PATIENTS MEDICARE DOCTORS CO-PAY HEALTH-INSURANCE HOSPITALS MEDICINE NURSES MEDICAID PRE-NATAL CARE PREVENTION SURGERY LONG-TERM CARE OPERATING ROOM

A Policymaker's Primer on ObamaCare:

The Myths, the Costs, and a Practical Guide to Defunding the Government Takeover of Healthcare in the 112th Congress

ANTI-INFLAMMATORY HOSPICE X-RAY SURGEON VACCINE MEDICAL DEVICE EMERGENCY ROOM DEDUCTIBLE PRESCRIPTIONS CRITICAL CONDITION LONG-TERM-CARE CHIP PHYSICIAN ONCOLOGY CARDIOLOGY ANALGESIC INNOVATION ONCOLOGY PEDIATRICS HOSPITAL BED OVER-THE-COUNTER PRE-EXISTING CONDITION PREMIUMS HEALTH INFORMATION TECHNOLOGY REIMBURSEMENT RATES PREVENTION

American Healthcare Education Coalition

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American Healthcare
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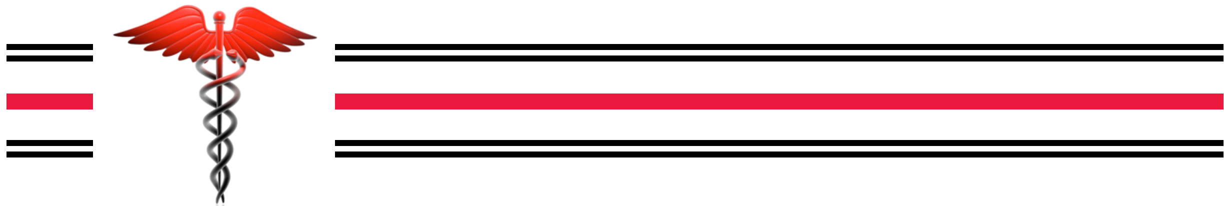
The American Healthcare Education Coalition (AHEC) is a national non-profit, public interest organization with the goal of educating the American public about policy issues affecting our nation's healthcare system.

AHEC seeks to advance a healthcare system that places patients and doctors at the center of health decisions. AHEC seeks to advance a free-market healthcare system and to incentivize innovation as the best way to achieve both high quality of care and value for consumers.

ABSTRACT:

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act, which is commonly referred to as ObamaCare. This law includes a series of provisions that will have a dramatic impact on America's healthcare system, including: (1) increased taxes and compliance burdens imposed on small businesses; (2) changes to HSAs that make them less useful to individual consumers and increased fines for non-qualified distributions; (3) deep cuts to Medicare Advantage, the free-market portion of Medicare; (4) a significant expansion of Medicaid, which will threaten state budgets; and (5) an unprecedented use of the Constitution's commerce clause to justify the imposition of an individual mandate requiring individuals to carry health insurance or face serious tax penalties. Supporters of the law have made a series of promises about this law, including that it will reduce costs and expand access to insurance. Opponents of the law, however, note that these promises have proven false, and that the law will actually increase insurance costs, increase federal budget deficits, and damage the U.S. economy. In response to the clearly negative impact the law will have on businesses, individual consumers, and America as a whole, this primer concludes that it is necessary to repeal ObamaCare and recommends a course of action for state and local policymakers to achieve that objective.



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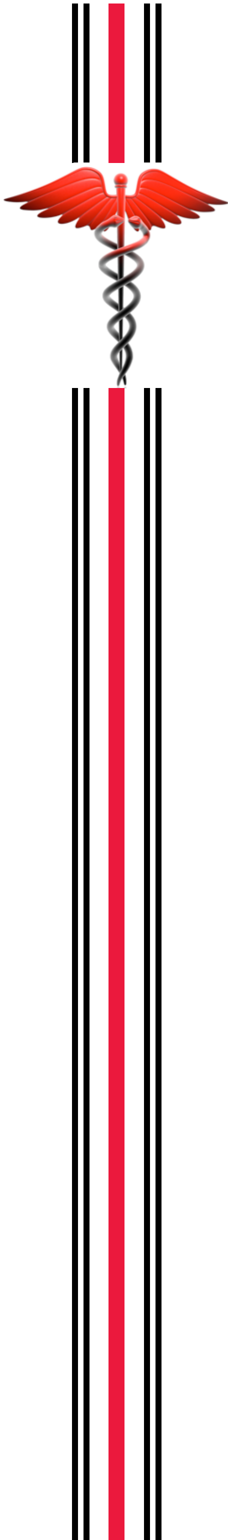


Talking Points on ObamaCare

- ObamaCare puts America on the same failed path of socialized medicine that England, France, Cuba, and Canada have experimented with.

- The American public increasingly disapproves of the healthcare overhaul.

- ObamaCare relies on a series of budget gimmicks to mask the real costs associated with the bill and its impact on the deficit.

- ObamaCare will impose significant costs on state Medicaid budgets.

- ObamaCare will lead to less competition in the health insurance and health care industries.

- ObamaCare will necessarily lead to higher prices for health insurance and health care services.

- ObamaCare, to keep costs from escalating, will ration care the same way that England's and Canada's healthcare systems ration care.

- ObamaCare represents the largest tax increase in American history.

- ObamaCare will cripple the economy, burdening small business owners.

- ObamaCare unfairly victimizes seniors; the healthcare overhaul first guts Medicare Advantage and takes money from Medicare to fund other entitlement programs.

- ObamaCare will lead to massive doctor shortages across the country and in every medical specialty.

Introduction
A Summary of the Healthcare Overhaul

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, commonly referred to as ObamaCare. Despite its formal name, it has become increasingly apparent that the new healthcare law offers neither patient protection nor greater affordability for the American people. Instead, the new law establishes price controls and places numerous restrictions on the insurance market, which will soon result in fewer health insurance options available to consumers.

In 2009 and early 2010, President Obama and Democrats in Congress argued that healthcare reform was necessary in order to end the practice of denying coverage to people with pre-existing conditions. While it is true that ObamaCare prohibits insurers from charging higher premiums for people who have a pre-existing condition, the new law does so in a way that incentivizes healthy people not to carry health insurance because they are guaranteed access to a policy once they fall ill. By prohibiting health insurance companies from charging higher premiums for people with pre-existing conditions, the law divorces pricing from relative risk. This provision in the healthcare law is a form of a price control that threatens to sink the entire health insurance industry.

In addition to these price controls, ObamaCare also imposes numerous taxes and financial burdens on American families and small businesses. These new taxes and fees include punitive taxes for people who do not have insurance, restrictions on the use of private health-savings accounts, and costly new accounting and IRS reporting mandates.[1]

Perhaps one of the more onerous features of the new health care law is the individual mandate, which requires Americans to purchase health insurance and levies a punitive tax on those who do not to carry a health insurance policy.[2] While there are many arguments in favor of incentivizing the purchase of health insurance, it is improper – and unconstitutional – for the federal government to dictate that all individuals must either carry health insurance at all times or pay punitive fees and taxes.[3]

Another nefarious aspect of ObamaCare is the unintended consequence that will lead many employers to eliminate their company-sponsored insurance plans. Prior to the passage of ObamaCare, more than 163 million Americans had employer-sponsored health insurance.[4] ObamaCare disrupts health insurance markets by creating state insurance exchanges and establishing burdens that will compel employers to drop their company-sponsored programs and shift their employees over to state-run Medicaid-type programs.[5] Douglas Holtz-Eakin, who previously served as the director of the Congressional Budget Office (CBO), argues that employers will also be incentivized to drop employer-sponsored plans and that nearly 43 million people who are presently covered by employer-sponsored insurance may lose their coverage as a result.[6]

In addition to incentivizing employers to drop their coverage, ObamaCare also provides strong incentives for individuals to drop their coverage and move over to taxpayer-subsidized plans in their states. Holtz-Eakin reports that employees who make less than 2.5 times the federal poverty level (around $55,000 for a family of four in 2010) will face an economic incentive to drop their private health insurance coverage.[7]

Furthermore, ObamaCare passes on significant financial burdens to state governments. The final version of the law guarantees that the federal government will initially cover 100% of

the expansion of Medicaid benefits in all 50 states plus Washington, D.C. until 2017, but the Federal matching rate subsequently decreases to 93% by 2019.[8] Beyond that decrease, the Heritage Foundation also notes that the 100% match from the federal government does not include any administrative expenses, which will cost the states a total of $9.6 billion between 2014 and 2019.[9]

ObamaCare further adds to states' costs by changing the Medicaid funding formulas. The new law increases payments for primary care providers to match the Medicare payment rate. In the first two years of the new healthcare law, the federal government will provide 100% of the funding, but after that brief two-year period, federal funding for increases in provider payment rates will end, which will force states either to find a way to pick up the new costs or to go back to lower reimbursement rates.

