WHITE PAPER

Healthcare Reform 2.0:

How the current administration may transform the industry

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Hospitals, health plan issuers[1], and states are trying to understand the impact of the various repeal and replace scenarios under consideration by the Trump administration and possibly influence the direction of these policy decisions. Wakely's goal is to provide quantitative, objective information to support these discussions. Our perspective is based on extensive experience supporting states, provider systems, issuers, the federal government and others prior to and during the implementation of the Affordable Care Act (ACA) and over the subsequent years of its operation, and is informed by proprietary Wakely data sources[2] and studies using those data[3].

This paper explores the most prominent policies under consideration and the issues that stakeholder should be keyed in on as the legislative process develops. Wakely is working on other papers that will dive more deeply into some of the key issues discussed below, especially those that affect financing and risk selection. The opinions expressed in this paper are those of the authors and do not represent any official position of Wakely Consulting Group.

The Fundamental Issue at Play

One of the biggest questions that the drafters of the ACA faced was how to make quality health coverage available to everyone while controlling anti-selection impacts to the market. Their solution was to require issuers to provide health insurance without consideration to health status, and then implement a complex set of subsidies, penalties, mandates, enrollment periods, benefit requirements, and premium stabilization mechanisms to help ensure broad take-up. The ACA has been credited with decreasing the uninsured rate as well as providing insurance to individuals who had difficulty obtaining it in the past due to health status. However, this approach has also been criticized for reducing the ability of issuers to innovate, increasing administrative overhead, and increasing the costs of coverage considerably.

[1] In the remainder of this paper we use the term "issuer" to refer to insurance companies and other health plans subject to the ACA

[2] Wakely has collected data representing over 25 million lives in the individual and small group markets through the Wakely National Risk Adjustment Reporting (WNRAR) project, the Wakely Risk Insights National Reporting (WRINR) project, and through other initiatives.

[3] For example, see "The Profitable Conditions" at http://www.wakely.com/wp-content/uploads/2016/11/The-Profitable-Conditions-White-Paper.pdf, "The Profitability of the Sickest Members" at http://www.wakely.com/wp-content/uploads/2016/11/The-Profitability-of-the-Top-0.5-Sickest-White-Paper.pdf, and "Young, Healthy, and the Transitional Members – The Unexpected Consequences" at http://www.wakely.com/wp-content/uploads/2016/11/The-Young-and-Healthy-The-Unexpected-Consequences-White-Paper.pdf

The challenge now faced by congressional Republicans is to devise an approach that keeps the portions of the law that are perceived by both parties as achieving a societal good, such as guaranteed issue requirements, while lowering costs and fostering a fair, competitive marketplace[4]. So what dimensions will the new administration have to consider, what options are currently on the table, and how likely are they to work? Those are the complex questions that we begin to explore in this paper.

Political Considerations

In the weeks preceding the inauguration of Donald Trump, the House of Representatives initiated a budget reconciliation process with the intent of defunding most aspects of the ACA. By writing the initial reform as a budget bill, the Republicans were able to advance the bill through the Senate with only a simple majority instead of the 60 vote super-majority normally needed to end debate and avoid an inevitable Democrat filibuster.

Shortly following his inauguration, the President signed an executive order calling on federal agencies to waive or delay ACA rules that they deemed onerous. Given the vague and open-ended nature of this order, the ultimate manner in which it may be interpreted is largely unknown at this point.

There are several sponsored plans that have been proposed for replacement of the ACA. These plans include:

- A Better Way – Congressman Paul Ryan (R-WI)[5]
- Empowering Patients First Act – HHS Secretary Tom Price (R-GA)[6]
- Patient CARE Act – Sen. Orrin Hatch (R-UT), Sen. Richard Burr (R-NC), Congressman Fred Upton (R-MI)[7]
- Health Care Choice Act - Sen. Ted Cruz (R-TX)[8]
- American Health Care Reform Act - Congressman David Roe (R-TN)

[4] For background see "An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes" published by the AAA at https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf and "Washington State Health Insurance Market Analysis" published by Wakely Consulting Group at https://www.insurance.wa.gov/about-oic/reports/commissioner-reports/documents/hbe-market-analysis-final.pdf

