from a poor Maryland family on Medicaid. When Deamonte complained of a toothache, his mother tried to find a dentist who would take Medicaid. But only 900 of 5,500 dentists in Maryland do. By the time she found one and got the boy to the appointment, his tooth had abscessed, and the infection had spread to his brain. Now she needed to find a brain specialist who took Medicaid. Before she could locate one, the boy was rushed to Children's Hospital for emergency surgery. He called his mother from his hospital room one night to say, "Make sure you pray before you go to sleep." The next morning, Deamonte was dead.[18]

With private health insurance purchased with the help of the universal health insurance tax credit – supplemented for the poor with Medicaid health insurance vouchers – families like the Drivers would enjoy the same health care as the middle class. That is because they would have the same health insurance as the middle class, which is forced by competitive market pressures to pay enough to the doctors and hospitals to ensure those covered by the insurance can get timely, essential health care. This would provide an enormous gain for the poor compared to the current Medicaid program.

States would have the flexibility under these block grants to adopt a work requirement for lower income families to receive Medicaid assistance. The new block grant incentives for states to control Medicaid costs and economic and political competition among the states would lead to widespread adoption of Medicaid work requirements among the states. Such work requirements would have to accommodate those who are too sick to work with temporary relief from the requirements until

they get well.

Those who suffer from such extended illness that they are effectively disabled from sustained work would have to qualify for assistance under disability programs, which, of course, could not require work. Because of the new flexibility allowed to states from the block grants, the new incentives of the block grants to control Medicaid costs, especially as compared to the current matching federal financing incentives, and the cost savings from newly adopted Medicaid work requirements, the Medicaid block grants would not need to grow as fast as current Medicaid federal financing.

The Congressional Budget Office has scored the Medicaid block grants proposed by the House Budget Committee, already included in the last five GOP budgets adopted by the entire House, as saving nearly $1 trillion over the first 10 years alone.

Per-capita allotments would provide a specified amount of federal funds to each state for each Medicaid dependent in four categories: aged, blind and disabled, children, and adults. The specific federal allotment for each Medicaid dependent would depend on medical costs in the state for each of the four categories. This federal financing would not vary by the amount each state spent. So if the state's Medicaid changes cost more, the state would bear 100 percent of the added costs; if the state's changes cost less, the state could keep the savings.

States also would have the flexibility under these per-capita allotments to adopt work requirements for lower income families to receive Medicaid assistance. The per-capita allotments would result in the same cost-saving controls as the block grants discussed above. These cost-saving controls would consequently enable federal financing under these per-capita allotments to grow more slowly than current federal Medicaid financing.

State Uninsurable Risk Pools and Coverage for Pre-Existing Conditions

The House Republican plan would provide a new stream of federal funding states could use to help set up their own risk pools to provide coverage to the uninsured who become too sick and costly to obtain insurance in the marketplace. Those insured by the pools would pay premiums based on their ability to pay, so the pools would serve a safety net function. The state would finance the remaining costs.

Thirty-five states had set up such risk pools even before Obamacare.[19] They proved to be a low-cost means of providing for treatment of preexisting conditions for those who were uninsured when they contracted a very costly illness, such as cancer or heart disease. That is because only a very small percentage of people become truly uninsurable in the private market. Such pools are far less expensive and intrusive than regulation requiring guaranteed issue and community rating, which raise health insurance costs sharply for everyone, creating more uninsured as a result.

The Republican plan also would prohibit coverage exclusion for preexisting conditions for everyone who had maintained continuous coverage and wanted to change insurance coverage after they got sick. Just like current law would provide for guaranteed renewability for everyone who continued to pay premiums, no matter how sick they became, no could be excluded from coverage for preexisting conditions, as long as they maintained continuous coverage. That provision already exists for employer group coverage under the federal Health Insurance Portability and Accountability Act (HIPPA). The Republican plan would extend that to the individual market.

The Republican plan also would provide for a one-time open enrollment period for everyone, where Americans could get health insurance without any exclusion for preexisting conditions. That would be workable as a limited one-time opportunity for everyone to get a fresh start for health coverage.

Competing Pooling Exchanges

The House Republican plan to replace Obamacare also would enable the private sector to establish competing private exchanges for the purchase of health insurance. Small businesses, for example, could pool their employees into larger groups to compete against larger employer pools. Social associations and organizations – such as the Knights of Columbus, or the NAACP, or the Boy Scouts – could establish exchanges to better enable their members to get health insurance. Any combination of individuals who desired to do so could form their own pool and competing exchange to extend health insurance coverage opportunities. This would create new, competing avenues to expand coverage to more of the uninsured.