Finally, ObamaCare fails to provide a satisfactory solution to Medicare's weaknesses. Medicare is due to become insolvent in 2016, and long-term unfunded liabilities are currently in excess of $38 trillion.[10] To address this shortfall, Medicare provider payment rates are scheduled to decrease annually according to the Sustainable Growth Rate. Not only does ObamaCare fail to address Medicare's funding problem, it also cuts billions of dollars from the popular Medicare Advantage program, which has been one of the most cost-effective programs within Medicare.[11]

This publication presents a concise case against ObamaCare, exploring many of the outcomes and consequences of the law. In short, ObamaCare will: (1) expand unsustainable healthcare entitlements, thus straining both the federal and state budgets; (2) create negative incentives, including tax increases that will encourage people to drop private coverage in favor of taxpayer-subsidized coverage; (3) reduce consumers' choices for insurance policies and

options, including the popular Health Savings Accounts (HSA's); (4) require people to pay for more expensive insurance as a result of the individual mandate; (5) impose price controls on the insurance industry, which will result in many insurance companies exiting the market; and (6) impose counter-productive taxes on life-saving medical technology and medical device companies that will incentivize these companies to leave the United States.

Furthermore, this guide also offers practical solutions for policymakers on how to dismantle ObamaCare and replace it with legislation that constitutes real reform rooted in free-market principles to successfully address both the cost and quality of care.

Chapter 1: Facts vs. Fiction

The Myths and Broken Promises of ObamaCare

MYTH: ***Individuals will keep their coverage***

During the healthcare policy discussions in 2009 and 2010, one of the central promises touted by the Obama Administration and Democrats in Congress was that people in the United States who liked their health insurance would be able to keep those plans without changes. Now, nearly a year after ObamaCare became law, the Obama Administration predicts "many employers will be forced to make changes to their health plans under the new law. In just three years, a majority of workers – 51% – will be in plans subject to new federal requirements."[12]

In spite of the Democrats' promises, ObamaCare has already caused tens of thousands of Americans to lose their healthcare coverage. In November 2010, an SEIU-affiliate in New York cancelled its coverage for 6,000 children because of the new requirements under ObamaCare.[13] Additionally, Medicare Advantage plans across the country have been cancelled because of the new healthcare law.[14] As a result, tens of thousands of seniors have been forced to find new health insurance plans.

MYTH: ***ObamaCare will curb the cost of healthcare and help to lower insurance premiums***

Throughout 2010, Democrats consistently argued that the health care bill would lower insurance premiums and reduce families' out-of-pocket medical expenses. As many of the provisions begin to go into effect, however, it is becoming increasingly clear that the legislation will actually increase consumers' costs. For example, according to the Obama Administration's own Centers for Medicare & Medicaid Services (CMS), ObamaCare imposes a number of annual fees on drug manufacturers, prescription drug importers, and health insurance plans.[15] Moreover, the healthcare law establishes new taxes on certain retail sales by manufacturers and importers of medical devices. CMS anticipates that these fees and taxes will "generally be passed through to health consumers in the form of higher drug and device prices and higher insurance premiums."[16]

Moreover, ObamaCare will increase health insurance premiums for millions of Americans. The RAND Corporation estimates that young, healthy Americans will see their premiums rise approximately 17%, or about $42 per month.[17] In addition, the Congressional Budget Office

notes that workers who buy their own insurance (rather than getting it through their employer) will likely see their premiums increase between 10 and 13% faster than if the bill had never passed.[18]

MYTH: ***ObamaCare is a deficit reduction bill***

According to the Heritage Foundation, ObamaCare relies on "several budgetary gimmicks" in order to make it appear as though the legislation would actually reduce the deficit.[19] These gimmicks include "double-counting savings from Medicare and the CLASS Act, indexing benefits to general inflation rather than medical inflation, and delaying the expensive provisions of the bill."[20] When these costs are included, ObamaCare's total price tag is close to $2.5 trillion.

MYTH: ***ObamaCare stabilizes the federal budget and cuts government overspending***

The Obama administration itself has debunked this myth. CMS "estimate[s] that Federal expenditures will increase by a net total of $251 billion" over the next decade as a result of the enactment of ObamaCare.[21]

MYTH: ***ObamaCare prohibits the use of federal funds for abortion***

Rather than pass the Stupak-Pitts Amendment,[22] which would have clearly prohibited taxpayer-funded abortions under ObamaCare, President Obama attempted to satisfy pro-life Democrats with a weak Executive Order (EO) that prohibited the use of taxpayer funds for abortion. Beginning in July 2010, however, media reports explained that federal funds from ObamaCare will now be available in high-risk insurance pools in New Mexico and Pennsylvania for abortion funding.[23] This development highlights one of the main weaknesses of Obama's Executive Order – namely, that it is completely unable to prevent states from using federal funds for abortion.

In response to proposed state regulations to cover abortions, Secretary of Health and Human Services (HHS), Kathleen Sebelius announced that states could not pay for abortions with ObamaCare funds, except in cases of rape or incest, or when the mother's life is in danger. The fact that HHS had to respond to this issue further undermines any claims that the EO effectively stopped abortion funding under ObamaCare.

MYTH: ***ObamaCare is good for the economy***

ObamaCare contains an unpopular provision that will require every small business to file 1099 reports with the IRS any time a business buys more than $600 a year in goods or services from a vendor beginning in the year 2012.[24] According to Chris Edwards of the Cato Institute, this costly new mandate "will force millions of businesses to issue hundreds of millions, perhaps billions, of additional IRS Form 1099s every year."[25] This new requirement will hurt small businesses because they will be forced to waste time filling out forms, modifying their computer systems, collecting and organizing information, and dealing with the bureaucratic nightmare that is the IRS.

MYTH: ***The individual mandate is not a tax increase***

One of the chief criticisms against ObamaCare's individual mandate is that it is a *de facto* tax on every American citizen. The response from Democrats in Congress and the Obama Administration in early 2010 was that this fee is not a tax. However, now that 27 states have sued the federal government over this particular provision, the Obama Administration is making the opposite argument – that the individual mandate should be seen as a tax.

The 27 states engaged in lawsuits against the federal government have collectively argued that the individual mandate is unconstitutional because it over-reaches with its interpretation of the Constitution's Commerce Clause. In defending the constitutionality of this provision, the Obama Administration has argued that Congress has the "power to lay and collect taxes."[26] Thus, in a desperate attempt to justify the individual mandate, President Obama is now defending this provision by arguing that it is a tax, even though for months the Democrats insisted that the individual mandate was not tantamount to a new tax. In its court brief, Obama's Justice Department stated that this mandate will raise $4 billion in tax revenues annually by 2017, that individuals must report compliance on their tax returns "as an addition to income tax liability," and that the IRS is responsible for ensuring compliance and collecting fines.[27]

MYTH: ***ObamaCare protects Medicare***

In June of 2010, *The Wall Street Journal* reported that "many insurance companies are planning to increase costs for a range of services for seniors next year."[28] ObamaCare has forced "[d]ozens of Medicare Advantage providers…to cut back vision, dental and prescription benefits."

Additionally, some Medicare plans are now raising fees for hearing aides, eye glasses, and emergency-room visits.[29] According to medical consultants, the primary reason for the cutbacks is that ObamaCare imposes drastic cuts to payments from the federal government to insurers that provide Medicare Advantage plans.

MYTH: ***ObamaCare does not benefit illegal immigrants***

One of the assurances that Democrats made in passing this healthcare law was that illegal immigrants would not be able to benefit from new taxpayer-subsidized health insurance plans. However, the legislation that President Obama signed into law does not contain a meaningful verification system that would effectively prohibit illegal aliens from being able to access taxpayer subsidies contained in the law. One of the main problems with ObamaCare is that the law does not require anyone to present a government-issued photo I.D. when applying for healthcare benefits.[30] In other words, the law contains no safeguards to protect taxpayers from paying for expensive medical care for people who have illegally entered the country.