[5] http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf

[6] http://tomprice.house.gov/sites/tomprice.house.gov/files/Section%20by%20Section%20of%20HR%202300%20Empowering%20Patients%20First%20Act%202015.pdf

[7] http://www.hatch.senate.gov/public/_cache/files/bf0c9823-29c7-4078-b8af-aa9a12213eca/The%20Patient%20CARE%20Act%20-%20LEGISLATIVE%20PROPOSAL.pdf

[8] https://www.cruz.senate.gov/files/documents/Bills/20150302_Healthcare_Choice.pdf

- Patient Freedom Act – Senators Bill Cassidy (R-LA), Susan Collins (R-ME), Shelley Moore Capito (R-WV), Johnny Isakson (R-GA)

Despite Republican control of the Executive and congressional branches, there is a wide range of outcomes that may result from the legislative process. Some possible scenarios include the following:

- In-fighting between more extreme and more moderate Republicans, combined with the filibuster power of Democrats in the Senate may result in no change to the law,
- The law may be cosmetically altered and re-branded under a so-called "repair" scenario,
- The law may be changed primarily insofar as passing to the states the power to keep or alter portions of the law under a more robust form of the waiver process than was written into the original ACA,
- One or more of the competing legislative proposals may be used or combined in a way that can achieve the necessary votes for adoption in both houses of Congress, or
- The ACA may be repealed without a feasible plan for replacing it with a new regime, though political considerations make this scenario unlikely.

A few common themes are shared between several of the draft versions of legislation proposed so far. While the final legislation, assuming a new law is ultimately passed, is far from known at this point, we believe it will likely include several of the following characteristics based on these common themes and consistent signals provided by Republicans:

- Inclusion of guaranteed issue requirements
- Some form of income tax credits
- Elimination of the individual and employer mandates, or move to late enrollment penalties analogous to those used for Medicare Part D
- Elimination of most essential health benefit and actuarial value requirements
- Elimination or loosening of age / sex rating requirements
- Favorable tax treatment of individual health savings accounts (HSAs)
- Expanded risk pooling options
- Re-introduction of some form of high risk pools or other funding mechanism for high-risk enrollees

- Maintenance of dependent coverage requirement to age 26
- Permission to sell health insurance across state lines
- Elimination of the Medicaid expansion or a move give states more control over how to spend grant funds
- Repeal of ACA taxes and fees

The level of detail provided in the versions of draft legislation varies enormously across the drafts, from conceptual framework to fully specified proposal.

The Individual Mandate

One essential component of the ACA is a tax penalty for individuals without health insurance. The goal of this rule was to encourage young and health people to buy insurance, keeping the overall risk pool healthy and rates affordable and stable. The problem is that the penalty was set low enough that someone who did not want insurance could benefit from declining coverage.

If the ultimate form of the replacement legislation for the ACA ends up keeping in place provisions that continue to make the market unattractive for young and healthy individuals (e.g., 3:1 age rating), then the challenges associated with designing and enforcing an individual mandate will have to be considered. Virtually all forms of Republican draft legislation considered to date repeal the individual mandate. As a result of Trump's executive order the IRS has made optional the question on 2016 income tax returns asking whether the filer had maintained health coverage during the year, essentially eliminating enforcement of the individual mandate.

High-Risk Pools

Republicans have discussed high-risk pools as a solution to help increase the overall number of people with health coverage, increase the number of issuers participating in the insured markets, and reduce premiums for non-high-risk pool members. Some of these plans specify a certain level of federal funding to help defray the substantial cost of these pools. Sen. Ryan's "A Better Way" plan, for example, would provide $25 billion over 10 years in grants to help fund these high-risk pools. The pools would be required to cap premiums (though it is not clear at what levels) and would be prohibited from imposing waiting lists.

Several of the prominent plans under discussion introduce continuous coverage protection, modeled after the Health Insurance Portability and Accountability Act (HIPAA), which would apply to individuals in both the employer and individual markets. For plans proposing this protection, anyone who maintains continuous coverage cannot be charged more than standard rates. High-risk pools would be established to provide a safety net option of coverage to those who do not maintain continuous coverage. Under this

approach, high-risk pool premiums would likely be higher than standard rates in order to mitigate adverse selection associated with people choosing coverage only when they need care.