Preserving Employer Self-Insurance

Another way employers, especially large employers, extend health coverage is through employer self-insurance. Instead of paying health insurance companies, employers sometimes choose to pay directly for their employees' health care. When an employer is large enough, it effectively has a randomized, insurable pool among its own employees.

Self-insuring employers often protect themselves against a run of bad-luck costs by purchasing stop loss coverage for their employee health care expenses. This puts a limit on the employer's liability for worker health expenses, so a cluster of sudden cancer or stroke or heart attack liabilities don't imperil an employer's finances.

The House Republican plan protects the freedom of employers to exercise this option for their employee health plans, free from encroachment by overzealous government bureaucrats acting to shut down alternatives to government coverage.

Universal Health Care for All Americans When Needed

Unlike Obamacare, these reforms would assure health care for all. Everyone without employer-provided health insurance gets the universal health insurance tax credit, which they can use to help pay for the health insurance of their choice. Once they're insured, the pre-Obamacare law already provided for guaranteed renewability – which means their coverage must continue as long as they continue to pay premiums, and those premiums could not be raised discriminatorily, no matter how sick the insured person became.

The poor would get additional assistance to purchase insurance through Medicaid vouchers, empowering them to get essential health coverage. Those who had become uninsurable due to the development of costly diseases could turn to the uninsurable risk pools for their coverage. The Republican plan also would ban preexisting condition exclusions for those who maintained continuous coverage, and with a one-time, limited, open enrollment period for everyone. And new, competing pools and exchanges would create new opportunities to expand coverage, while protection for employer self-insurance plans would preserve that coverage option.

Health Savings Accounts for All Americans

Health savings accounts (HSAs) are designed to reduce the growth in health care costs by giving patients more control over their own health care, and by establishing market incentives to reduce those costs. HSAs include catastrophic health insurance with a high deductible, in the range of $2,000 to $6,000 a year or more, as chosen by each worker. That insurance pays for health care costs each year above the deductible. The premium savings created by the high deductible, as compared to more traditional, first-dollar coverage insurance, would be saved in the HSA and used to pay for health care expenses below the deductible. The patient keeps any funds remaining in the HSA each year for future health care expenses, or to spend on anything in retirement.

This framework creates full market incentives to control costs for all non-catastrophic health care, because the patient is effectively using his or her own money to pay for them. Since the patient is now concerned about costs, doctors and hospitals will compete to control costs. The incentives flow all the way through to the developers of health care technology, who would have market incentives to develop technology that reduces health care costs in addition to improving health care quality and effectiveness.

After one healthy year, a person covered by an HSA typically has more than enough in the account to pay for all expenses below the deductible. Moreover, patients with HSAs enjoy complete control over how to spend their HSA funds. They don't need to ask for approval from an insurance company or other third party.

HSAs can be especially advantageous for vulnerable populations, particularly the sick and the poor. Because they have complete control over their HSA funds, the sick become empowered consumers in the medical marketplace. Because they can pay for care themselves out of their HSA account, the poor have ready access to a wide range of providers (unlike in Medicaid today). With HSAs, the poor have funds in their accounts to pay for effective preventive care, too.

HSAs and their incentives have proven very effective in controlling costs in the real world. Total HSA costs have run about 25 percent less than costs for traditional health insurance with much lower

deductibles.[20] Annual cost increases for HSA/high-deductible health insurance plans have run more than 50 percent less than for conventional health care coverage, sometimes with zero premium increases.[21] A 2012 Rand Corporation study found those covered by HSAs spend 21 percent less on average on health care in the first year after switching from more traditional coverage.[22] Rand estimated annual health costs would fall by nearly $60 billion if half of all workers were covered by HSAs.[23]