MYTH: ***ObamaCare does not ration care***

Dr. Donald Berwick, President Obama's choice to head the Centers for Medicare and Medicaid Services (CMS), is a proponent of rationing care and has stated on numerous occasions that the only way to curb the cost of healthcare in a meaningful way is to limit the number of services and the type of care available. Dr. Berwick – who was appointed during a Congressional recess and therefore not subject to the Senate's usual "advise and consent" vetting process – has praised the British system of socialized medicine and the rationing of health care.[31] According to Dr. Berwick, "The decision is not whether or not we will ration care – the decision is whether we will ration with our eyes open."[32] It seems clear from this high-level appointment that the Obama Administration is open to discussions on rationing health care in the United States.

Chapter 2: ObamaCare's Burdens on Small Businesses

ObamaCare places unprecedented burdens on small businesses in the form of new IRS reporting requirements, higher premiums for healthcare coverage, and new fines and taxes. This chapter outlines many of the new financial burdens and administrative regulations that will confront small-business owners as a result of ObamaCare.

Small businesses in the United States constitute 80% of all new jobs. Given the current economic downturn, small-business owners have an important role to play in improving the unemployment numbers and helping to put Americans back to work. Unfortunately, ObamaCare saddles small-businesses with numerous unnecessary and onerous burdens that will hamper their ability to create new productive jobs.

New IRS Reporting Requirements

One of the most significant changes that will occur next year under ObamaCare is the new IRS reporting requirement for small-business owners. Small-business owners are currently required to issue IRS Form 1099 in a few limited circumstances, such as when they hire freelance workers or consultants. However, under ObamaCare, in every instance when a small-business owner engages in more than $600 of business with a vendor or company, the business-owner will have to issue a 1099 form to that vendor. Consider the following examples:

- A small business that purchases two plane tickets from United Airlines for $695 will have to issue a 1099 to United Airlines.
- A small-business owner pays $100 a month for his cell phone with Verizon (a total of $1,200 for the year). He will have to issue a 1099 to Verizon next year.
- A small-business owner who purchases a $720 copy machine/printer from Office Max will have to issue a 1099 to Office Max.
- A Laundromat in New Jersey that purchases more than $600 of laundry detergent direct from the distributor will have to issue a 1099 to the soap distributor.

Small-business owners next year will be forced to hire accounting services or spend more time laboring over tax documents and forms. This reporting requirement illustrates the extent to

which ObamaCare is actually a bill to increase taxes masquerading as legislation to reform America's healthcare system.

Higher Premiums and Healthcare Costs

Another way in which small businesses will experience financial burdens from ObamaCare is the increased cost of healthcare. The majority of Americans receive their health insurance through employer-sponsored (or employer-subsidized) plans. ObamaCare has already raised premiums for health insurance policies. For example, Anthem Blue Cross Blue Shield (Connecticut) in October 2010 said that their premiums are set to rise up to 47% to comply with the new requirements under ObamaCare.[33] While some employers may pass a portion of these premium hikes on to their employees, many employers will have no choice but to absorb a portion of these costs.

New Fines and Taxes

For those small businesses that are unable to provide health insurance benefits, ObamaCare levies a punitive tax against them. ObamaCare, for the purpose of levying this fee, distinguishes between small businesses that hire fewer than 50 employees, and those that hire 50 or more people. ObamaCare's tax policy dictates that small businesses with fewer than 50 people will be exempt from the fines, but businesses with 50 people or more that do not provide "approved" health insurance plans will be forced to pay a $2,000 fine per employee. (The law exempts the first 30 employees for the purpose of assessing the fine.) This provision will actually operate as an incentive for employers to lay people off in order to reduce their workforce below 50 people so as to avoid this punitive tax.

As an example, consider a hypothetical small business in Flint, Michigan that produces air conditioners. This particular business employs 53 people but its profit margins have been so low due to Michigan's faltering economy that the company has been unable to offer health insurance benefits. Under ObamaCare, this small business will now be forced to pay a $46,000 fine to the federal government. This small business, which already struggles to cover its overhead and make payroll, will be forced to decide whether or not it should lay off 4 people (bringing the total employment to 49) in order to escape this onerous tax fine.

Chapter 3: ObamaCare and Seniors

Since ObamaCare became law in the spring of 2010, the Obama Administration has been promoting the healthcare overhaul to seniors and trying to convince them that these changes will improve their health care. As part of that effort, the Department of Health and Human Services (HHS) distributed a mailer to all Medicare beneficiaries in the summer of 2010, listing all of the "benefits" of the new law for seniors.[34] More recently, HHS launched a television advertising effort featuring Andy Griffith, touting the idea that good things are on the way with the new law.[35]

In spite of the expensive, taxpayer-funded propaganda designed to garner support for ObamaCare, seniors remain firmly opposed to the healthcare takeover. The new law imposes steep cuts in Medicare to pay for other federal entitlement spending. The cuts in Medicare spending will reduce seniors' choices and control over the healthcare and also increase their costs.

Gutting Medicare's only free-market provision: Medicare Advantage

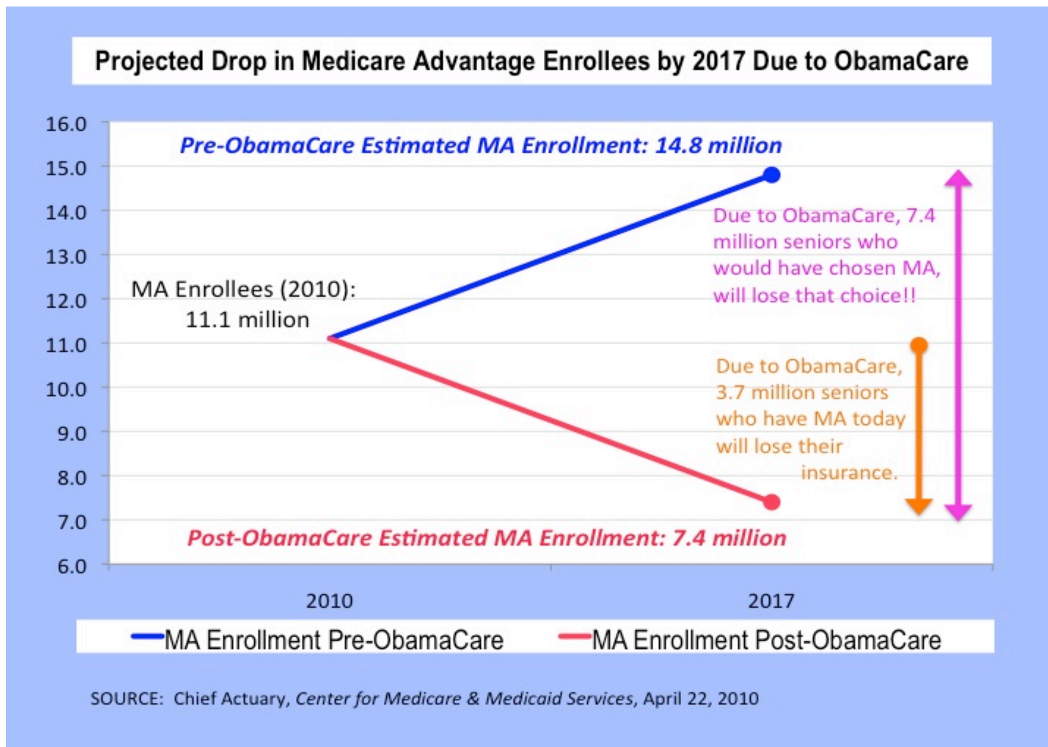
Perhaps most troubling is the law's cut to the Medicare Advantage program. Medicare Advantage (MA) is one of the most popular aspects of Medicare among seniors because of the unique ways it empowers seniors to exercise choices in their healthcare decisions. MA is the private insurance option in Medicare through which beneficiaries can voluntarily elect to get their Medicare coverage through MA plans. Most MA plans provide additional benefits and lower cost-sharing than provided by the traditional Medicare program, which may be one of the reasons more than 10 million Medicare beneficiaries have opted to get their Medicare benefits through these types of programs.

The cuts to Medicare Advantage begin right away, with payment rates frozen in 2011 at their 2010 levels.[36] The reimbursement rates for doctors continue to decline; between 2012 and 2017, the law phases in a new formula for setting maximum MA payments by region. This new formula will dramatically lower MA payments in every region of the country. The new law also makes large cuts to the payment rates for hospitals and other medical providers in the government-managed fee-for-service Medicare program, and a portion of these cuts automatically gets passed through to MA plans as well in the form of even lower maximum rates.