The proposed solution of high-risk pools comes with many questions and an abundance of criticism and skepticism. Will there be waiting periods? Will there be lock-in periods (i.e., the member must remain in the high-risk pool for at least a certain number of months)? When and how will members transition back into the larger risk pool? What premiums will these consumers be charged (i.e., what percent above average non-high-risk pool rates)? What benefits will they be offered? And to what extent will states versus the federal government make these and other policy decisions?

Past experience with 35 state-based high-risk pools and more recent experience with the national Pre-Existing Condition Insurance Plan (PCIP) shed light on some of the criticisms of this approach. A fundamental question regarding high risk pools is that if they just take costs out of one pool and put them in another, thereby not really changing overall costs, this may only create a mechanism to charge people who are not eligible for the standard risk pool more than someone who can (i.e., it creates two risk pools). High-risk pools have historically proven to be expensive for states to administer, expensive for consumers to join, and offered limited choice, if any, in selecting a network of providers. The more individuals who opt out of enrollment in response to these obstacles, the more uncompensated care ends up being delivered by providers, resulting in a different problem to fund. Republicans recognize the difficulty in funding high-risk pools, and there will likely be efforts to resolve this difficult problem.[9]

Association Health Plans

Since before the introduction of the ACA, some individuals or small businesses banded together in the form of Association Health Plans. These plans were effectively treated as large group plans, and attained many of the same benefits as large employer plans. These plans could be operated with lower premium rates since they incurred lower commissions and other administrative expenses, achieved good pooling of risks, and if they were self-insured did not have to comply with mandated benefit requirements or pay premium tax.

On implementation of the ACA these plans, in their traditional form, threatened the spirit of the law since they would have permitted groups of healthy members to form, seek coverage as a large group, and worsen the health status of the remaining members in the individual and small group markets. To resolve this issue the authors of the ACA decided that except under stringent criteria, associations would be regulated under the market from which their members would have enrolled in the absence of the association (i.e., either individual or small group), eliminating some of the incentives that these plans had to form. One response to this change was a move towards self-insured small groups when allowed by

[9] For additional background see "Using High-Risk Pools to Cover High-Risk Enrollees" published by the AAA at http://www.actuary.org/content/using-high-risk-pools-cover-high-risk-enrollees

state law. Note that in practice, the actual regulation of associations and self-insured small groups varies substantially from state to state, as well as the interpretation and enforcement of these rules.

Several of the proposed versions of draft legislation explicitly seek to create and regulate a thriving association market. For the reasons described above, this approach is generally not consistent with a single risk pool environment. As regulation develops, the decisions made in the area of permitted risk pooling will influence the degree to which health status ends up impacting rates and the overall structure of the insurance markets throughout the country.

Rating Rules

Section 147.102 of the ACA sets in place several premium rating rules intended to ensure fair health insurance premiums. These rules restrict variation in premium rate setting by age, gender, smoker status and family size. Few specifics are yet available on what proposed restrictions may be incorporated into future legislation with the exception of age rating. Several of the proposed plans would increase the current 3:1 ACA age restriction and allow issuers to charge the oldest enrollees five times as much as younger enrollees. In addition, these plans allow for States to elect a different ratio.

The 3:1 age ratio restriction has been controversial and considered one of the cost drivers that are keeping young people from entering the insurance marketplaces. The ratio is blamed for artificially increasing premium on younger and healthier individuals, resulting in an older and sicker risk pool for the remaining market.

In an analysis completed by the RAND Corporation, the premium rate for a 24 year old would decline from $2,800 to $2,100 while the rate for a 64 year old would increase from $8,500 to $11,000[10]. Their review indicates that while widening the ratio may increase the number of younger people with coverage, older people will end up being priced out of the market. Their final conclusion is that limited coverage gains would result from a change in the age rating ratios.

The Minimum Loss Ratio (MLR) requirements of the ACA have been a foundation of the law since 2011. While no proposed replacement plan specifically addresses the MLR, this requirement will likely be a fixture in healthcare financing. The MLR requirement has also become a component of Medicare and is soon to be implemented for Medicaid reporting in 2017, further supporting its continuation.