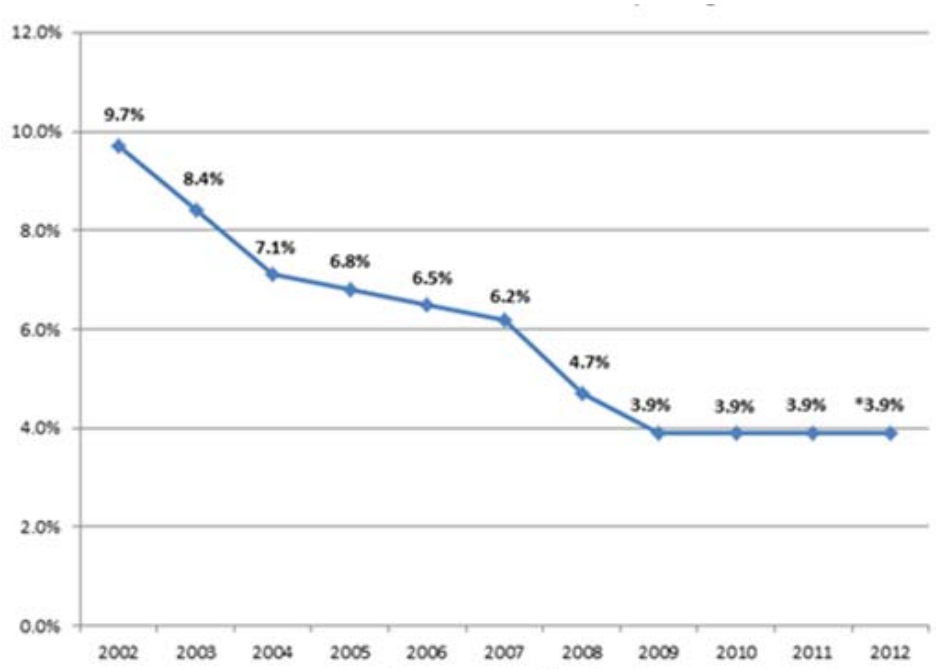
Obama has repeatedly tried to claim a long-established trend of slowing health care costs is due to Obamacare. But that downward cost trend started in 2003, when Barack Obama was a state senator in Illinois and Obamacare, which went into effect at the start of 2014, was just a gleam in his eye.

What happened in 2003 to start the downward trend in health care costs? The Republican Congress enacted modern health savings accounts (HSAs) combined with consumer-directed health plans (CDHPs). The share of the U.S. population covered by HSAs, which maximize patient power and control over health care, has increased by double digits every year since 2003, reducing annual growth for health costs by 40 percent, as shown in Figure 1.

Along with the rise of these HSA/CDHPs, national health care spending growth declined, slowing to 3.9 percent each year from 2009 to 2011, and 3.6 percent for 2012, almost two-thirds slower than a decade before. That is the slowest rate of increase since the 1960s (which was the last time the government role in health care increased dramatically). All that the 2010 passage of Obamacare did during that time, with one exception, was contribute to increased health care costs. The one exception is the beginning of the trillion dollars in Medicare cuts adopted in Obamacare.

The market-based HSA incentives become more effective at controlling health care costs the more people are covered by HSAs. Under the House Republican plan, HSAs would be extended throughout the health insurance marketplace. All Americans would be free to choose HSAs for their coverage. Workers would be free to use their universal health insurance tax credit for HSAs, the poor on Medicaid would be free to use their tax

Figure 1
Annual Growth of National Health Care Spending
2002–2012



Source: CMS National Expenditure Accounts, Table 1, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf

Note: *3.9% is the projected growth rate for 2012.

credit and Medicaid voucher for HSAs, and seniors on Medicare would be free to choose HSAs for their Medicare benefits under Medicare Part C.

Under the Republican plan, the limit for annual contributions to HSAs would be increased to equal the amount of the deductible for the catastrophic insurance. That means everyone would be free to provide for savings in the HSA at least equal to all expenses below the deductible. Spouses would be allowed to make catch-up contributions to any HSA plan.

Medical Malpractice and Liability Reform

The House Republican plan to replace Obamacare would further reduce costs by expanding proven state reforms reducing health costs through medical malpractice reform nationwide. California and Texas have shown that medical malpractice and liability reforms that include caps on non-economic damages can reduce costs sharply, while still preserving the freedom of patients to recover real damages if their providers fail to provide adequate care. Such reforms in California reduced cost increases for medical liability insurance by two-thirds. The Texas reforms freed doctors and hospitals to increase their supply of health care.

States would be free to experiment with further reforms, such as safe harbor practices that follow established guidelines, specialized health courts, loser pays rules, and independent, pre-discovery medical review panels.

Controlling and Reducing Costs of Health Care and Insurance in a National Market

Consumer choice, market incentives, and competition resulting from the universal health insurance tax credit would further help to reduce costs, as consumers choose among varying marketplace options. The plan to replace Obamacare would increase such competition, choice, and market incentives by allowing nationwide competition among insurers across state lines.