Facing these steep cuts, insurance companies that offer MA plans will be forced to make adjustments in their coverage, raise their premiums, increase their deductibles and co-payments, or eliminate many benefits. In response to ObamaCare's new rules, some plans have already exited the market altogether, taking away many of seniors' options for Medicare Advantage plans.

Furthermore, the Democrats consistently stressed before the passage of the law that anyone who liked his or her health insurance plan would be able to keep it under the new law. For millions of seniors who lose their Medicare Advantage plans, which rate highly for satisfaction among seniors, this promise now rings hollow.

Before ObamaCare passed, the chief actuary for Medicare expected MA enrollment to increase to about 14.8 million in 2017. Now, however, after passage, the chief actuary for Medicare predicts MA enrollment to fall to 7.4 million in 2017.



The deep reductions in MA payment rates and services covered will hit low-income seniors disproportionately hard. Many retirees who have worked for large employers or state and local governments have access to retiree wraparound plans that cover what Medicare does not. Other retirees with sufficient income can purchase Medigap coverage. But lower-income seniors do not have such options. For them, Medicare Advantage has offered better coverage and lower out-of-

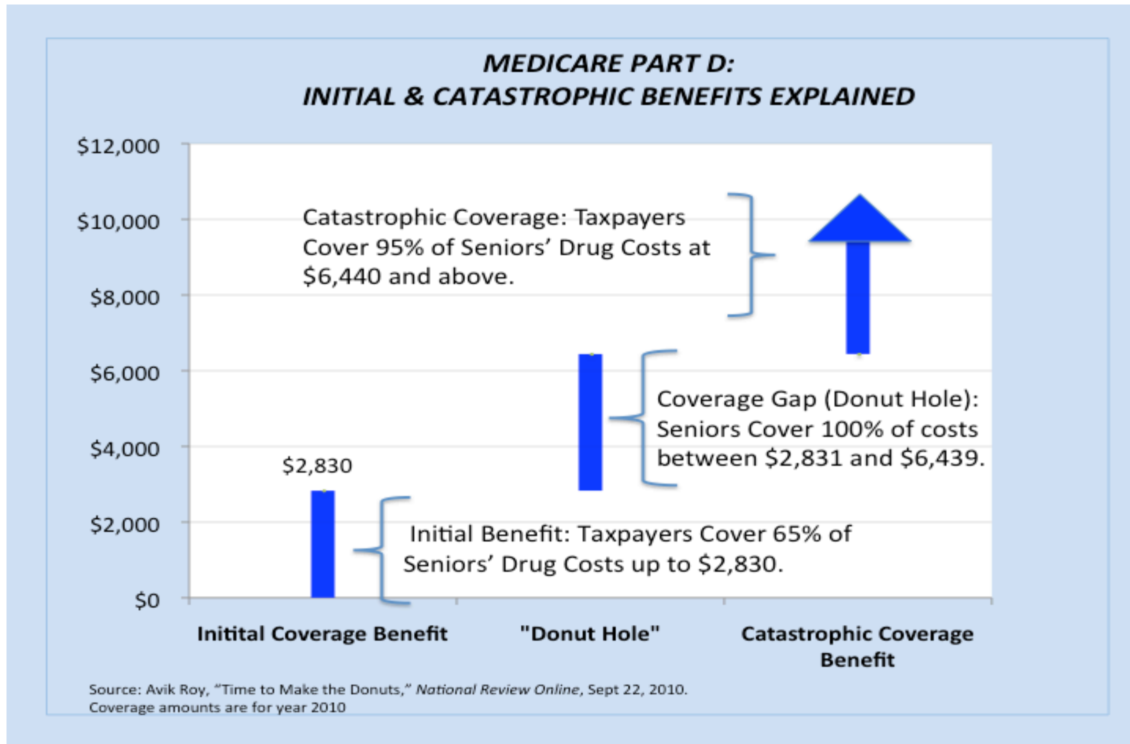
pocket costs than traditional Medicare – and without the expense of another premium payment. Consequently, these lower-income seniors are much more likely than higher-income beneficiaries to sign up with an MA plan, and the cuts will hit them especially hard. It is estimated that a full 70% of the MA reductions will fall on seniors with incomes below $32,400 annually (in today's dollars).[37]

On September 28, 2010 The Boston Globe reported that Harvard Pilgrim Health Care, which is the second-largest health insurer in Massachusetts, dropped out of the market-oriented Medicare Advantage program. As a result, 22,000 senior citizens in Massachusetts, New Hampshire, and Maine will have to find alternative supplemental Medicare coverage.

Because ObamaCare eliminates $548 billion of funding for the privately-managed Medicare Advantage plans, many additional programs are sure to follow Harvard Pilgrim's lead and get out before they start losing money.

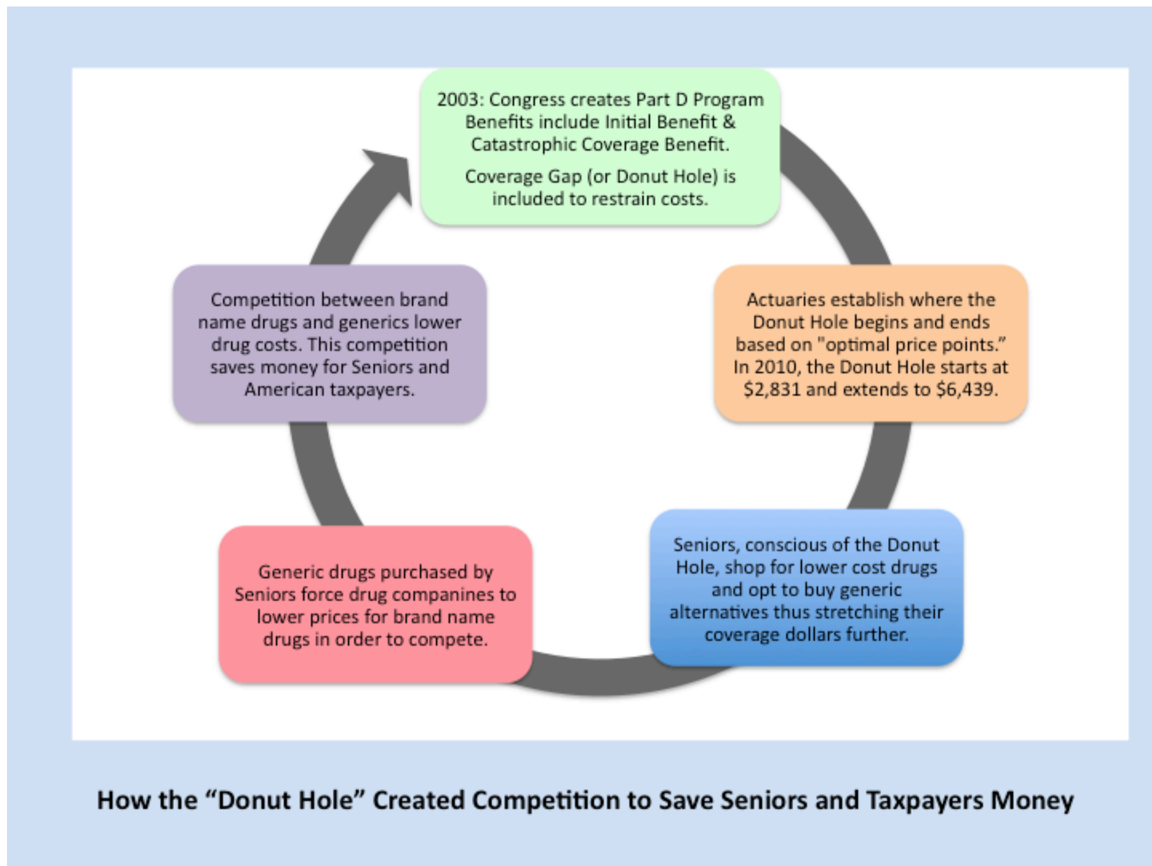
Eliminating the Donut Hole

One of the most devastating provisions of ObamaCare for taxpayers is that it eliminates the Medicare "donut hole." The donut hole is the term for the Medicare Part D coverage gap. It is the difference of the initial coverage limit and the catastrophic coverage threshold. After a Medicare beneficiary exceeds the coverage limit ($2,830 in 2010), he or she enters a "coverage gap" or the "donut hole," at which point 100% of the coverage becomes the Medicare beneficiary's responsibility until the catastrophic coverage begins. However, once that senior hits $6,440 in annual prescription drug expenses, the federal government steps in again with an additional benefit for seniors to cover all costs above that amount. This provision of the Part D program effectively resulted in two levels of coverage for seniors, the first consisting of a "initial" coverage benefit and then second level of coverage consisting of a "catastrophic" benefit. The following chart demonstrates how the donut hole has worked to protect seniors.