Plan Designs

The ACA mandated certain plan design requirements including benefit richness targets called actuarial values (AVs), and a package of minimum covered benefits, called the Essential Health Benefits (EHBs). In short, AVs require that issuers classify plans into one of several coverage tiers (or metal levels) based on

[10] http://www.commonwealthfund.org/publications/blog/2015/sept/charging-older-adults-higher-premiums-could-cost-taxpayers

the expected percentage of allowed charges that will be paid by the issuer for a standard population. For example, a Gold plan is a plan with an AV between 78% and 82%[11]. This means that the issuer, on average for a standardized population, would pay between 78% and 82% of total medical expenses, with members paying the remainder in way of cost sharing. EHBs are a set of 10 required benefits that must be covered under all ACA-compliant plans. Issuers may offer benefits on top of EHBs but, at minimum, the EHBs must be covered in each plan.

Sen. Paul Ryan's bill, for example, discusses removing the AV and EHB requirements in order to reduce premiums through higher levels of cost-sharing (i.e., lower AVs) and more limited benefits (i.e., not covering all EHBs). This could be more appealing to younger and healthier consumers or those not receiving subsidies under the ACA because they are above the income threshold. On the other hand, it could also lead to plans not covering maternity or limiting mental and behavioral health coverage as was common prior to the implementation of the ACA. EHBs are part of the package of ACA provisions that limit incentives to enroll healthy individuals. In the absence of EHBs and risk adjustment, issuers would have incentives to exclude coverage for services related to certain high cost conditions such as maternity.

Taxes & Fees

The approaches proposed by the sponsored plans compared to existing ACA taxation and fee elements in addition to a possible budget reconciliation include the following:

Elimination of Employer Mandate

The employer mandate penalizes employers for failing to offer affordable, minimum value medical coverage to their full-time employees and their dependents.

- The budget reconciliation approach essentially eliminated the mandate by revising the penalty to $0.
- The "Health Care Choice Act" would eliminate the mandate without additional restrictions.
- Three other plans, "A Better Way", "Empowering Patients First Act" and the "Patient CARE Act" would replace the mandate and penalty with a cap on the tax exclusion for employer sponsored coverage. The "A Better Way" plan does not yet specify the amount of the cap, but the "Employing Patients First Act" proposes a cap of $8,000 for an individual and $20,000 for a family. The amount will be indexed.[12] The "Patient CARE Act" will institute a higher cap on the exclusion for employees' health coverage at $12,000 for an individual and $30,000 for a family and index it at CPI+1 in perpetuity.

[11] A recently proposed rule would expand the range of these AV thresholds for 2018
[12] http://www.commonwealthfund.org/publications/issue-briefs/2015/mar/medical-loss-ratio-year-three

Elimination of the High-Cost Plan Tax

- The high-cost plan tax popularly known as the "Cadillac Tax" will most likely be eliminated. This feature of the ACA has been highly unpopular and its implementation was already delayed to 2020 with the December 2015 appropriations bill. The tax could easily be eliminated through budget reconciliation or through anticipated changes in how employer-sponsored plans will be handled in proposed plans.
- No proposed plan contemplates extension of the Cadillac tax or incorporating a similar mechanism.

Elimination of the Medicare Tax

- The ACA currently applies a 0.9% payroll tax on wages and self-employment income and a 3.8% tax on dividends, capital gains, and other investment income for taxpayers earning over $200,000 (singles)/$250,000 (married).
- The tax could easily be eliminated with a budget reconciliation measure. No proposed senator-sponsored plan specifically address changes to the Medicare program and its taxation. The "Better Health" program does incorporate a mission to improve the "fiscal health of Medicare".
- The "Health Care Choice Act" would not change this component of the ACA.
- Dependent upon budgetary concerns, the Medicare Tax could persist.

Elimination of the Health Insurance Provider (9010) Fee

Similar to the Cadillac Tax, the Health Insurance Provider (9010) Fee has been highly unpopular, and the December 2015 appropriations bill put a one-year moratorium on this tax for 2017. It would likely only require a simple budget reconciliation measure to eliminate this tax indefinitely. The Republican plans as proposed do not indicate a continuation of this fee, implying that it will be eliminated.