The repeal of Obamacare regulations and taxes would further reduce health costs. States would reassume the regulatory authority they exercised over health insurance before Obamacare. Such state regulation proved far more effective in controlling costs than Obamacare federal regulation.

Complete Package to Control Costs

These Republican cost-control reforms constitute a complete package to control health costs. Health savings accounts, proven effective at controlling costs, would be expanded and accessible by everyone – workers, seniors on Medicare, and the poor on Medicaid. The universal health insurance tax credit and national deregulation would control costs through competition in a nationally competitive marketplace. Repealing Obamacare taxes and regulations, including the employer mandate and the individual mandate, and restoring state control over health insurance regulation would sharply reduce health costs. So would national medical liability and malpractice reforms.

Restoring Economic Growth, Jobs, and Prosperity

Repealing Obamacare tax increases, particularly those on capital investment, and Obamacare's federal overregulation would help restore economic growth, jobs, and prosperity to the American economy. Gone would be the employer mandate and the individual mandate: two onerous taxes that are killing jobs and prosperity.

Replacing the Obamacare-induced, part-time, 29-hour work week for millions of Americans with the return of the standard, middle-class, 40-hour work week will mean the return of rising wages and incomes for the middle class and working people. Reduced costs for health care and insurance would be another major tax cut boosting the economy.

The Original Promises of Obamacare Redeemed

The plan to replace Obamacare would make good on all the false promises Obama made for Obamacare. Health insurance costs would decline through the market incentives of health savings accounts available to all, market competition for consumer choice with universal health insurance tax credits, a national competitive market crossing state lines, and the repeal of costly Obamacare overregulation and taxes.

All Americans would be free to choose the health insurance they like, covering their preferred doctors. Universal health care would be assured for all when needed – with no individual mandate, no employer mandate, and trillions of dollars in reduced taxes,

spending, and regulatory costs. The nearly $1 trillion in Medicare cuts would be reversed. This alternative would be far more popular with the American people than Obamacare.

[1] *Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage, 1999–2015*, The Henry J. Kaiser Family Foundation, 2016; J.B. Wogan, "No Cut in Premiums for Typical Family," *Politifact*, August 31, 2012.

[2] Henry J. Kaiser Family Foundation, *ibid.*

[3] Drew Gonshorowski and Edmund Haislmaier, "3 Ways ObamaCare's Insurance Regulations Could Cost You," *The Daily Signal*, March 28, 2016.

[4] "Policy notifications and current status, by state," The Associated Press, December 26, 2013.

[5] *Report of the Health Care Reform Task Force*, U.S. House of Representatives, June 22, 2016, p. 9; "Exchange Plans Include 34 Percent Fewer Providers than the Average for Commercial Plans," *Avalere*, July 15, 2015; Bob Herman, "Network Squeeze: Controversies Continue Over Narrow Health Plans," *Modern Healthcare*, March 28, 2015.

[6] Bureau of Labor Statistics, "Employment Situation Summary," October 7, 2016.

[7] John D. Shatto and Kent Clemens, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*, Office of the Actuary, Centers for Medicare and Medicaid Services, August 5, 2010.

[8] Shatto and Clemens, *supra* note 7.

[9] *Ibid.*

[10] *Ibid.*

[11] Timothy Jost, "Subsidies and the Survival of the ACA – Divided Decisions on Premium Tax Credits," *New England Journal of Medicine*, July 30, 2014.

[12] Shatto and Clemens, *supra* note 7.

[13] Scott Gottlieb, "Medicaid Is Worse Than No Coverage at All," *The Wall Street Journal*, March 10, 2011

[14] *Ibid*.

[15] Joseph Kwok, *et al.*, "The Impact of Health Insurance Status on the Survival of Patients with Head and Neck Cancer," *Cancer* **116** (January 2010): 476–85.

[16] Michael A. Gaglia Jr., *et al.*, "Effect of Insurance Type on Adverse Cardiac Events After Percutaneous Coronary Intervention," *American Journal of Cardiology* **107** (March 2011): 675–80.

[17] Damien J. LaPar *et al.*, "Primary Payer Status Affects Mortality For Major Surgical Operations," American Surgical Association 130th Annual Meeting, Chicago, Ill., April 8–10, 2010.

[18] Laura Owings, "Toothache Leads to Boy's Death," ABC News, March 5, 2007; Anne Alstott, "Hidden Rations: Why Poor Kids Cannot Find a Dentist," *Slate*, March 5, 2007.