Contrary to the Democrats' claims that the donut hole is somehow unfair or bad policy, the donut hole has worked effectively to ***reduce costs*** for consumers and taxpayers alike by incentivizing smart choices by seniors and competition among drug manufacturers. Like HSA's, the donut hole causes seniors to make price-conscious decisions, and encourages them to shop for cheaper alternatives.

As the following chart shows, the donut hole has resulted in lower prices for consumers and for the American taxpayers.



How the "Donut Hole" Created Competition to Save Seniors and Taxpayers Money

The donut hole is one reason why the Medicare Prescription Drug Program has cost taxpayers, and seniors, less than originally projected. Its elimination is another blow to a well-functioning free-market healthcare system.

Decreasing Seniors' Access to Care

One of the many unintended consequences of the bureaucracy and increased regulations established in ObamaCare will be a severe shortage of doctors, particularly doctors who will accept Medicare patients.

In Texas in 2010, only 38% of primary-care doctors will take new Medicare patients. The Mayo Clinic, too, is moving toward cutting its acceptance of Medicare patients because of the low payment rates.

ObamaCare requires a 30% payment cut for Medicare reimbursements to doctors, beginning in January 2011. A recent poll conducted by the American Osteopathic Association found only about

40% of physicians say they will be able to continue seeing their current Medicare patients when these cuts occur. Medicare payments barely cover their costs now, and many doctors foresee losing money on every Medicare patient they treat.

AARP's Special Interest in ObamaCare

AARP, the nation's largest lobbying organization with the mission of protecting the interests of senior citizens, silently allowed Congress to approve cuts to Medicare spending by $400 billion. How could that happen?

AARP takes in more than half of its $1.1 billion annual budget in royalty fees from health insurance companies and other vendors that market services with the organization's name. Medicare supplementary policies, called "Medigap" plans, make up the biggest piece of their royalty pie.

AARP, of course, has a financial interest in selling more Medigap plans. Unfortunately for seniors, Medicare Advantage created unwanted competition and AARP used ObamaCare to eliminate that competition – to the detriment of America's seniors. One of the reasons seniors embraced Medicare Advantage is that it gave them the power to choose better health care services. Seniors who elected plans under Medicare Advantage are currently able to shop around and find plans with lower premiums, better drug coverage, dental care and eyeglasses, and more comprehensive coverage for major medical expenses. Approximately one-fourth of all Medicare beneficiaries participate in Medicare Advantage.

ObamaCare, however, cuts spending for Medicare Advantage by at least $150 billion. Democrats have criticized Medicare Advantage as a "give-away" to private insurance companies.[38] The reality, however, is that nearly all of the additional money spent on this program goes back to seniors in the form of better benefits, so it will be the seniors – not the insurance companies – who have the most to lose.

A *Washington Post* front-page story on October 27, 2009 questioned whether AARP has a conflict of interest in appearing to represent seniors while allowing Congress to cut Medicare. "Democratic proposals to slash reimbursements for…Medicare Advantage are widely expected to drive up demand for private Medigap policies like the ones offered by AARP, according to health-care experts, legislative aides and documents," the *Post* reported.[39]

Chapter 4: ObamaCare's Burdens on the States

Under ObamaCare, by 2014 the federal government will use the 50 states as the primary implementers of the new legislation. ObamaCare imposes significant financial and regulatory burdens on states, including requiring them to create new programs and significantly expand their Medicaid programs.

- States are required to establish at least one "American Health Benefits Exchange" for the purchase of federally-approved health insurance (Unfortunately, the Administration has already distributed, and many states have accepted, federal grant money to encourage the states to explore the creation of these exchanges).
- States have received funding, in the form of grants, from the federal government to implement expensive commissions to oversee health insurance premium rate increases.
- States are required to establish reinsurance programs for plans with high claims.
- States are required to expand Medicaid eligibility for all persons under the age of 65 with incomes at or below 133% of the federal poverty level.

Opposition from the States

Not all states have willingly accepted the new regulations and financial burdens of ObamaCare. In fact, as of January 2011, there are 27 states that are suing in federal court to fight against the massive financial burdens that ObamaCare places on states' burdens.

Florida is among those states resisting ObamaCare. While the states have varying reasons for filing lawsuits, ranging from fiscal reasons to objections based on federalism, Florida's primary complaint about ObamaCare is the financial burden that will result from the Medicaid expansion requirement. As Florida's former Attorney General Bill McCollum said: "[O]ur system of federalism under the U.S. Constitution ensures that federal government cannot bully the states by forcing us into a no-win decision. Obamacare imposes a massive expansion of the Medicaid entitlement program on the states – a financial burden that states and taxpayers do not want and cannot afford."[40]

What the State Legislators Can Do

It is important for state lawmakers to understand that the founding fathers did not envision that the states would serve as the mere implementers of the federal government's massive and overreaching legislation. The system of federalism was designed, in part, to act as a check on the federal government's growth and power. With that in mind, state lawmakers should take actions that put pressure on Congress to abandon or completely overhaul ObamaCare.

1. Reject Federal Funds

One of the most important ways for states to protect themselves from ObamaCare is simply to refuse any of the federal funding attached to the new ObamaCare programs. ObamaCare consists of more than 110 grants for states to apply for, ranging from funding for establishing state exchange programs to grant money for conducting research on the insufficiencies of private health insurance. If states want to remain in control of their health care policies, they should abstain from accepting federal funds, which always come with strings attached.

2. Health Care Compacts

There is also an effort in the states to advance an interstate compact, whereby the federal government would agree to turn over the regulation and oversight of the health insurance industry to each state along with the state's equivalent share of Medicare and Medicaid funding.[41] The states would then assume the responsibility of managing health care with the maximum flexibility afforded the states, free of federal intrusion.

3. Ballot Initiatives

In August 2010, Missouri voters overwhelmingly approved a ballot initiative objecting to the individual mandate contained in ObamaCare. While viewed as largely symbolic, this vote also served notice on Washington of the deep-seated public opposition to ObamaCare and served as a harbinger of the 2010 November elections. These ballot initiatives serve as a legitimate way for citizens to engage on the issues and for lawmakers to fully assess public opposition to ObamaCare.

Chapter 5: Reversing ObamaCare

ObamaCare, if it is fully implemented, will bankrupt the United States, the individual states, eliminate jobs in the private sector, and forever stunt U.S. medical innovation. At a time when several other countries with socialized medical care are looking for ways to introduce free-market principles, it is paradoxical that the United States is moving in the wrong direction – towards a system of more regulation and more centralized control over the entire healthcare industry.[42] In the coming two years, policymakers at both the federal and the state levels should seek methods for reversing ObamaCare.

The most important priority for policymakers is to entirely repeal the healthcare law. There is historical precedent for repeal, and it is instructive to analyze the circumstances under which Congress has previously abandoned its healthcare initiatives. The Medicare Catastrophic Coverage Act of 1988 (H.R. 2470), which passed with bipartisan support in both the House and the Senate, was repealed only one year later. Similarly, the massive Clinton healthcare plan of 1994 faced a huge hurdle in the Senate due to public opposition. In both of these instances, the American public was strongly opposed to these new laws, and Congress moved swiftly to satisfy the public.

While repealing the healthcare law is the most desirable outcome, it is important to remember the current challenge: as long as President Obama remains in the White House, the chances of repeal are minimal. However, in lieu of a total repeal, the GOP – working in concert with moderate Democrats – can actively work to undermine, stall, challenge, and, ultimately, derail ObamaCare.

This chapter is organized around the concept of federalism – that derailing ObamaCare can occur at both the state and the federal levels.

I. At the State Level

As detailed in the previous chapter, ObamaCare forces states to serve as vehicles of the federal health care policy. States, as such, are required to comply with a multitude of new expensive regulations, including expanding Medicaid eligibility for all persons under the age of 65 with incomes at or below 138% of the federal poverty level. It is important to note that the CMS Actuary

estimates that slightly more than half of the anticipated 34 million newly insured Americans under the law will be covered by Medicaid.[43] This fact is important because it highlights the extent to which ObamaCare is a massive expansion of unsustainable entitlement programs, rather than a fundamental improvement of our nation's healthcare system.