There are several other taxes that are found in the ACA that have been unpopular and would likely face repeal. The first is the medical device tax which also received a moratorium with the December 2015 appropriations bill. Likewise, the tax on tanning beds is susceptible. Additionally, the Patient-Centered Outcomes Research Institute (PCORI) fee is susceptible to repeal. The ACA created the Patient-Centered Outcomes Research Trust Fund to serve as the funding vehicle for the PCORI. The PCORI, is a private, non-profit corporation which is charged with sponsoring clinical effectiveness research that assists patients, clinicians, employers, issuers and policymakers in making better informed health decisions.

Selling Across State Lines

Several of the proposed versions of draft legislation promote the idea of selling health insurance across state lines. Ostensibly, the rationale is that health insurance rates vary widely by geography due to limited

competition, and that lowering the barrier for an issuer to enter a new market would cause premiums to drop to the level of the most efficient issuers in the country.

In reality, this change is not likely to materially impact premium rates. The differences in rates by geography are primarily influenced by factors that would not go away under implementation of this rule such as difference in payment rates expected by providers and medical practice patterns, as well as the demographics, health status and income of the patient population in each market.

In addition, allowing issuers to sell insurance across state lines would not remove the biggest barrier against an issuer expanding its geographic reach. Most issuers are regionally limited due to the high costs of building a provider network robust enough to service new markets, so it is not clear to what extent this component of a proposed law would be used in practice without further details.

One of the consequences of this component of the draft legislation might be to corner states into deregulating health insurance. Plans with provider networks in multiple states may domicile their business in the state with the least restrictive regulations. Lack of regulations may translate into the ability to offer lower cost plans. For example, if an issuer is domiciled in a state that does not require autism coverage but all other states do, then all else equal, the issuer may be able to sell their plans at a lower cost in these 'other states' because it does not have to cover autism benefits while their competitors do. States may be forced to deregulate to prevent issuers from relocating their states of domicile to other states with fewer regulations.

Private Exchanges

Private exchanges are not new but their use expanded under the ACA. The private exchanges are online insurance marketplaces where employees and individuals can get information about health coverages, determine their eligibility for subsidies, and elect coverage. The private exchanges often include access to additional voluntary products and services that would not be available through federal or state run marketplaces.

Some of the advantages for employers and employees participating in these private exchanges are: 1) overall costs may be lowered through a defined contribution approach to healthcare, 2) more options are available to employees, and 3) administrative responsibilities for employees are lowered.

The value of the private exchanges is driven by the quality of information and tools available to employees to assist them in the decision making process. Although most healthcare proposals eliminate the employer mandate, it is unlikely that employer coverage will cease.

The use of private exchanges to date has been limited. Mercer's 2015 National Survey of Employer-Sponsored Health Plans found that only 6% of large employers either use a private exchange or planned

to implement one in 2016.[13] Their use may be of interest in a post-ACA healthcare reform environment. Several proposals indicate a move towards a limit on the employer tax exclusion, meaning the appeal of a per-employee defined contribution solution may increase for employers to maximize their tax position.

Subsidies

Subsidy Background and Present Landscape

Subsidies have been a cornerstone of the ACA, ensuring low- and middle-income families can afford health care coverage both through Advanced Premium Tax Credits (APTCs) and Cost Share Reduction (CSR) plans. Subsidies and Medicaid expansion drove the vast majority of the reduction in uninsured attributed to the ACA[14]. APTCs provide a premium subsidy to enrollees based on the difference in a premium contribution cap (calculated by the enrollee's Federal Poverty Level percentage) and a benchmark plan. CSRs reduce a member's cost sharing beyond a base silver plan while charging the enrollee the premium of a base silver. A key provision for these subsidies is that they can only be applied to enrollees purchasing coverage on Exchange, increasing the success of the Exchange marketplaces.

The uncertainty surrounding the ACA under the new administration pertains especially to the future of these subsidies. There is some speculation that it will be politically difficult to remove entitlement programs such as these subsidies and doubt that much change or restriction will occur as a result. However, many sources, including the Republican proposals, discuss altering the current subsidy structure or removing subsidies and replacing them with other mechanisms.

Impact of Removing Subsidies

Removing subsidies without a replacement will severely disrupt the market.