[19] *Coverage of Uninsurable Pre-Existing Conditions: State and Federal High Risk Pools*, National Conference of State Legislatures, June 2014, www.ncsl.org/research/health/high-risk-pools-for-health-coverage.aspx.

[20] John C. Goodman and Peter Ferrara, "The Real Reason Health Spending Has Slowed," *NCPA Brief Analysis* No. 793, National Center for Policy Analysis, February 12, 2014; Peter Ferrara, "Obamacare Is the Problem; Health Savings Accounts Are the Solution," *Issue Brief* No. 124, National Center for Policy Analysis, July 10, 2013; Employer Health Benefits 2009 Annual Survey, Kaiser Family Foundation, http://ehbs.kff.org/; National Survey of Employer-Sponsored Health Plans, Mercer Company, November 19, 2007, www.mercer.com/referencecontent.htm?idContent=1287790. - See more at www.ncpa.org/pub/ib124#sthash.rVEKzLaP.dpuf.

[21] Peter J. Ferrara, *Power to the People: The New Road to Freedom and Prosperity for the Poor, Seniors, and Those Most In Need of the World's Best Health Care* (Arlington Heights, IL: The Heartland Institute, 2015), p. 116; Goodman and Ferrara, *supra* note 20.

[22] Peter J. Ferrara, *Power to the People*, *ibid.*, p. 116; Goodman and Ferrara, *supra* note 20.

[23] Peter J. Ferrara, *Power to the People*, *ibid*.; Ferrara, "Obamacare Is the Problem," *supra* note 20.

About the Authors

Peter Ferrara is senior fellow for entitlement and budget policy at The Heartland Institute and a senior fellow at the Social Security Institute. He served in the White House Office of Policy Development under President Ronald Reagan and as associate deputy attorney general of the United States under President George H.W. Bush. He is a graduate of Harvard College and Harvard Law School.

Ferrara is author of several books, including *The Obamacare Disaster,* from The Heartland Institute, *President Obama's Tax Piracy,* and *America's Ticking Bankruptcy Bomb: How the Looming Debt Crisis Threatens the American Dream – and How We Can Turn the Tide Before It's Too Late*. Ferrara's latest book (Heartland Institute, 2015) is *Power to the People: The New Road to Freedom and Prosperity for the Poor, Seniors, and Those Most in Need of the World's Best Health Care.*

Lewis K. "Lew" Uhler is founder and president of the National Tax Limitation Committee, one of the nation's leading grassroots taxpayer lobbies. With offices in the Sacramento area and Washington, DC, NTLC works with the White House, members of Congress, legislators in states across the nation, and grassroots organizations to limit state and federal spending through legal restrictions and constitutional change.

Uhler has been at the forefront of the national movements for a tax limitation/balanced budget amendment to the United States Constitution and for term limits. He has written numerous articles and opinion pieces on taxes and spending. In 2010, Uhler co-authored with Erick Erickson the book *Red State Uprising: How to Take Back America.* Uhler also wrote the book *Setting Limits: Constitutional Control of Government,* with a foreword by Milton Friedman, published in 1989. Uhler speaks internationally on fiscal issues and has appeared on numerous national, regional, and local television and radio programs and has been widely quoted in the print media.

About the National Tax Limitation Committee

The National Tax Limitation Committee (NTLC) was organized in 1975. Its mission is to provide national leadership to achieve the optimal size and functions of government and promote candidates and initiatives that support these goals.

NTLC and its foundation, the National Tax Limitation Foundation (NTLF), have organized numerous conferences and seminars around the nation on critical issues. Uhler speaks regularly at the annual Conservative Political Action Conference (CPAC) in Washington, sponsored by the American Conservative Union (ACU), on whose board he served for many years. NTLC's operating philosophy has always been to partner with other groups and individuals in the accomplishment of mutual goals. NTLC and NTLF are further supported by a distinguished Board of Advisors.

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About The Heartland Institute

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Heartland is approximately 5,500 men and women funding a nonprofit research and education organization devoted to discovering, developing, and promoting free-market solutions to social and economic problems. We believe ideas matter, and the most important idea in human history is freedom.

Heartland has a full-time staff of 38. Joseph Bast is cofounder, president, and CEO. Dr. Herbert Walberg is chairman of the 10-member Board of Directors. Approximately 250 academics participate in the peer review of its publications and more than 200 elected officials pay annual dues to serve on its Legislative Forum.

For more information, visit our website at www.heartland.org, call 312/377-4000, or visit us at 3939 North Wilke Road, Arlington Heights, Illinois.