All of these new regulations open up possibilities for states to rebel and refuse to comply with the additional financial burdens, which will undoubtedly drive many states' budgets further into the red.

As of January 2011, a sizeable majority of the governorships across the country are now held by Republicans who oppose ObamaCare. These governors could simply refuse to implement the "health-care exchanges" which are such a central part of ObamaCare. Governors can also introduce market-friendly versions of exchanges as an alternative to ObamaCare. State-designed exchanges could provide consumers with a variety of options, which ObamaCare neglects, making the programs more attractive to voters. These state programs could provide better information to consumers, simplify enrollment, reduce costs, and expand coverage by granting individuals the same tax benefits as people covered by employer plans.

Another avenue that governors opposed to ObamaCare can pursue is the issuance of Executive Orders prohibiting the state agencies from applying for any ObamaCare grants. Former Minnesota Governor Tim Pawlenty issued an Executive Order to this effect and other governors would be wise to follow his lead.[44]

II. At the Federal Level

While the states can play an important role in non-compliance, the federal policymakers can play an important role in creating hefty oversight and launching investigations into the progress of ObamaCare. The following suggestions detail the various ways that Congress can scale back ObamaCare's effects before the law is fully repealed.

A. Congressional Oversight:

One of the most important things policymakers can do in the 112th Congress is to conduct oversight hearings and in-depth investigations. Congress should use its authority to investigate each new ObamaCare expenditure, particularly the ones that exceed previous predictions.

Furthermore, Congress can also disapprove regulations. Congress has the power, through the Congressional Review Act, to review all new regulations that will be contained in the implementation of ObamaCare. Most of the ObamaCare regulations put unjustifiable authority over personal healthcare matters in the hands of bureaucrats. Congress should remember that bureaucrats in the Executive Branch are unelected and thus, unaccountable to the voters and citizens of the United States. It is, therefore, increasingly important for Congress to maintain rigid review standards of all of the regulations that ObamaCare dictates.

Another opportunity for Congress would be to pass a law requiring that all ObamaCare boards, commissions, and new offices receive Congressional approval for their heads. This requirement would be extremely popular with Americans, as there is currently a heightened awareness of all the power and authority that regulators and bureaucrats possess.

B. Implementation

Congress should seek to postpone implementing some of ObamaCare's unpopular features, including those provisions related to tax increases, the expansion of Medicaid and the cuts to Medicare Advantage.

C. Defunding

Congress could begin by targeting the most unpopular provisions contained in the healthcare law and simply refuse to fund those provisions. Among the list of things that will require new funding:

- 16,000 new IRS agents (charged with enforcing the mandates in the law)
- The Indian health initiatives
- The grants for nurses' programs
- New facilities for community medicine

Congress should simply refuse to designate any funds that will be used for the new bureaucracies, offices, regulators, or grants under ObamaCare. In addition, ObamaCare contains a series of

appropriations for 2011 and beyond that should be repealed or the funding reprogrammed (used for offsets for other programs).

Chapter 6: Real Reform Proposals

Policymakers working to repeal ObamaCare must also recognize the importance of implementing real reform along the way to replace – not simply abolish – ObamaCare. The following chapter details many of the most pressing reform possibilities.

Addressing the cost of healthcare

Despite the rhetoric from the left, government has no ability to control the true cost of healthcare. Any attempts by government to establish price controls are arbitrary and artificial, as they do not take into account economic reality. As the respected economist Thomas Sowell has noted, government only has two mechanisms at its disposal to reduce prices: rationing care or forcing others to subsidize the healthcare costs of others. Neither of these options reduces the true cost of healthcare; instead they only serve to deny access or shift costs.

On the other hand, government can play a role in fostering competition within the health insurance industry. One of the ways to help lower costs within the free market is to widen the playing field. Related to the health insurance industry, this would generally require the ability for individuals to purchase health insurance across state lines.

Another significant way to reduce the cost of healthcare in the United States is to introduce tort reform and amend the laws that currently allow for frivolous, "junk" lawsuits.

Promoting healthy lifestyles

One of the things conservatives and liberals agree on, is that healthier lifestyles will dramatically curb health insurance costs for American families. Child and adult obesity levels have skyrocketed in recent decades, contributing to the country's high level of diabetes. Similarly, smoking, poor diets, alcohol, and lack of exercise contribute to many preventable diseases and ailments for Americans.

Liberals frequently choose to address these problems by establishing ineffective mandates and laws, or by creating taxpayer-funded commissions and councils. New York state's law requiring fast food companies to advertize their Calorie counts in each food item and First Lady Michelle Obama's "Let's Move" program are two examples that reveal the liberal mentality that Americans'

health habits can be altered through legislation and government commissions. Studies conducted by both New York University and Columbia University demonstrate the ineffectiveness of these types of programs.[45] The Democrats' anti-smoking, sex education, and weight reduction education programs have all failed miserably in their efforts to curb unhealthy behaviors.

A more realistic approach to promoting healthy lifestyles is to enable (and encourage) health insurance companies to offer discounted rates to people who exercise regularly, have normal body weight, and do not smoke. These types of financial incentives have proven to be an effective mechanism for improving people's health. Furthermore, this type of approach recognizes that health insurance companies are in the business of managing and assessing risk and this mechanism empowers the health insurance companies to offer discounts for healthy living, while not taking on unnecessary risks.

Addressing pre-existing conditions

Congress should address the challenge that many Americans with pre-existing conditions face when trying to switch jobs or move to a new state.

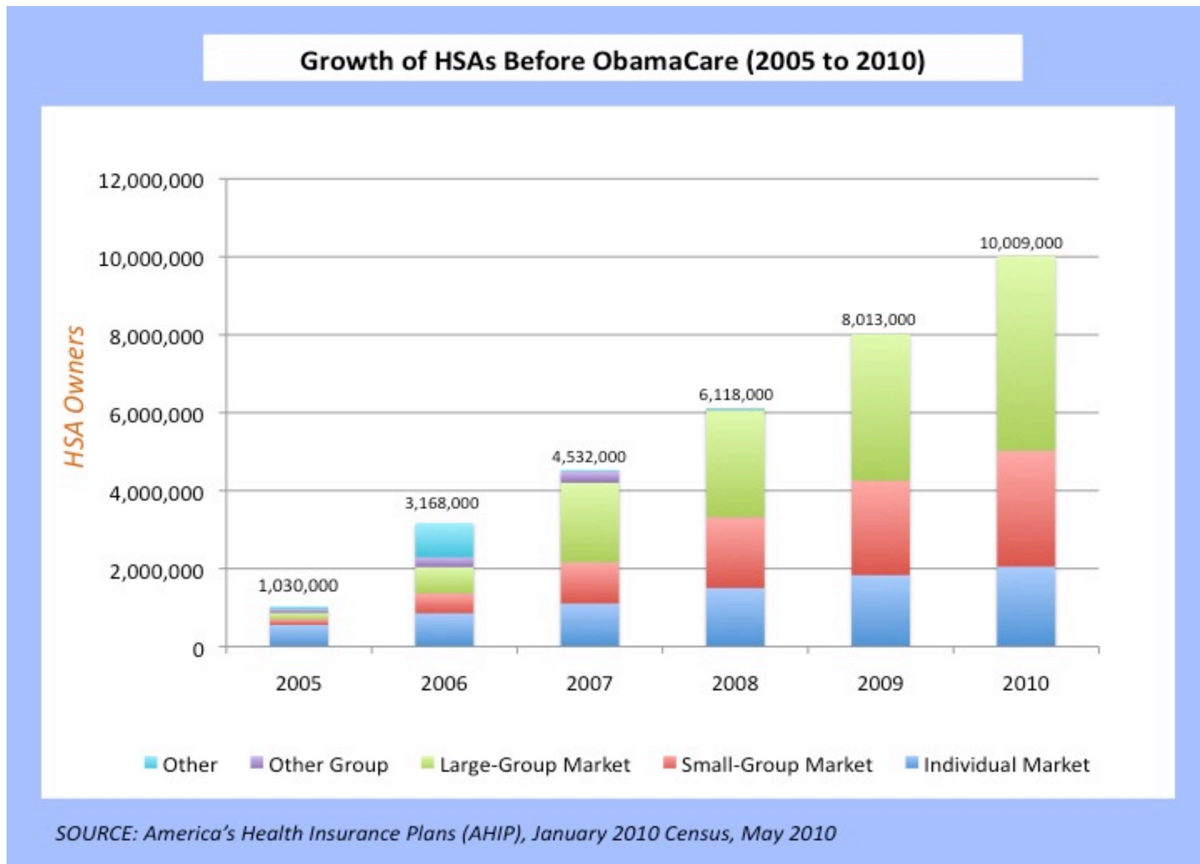
ObamaCare eliminates the ability of insurance companies to deny coverage for pre-existing conditions beginning in 2014, but it does so in a way that will actually encourage people to wait until the become seriously ill before obtaining insurance. This will only increase the cost of health insurance over the long-term. Imagine how expensive auto insurance would be if a driver could buy collision coverage *after* the driver has totaled his car (likely enough to cover all of the repairs). This would dramatically increase the cost for auto insurance.

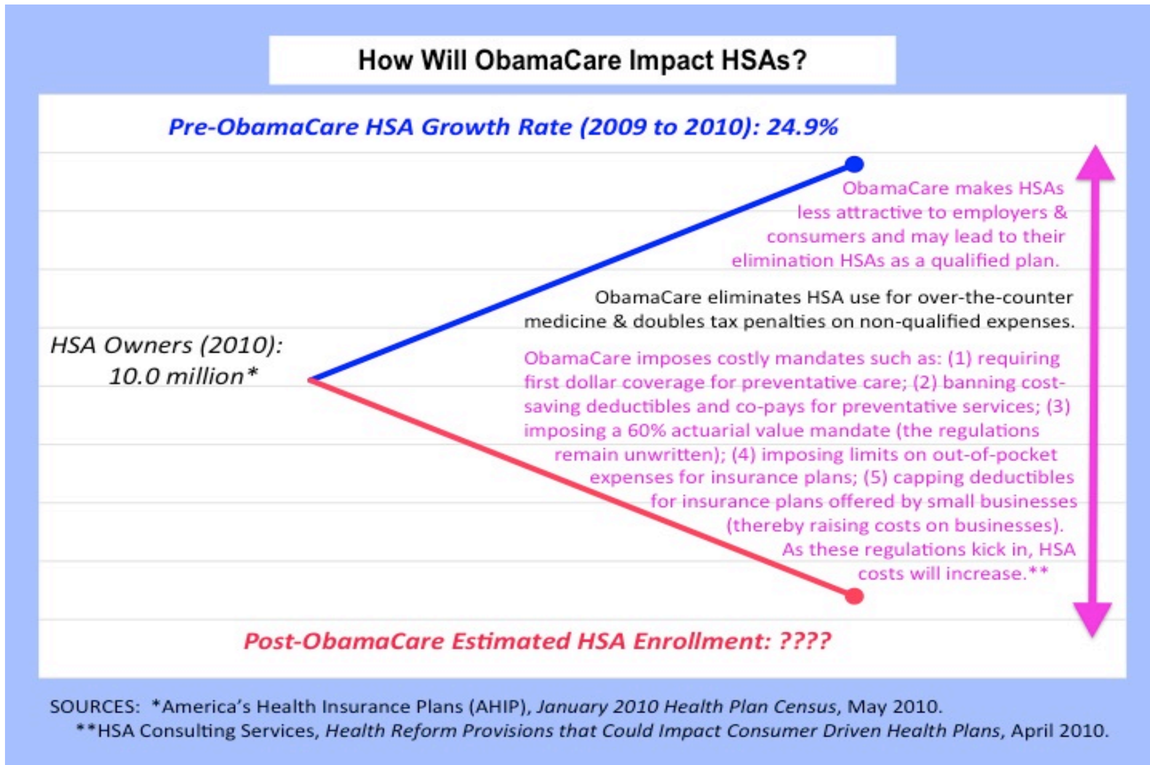
A better approach for Congress to deal with pre-existing conditions, while still encouraging people to maintain health insurance coverage before they get sick, would be to prevent denial of coverage for pre-existing conditions for persons who had comparable coverage in place at the time they were diagnosed with their condition.

Another way to protect Americans with pre-existing conditions is to create new restrictions, preventing insurers from unjustly cancelling a policy when people become ill.

Encouraging small-business health plans & health savings accounts (HSAs)

An important part of real healthcare reform includes provisions that allow self-employed Americans and small businesses to pool together to buy health insurance in the same way that large corporations do. Additionally, the tax code should not discriminate against individuals who buy a high deductible health plan (HDHP) coupled with a personal health savings account (HSA). Americans who choose HSAs currently have to use post-tax dollars to pay their health-care premiums. However, Congress could change the law to allow consumers to pay for these premiums with pre-tax dollars, out of an individual's HSA, thus creating a level playing ground for small-business employees and self-employed Americans.





As the effort to defund and dismantle ObamaCare continues it will be important for opponents of the new law Congress to adopt policies that adhere to free-market principles and rely on innovative and practical ideas to improve America's healthcare system, including ways to protect people with pre-existing conditions and those who are not employed by large corporations.

CONCLUSION

As Congress works to repeal ObamaCare, it is increasingly important to look for solutions that will put the free market front and center. While the U.S. healthcare system has several flaws and problems that should be addressed, ObamaCare's sweeping, one-size-fits-all approach that will bankrupt the states is certainly not the correct solution.

Congress should work to put consumers back in control of their healthcare by emphasizing HSA's over traditional employer-sponsored plans and by promoting and strengthening Medicare Advantage plans.

Appendix A: New Taxes Contained in ObamaCare

NEW TAX	10-Year Tax Revenue (In Billions)
New tax on individuals who do not purchase government-approved health insurance	**$17.0**
New tax on employers who fail to fully comply with government health insurance mandates	**$52.0**
New 40% excise tax on certain high-cost health plans	**$32.0**
New ban on the purchase of over-the-counter drugs using funds from FSAs, HSAs, and HRAs	**$5.0**
Increase the Medicare tax on wages and self-employment income by 0.9% and impose a new 3.8% surtax on certain investment income (for individuals over $200,000 and couples over $250,000)	**$210.2**
Increase, from 7.5% to 10% of income, the threshold after which individuals can deduct out-of-pocket medical expenses	**$15.2**
Impose a new $2,500 annual cap on FSA contributions	**$13.0**
New annual tax on health insurance	**$60.1**
New annual tax on brand name pharmaceuticals	**$27.0**
New 2.3% excise tax on certain medical devices	**$20.0**
New 10% tax on indoor UV tanning services	**$2.7**
New tax on insured and self-insured health plans	**$2.6**
Double the penalty for non-qualified HSA distributions	**$1.4**
Eliminate the deduction for expenses allocable to Medicare Part D subsidy	**$4.5**
Limit the deduction for compensation to officers, employees and directors of certain health insurance providers	**$0.6**
Require information reporting on payments to corporations	**$17.1**

Appendix B: Simple Steps to Derail ObamaCare

- ✓ *Don't fund it.* Begin with the most politically unpopular provisions, such as hiring 16,000 additional IRS agents to enforce the mandates in the new law, and refuse to fund them. Also eliminate funding for the new grant programs and councils and bureaucracies created by the law (including rescinding appropriations contained in the law itself).

- ✓ *Shore up bipartisan support:* Supporters of repeal in the House should begin looking for sections of ObamaCare that have bipartisan support for repeal. The 1099 filing burden for small-businesses, as well as the long-term-care CLASS Act are two possible areas for action. With enough bipartisan support, President Obama's veto pen will be rendered impotent.

- ✓ *Postpone implementation.* Postponing cuts to the popular Medicare Advantage program and putting off $500 billion in new taxes would be a politically sound move for the GOP in 2011.

- ✓ *Disapprove regulations.* Through the Congressional Review Act, Congress has the power to review (and thus, disapprove) the new regulations contained in ObamaCare. Simply disapproving of these numerous regulations would stall, and potentially derail, ObamaCare.

- ✓ *Provide oversight and launch investigations:* Former CBO director Doug Holtz-Eakin estimates subsidies for health insurance could cost as much as $1.4 trillion, not $450 billion as promised. Congress can use its authority to investigate each new ObamaCare expenditure.

Appendix C: ObamaCare Timeline for Implementation

2010

- States and federal officials review premium increases
- FDA authorized to approve "follow-on" biologics
- Increase brand name pharmaceutical Medicaid rebate (from 15.1% to 23.1%)
- Medicare payments to physicians in primarily rural areas increase (2 years)
- Deny "black liquor" eligibility for cellulosic bio-fuel producers credit
- Tax credits provided to certain small employers for healthcare-related expenses
- Increase adoption tax incentives for 2 years
- Codify economic substance doctrine and impose penalties for underpayments (transactions on/after 3/23/10)
- Provide income exclusion for specified Indian tribe health benefits provided after 3/23/10
- Temporary high-risk pool and high-cost union retiree reinsurance ($5 billion each for 3.5 years) (6/23/10)
- Impose 10% tax on indoor UV tanning (7/1/10)
- Medicare cuts to inpatient psych hospitals (7/1/10)
- Prohibits lifetime and annual benefit spending limits (plan years beginning 9/23/10)
- Prohibits non-group plans from canceling coverage (rescissions)(plan years beginning 9/23/10)
- Requires plans to cover, at no charge, most preventive care (plan years beginning 9/23/10)
- Allows dependents to stay on parents' policies through age 26 (plan years beginning 9/23/10)
- Provides limited protections to children with pre-existing conditions (plan years beginning 9/23/10)
- Hospitals in "Frontier States" (N.D., Mont., Wyo., S.D., Utah) receive higher Medicare payments (fiscal 2011)
- Hospitals in "low-cost" areas receive higher Medicare payments for 2 years ($400 million, Fiscal Year 2011)

2011

- Medicare Advantage cuts begin
- No longer allowed to use FSA, HSA, HRA, Archer MSA's for over-the-counter drugs
- Medicare cuts to home health begin
- Wealthier seniors ($85k/$170k) begin paying higher Part D premiums (not indexed for inflation in Parts B/D)
- Medicare reimbursement cuts for diagnostic imaging (like MRIs, CT scans, etc.)
- Medicare cuts for ambulance services, ASCs, diagnostic labs & durable medical equipment

- Impose new annual tax on brand name pharmaceutical companies
- Americans begin paying premiums for federal long-term care insurance (CLASS Act)
- Health plans required to spend a minimum of 80% of premiums on medical claims
- Physicians in "Frontier States" (N.D., Mont., Wyo., S.D., Utah) receive higher Medicare payments
- Prohibition on Medicare payments to new physician-owned hospitals
- Penalties for non-qualified HSA and Archer MSA distributions double (to 20%)
- Seniors prohibited from purchasing power wheelchairs unless they first rent for 13 Months
- Brand name drug companies begin providing 50% discount in the Part D "donut hole"
- 10% Medicare bonus payment for primary care and general surgery (5 years)
- Employers required to report value of health benefits on W-2
- Steps towards health insurance administrative simplification (reduced paperwork, etc) begins (five-year process)
- Additional funding for community health centers (five years)
- Seniors who hit Part D "donut hole "in 2010 receive $250 check (3/15/11)
- New Medicare cuts to long-term care hospitals begin (7/1/11)
- Additional Medicare cuts to hospitals and cuts to nursing homes and inpatient rehab facilities begin (fiscal 2012)
- New tax on all private health insurance policies to pay for comparative effective research (plan years beginning fiscal 2012)

2012

- Medicare cuts to dialysis treatment begins
- Require information reporting on payments to corporations
- Medicare to reduce spending by using an HMO-like coordinated care model (Accountable Care Organizations)
- Medicare Advantage plans with a 4 or 5 star rating receive a quality bonus Payment
- New Medicare cuts to inpatient psych hospitals (7/1/12)
- Hospital pay-for-quality program begins (fiscal 2013)
- Medicare cuts to hospitals with high readmission rates begin (fiscal 2013)
- Medicare cuts to hospice begin (fiscal 2013)

2013

- Impose $2,500 annual cap on FSA contributions (indexed to CPI)
- Increase Medicare wage tax by 0.9% and impose a new 3.8% tax on unearned, non-active business income for those earning over $200,000 or $250,000 for families (not indexed to inflation). Generally increases (7.5% to 10%) threshold at which medical expenses, as a percentage of income, can be deductible
- Eliminate deduction for Part D retiree drug subsidy employers receive

- Impose 2.3% excise tax on medical devices
- Medicare cuts to hospitals which treat low-income seniors begin
- Post-acute pay for quality reporting begins
- CO-OP Program: Secretary of Health and Human Services awards loans and grants for establishing nonprofit health insurers
- $500,000 deduction cap on compensation paid to insurance company executives
- Part D “donut hole” reduction begins, reaching a 25% reduction by 2020

2014

- Individuals without government-approved coverage are subject to a tax of the greater of $695 or 2.5% of income
- Employers who fail to offer “affordable” coverage would pay a $3,000 penalty for every employee that receives a subsidy through the Exchange
- Employers who do not offer insurance must pay a tax penalty of $2,000 for every full-time employee
- More Medicare cuts to home health begin
- States must have established Exchanges
- Employers with more than 200 employees can auto-enroll employees in health coverage, with opt-out
- All non-grandfathered and Exchange health plans required to meet federally mandated levels of coverage
- States must cover parents/childless adults up to 138% of poverty on Medicaid (receive increased FMAP)
- Tax credits available for Exchange-based coverage, amount varies by income up to 400% of poverty
- Insurers cannot impose any coverage restrictions on pre-existing conditions (guaranteed issue/renewability)
- Modified community rating: individual or family coverage; geography; 3:1 ratio for age; 1.5:1 for smoking
- Insurers must offer coverage to anyone wanting a policy and every policy has to be renewed
- Limits out-of-pocket cost-sharing (tied to limits in HSAs, currently $5,950/$11,900 indexed to COLA)
- Insurance plans must include government-defined “essential benefits ” and coverage levels
- OPM must offer at least two multi-state plans in every state
- Employers can offer some employees free choice vouchers for health insurance in the Exchange
- Government board (IPAB) begins submitting proposals to cut Medicare
- Impose tax on nearly all private health insurance plans
- Medicare payment cuts for hospital-acquired infections begin (fiscal 2015)

2015

- More Medicare cuts to home health begin

2016

- States can form interstate insurance compacts with HHS approval (2016)

2017

- Physician pay-for-quality program begins for all physicians
- States may allow large employers and multi-employer health plans to purchase coverage in the Exchange
- States may apply to the HHS secretary for a limited waiver from certain federal requirements

2018

- Impose “Cadillac” tax on “high cost” plans, 40% tax on the benefit value above a certain threshold: ($10,200 individual coverage, $27,500 family or self-only union multi-employer coverage

NOTES

[1] P.L. 111-148, see Sections 9004 (related to punitive taxes and increased restrictions on HSAs), 9002 (related to increased burden to report employer costs of health insurance on W-2s), and 9006 (related to expansion of 1099 reporting burden imposed on small businesses).
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[5] The incentive to drop employer-sponsored health care is not solely limited to the private sector. Former Democratic Governor of Tennessee, Phil Bredesen, criticized ObamaCare and explained how states would be financially better off by dropping employer-sponsored and retiree health plans and pushing their employees into the federal insurance exchanges. See Philip Bredesen, "ObamaCare's Incentive to Drop Insurance," *Wall Street Journal*, October 21, 2010. Available at: http://online.wsj.com/article/SB10001424052702304510704575562643804015252.html
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[21] Centers for Medicare & Medicaid Services, Actuarial Report, April 22, 2010. Available at: http://www.docstoc.com/docs/35791321/4222010-CMS-Actuary-Report-on-the-Affordable-Care-Act
[22] The Stupak-Pitts Amendment was an amendment to the proposed Affordable Health Care for America Act of 2010 (the House version healthcare reform). Reps. Bart Stupak (D-MI) and Joseph Pitts (R-PA) jointly submitted this amendment. The stated purpose of the Amendment was to prohibit the use of federal funds "to pay for any abortion, or to cover any part of the costs of any health plan that includes coverage of abortion." Exceptions would be made for cases of rape, incest, or physical risk to the mother. The amendment was adopted by the House, but was not included in the Senate version, the Patient Protection and Affordable Care Act, which passed and was subsequently "deemed to have been passed" by the House on March 23, 2010.
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[42] For more information about socialized medicine in other countries, see Sally C. Pipes, *The Truth about ObamaCare: What They Don't Want You to Know about Our New Health Care Law* (Washington, DC: Regnery Publishing, Inc, 2010), 7-21.
[43] Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010.
[44] "The Federal Health-Care Tease: Minnesota's Governor Declines to Take the ObamaCare Bait," *The Wall Street Journal*, September 9, 2010, p. A16.
[45] Tamara Dumanovsky et al, "Consumer Awareness of Fast-Food Calorie Information in New York City After Implementation," *Am J Public Health* 2010, 100: 2520-2525.