The RAND Corporation completed a study in 2014 considering the impact of removing APTCs from all states. They found that a complete removal of APTCs would cause enrollment in individual ACA-compliant plans to drop by 68% and cause unsubsidized premiums to increase by 43% in the individual market. In 2015, RAND completed another study, based only on removing APTCs from federally facilitated marketplace (FFM) states, and found similar results of enrollment decreasing by 70% within the ACA-compliant individual market (in FFM states) and unsubsidized premiums increasing by 47% in the ACA-compliant individual market (in FFM states).[15]

[13] https://www.mercer.com/newsroom/national-survey-of-employer-sponsored-health-plans-2015.html

[15] http://www.rand.org/pubs/research_reports/RR980.html

According to another source, “more than eight in 10 ACA customers receive federal subsidies to help pay for their premiums” which will not change before the new administration.[16]

Replacement for Subsidies

The “replacements” for subsidies discussed by the current administration include 1) providing tax credits that vary by age and / or income, 2) allowing individuals to deduct all health insurance premiums through changes in the tax code (effectively equalizing the tax treatment between individuals buying insurance through the Exchange and those purchasing insurance through employers), and 3) expanding availability of health savings accounts (HSAs). These methods have been criticized since those currently receiving subsidies often pay little in taxes (so the deduction of health premiums would have a minimal impact) and these enrollees do not necessarily have much discretionary income to contribute to HSAs.[17]

RAND has estimated the impact of the Republican proposed policies relative to the ACA as of 2018. The results are that a full repeal of the ACA would lead to 19.7 million more uninsured relative to the ACA. If the tax deduction for premiums was introduced, they estimated the insured would fall 15.6 million relative to the ACA.[18]

In regard to CSRs, the federal government could stop defending some lawsuits involving this subsidy, most notably *House v. Burwell*. If the appeal for *House v. Burwell* is withdrawn, the reimbursements to issuers for CSRs could stop with nothing to replace them.

Alternative Subsidy Scenarios

Alternative scenarios have been presented in various publications. Common proposals center around fixed-dollar tax credits or deductions to reduce healthcare premiums. Some proposals have universal fixed-dollar credits and deductions and others vary the payments based on an individual’s income level, age, or have different amounts for individuals versus families.

Most notable are the following proposals:

- **“Empowering Patients First Act”.** Refundable tax credits to purchase health plans, adjusted for age (but not income level), "tied to average insurance on individual market adjusted for inflation" (but not tied directly to a current plan offering).
- **“A Better Way”.** Refundable tax credits to purchase health plans, adjusted for age (but not income level), which would be "large enough to purchase the typical pre-Obamacare health insurance

[16] https://www.washingtonpost.com/news/to-your-health/wp/2016/11/17/the-ultimate-qa-about-health-care-under-president-trump/

[17] http://healthaffairs.org/blog/2016/11/09/day-one-and-beyond-what-trumps-election-means-for-the-aca/

[18] http://www.rand.org/blog/2016/09/estimating-the-impacts-of-the-trump-and-clinton-health.html

plan" through multiple portals including private exchanges. Any excess after purchasing a plan would be put into an HSA, and the amount of the credit would not be tied to a current plan offering.

- **"Patient CARE Act".** Refundable tax credits to purchase health plans, adjusted for age, for those with income less than 300% FPL (with a phase down between 300% FPL and 200% FPL) and aged 64 years or younger. The credit would be indexed to CPI+ 1, and the amount of the credit would not be tied to a current plan offering.

The 2014 RAND study compared the impact of the ACA subsidy structure to alternatives such as fixed-dollar contributions that do not vary by age or premium. The conclusion was, "premiums are more sensitive to changes in the share of young adult enrollees under alternative subsidy arrangements." Since the current APTC protects enrollees against premium increases, there are not large variations in premiums for enrollees receiving APTCs from year to year if they choose the benchmark plan. In a fixed-dollar scenario, however, enrollees would more greatly feel the impact of increasing premiums, with younger and healthier members potentially dropping out if premiums increase too much.[19] Proponents of fixed-dollar contributions argue that this method reduces the government's obligation for healthcare inflation and keeps insurance companies "in check" by fostering competition to keep as many enrollees as possible.

However, any regulation would likely take time to be drafted, passed, implemented, and summarized for public education. Under Sen. Paul Ryan's plan, the current subsidy would be phased out over several years to allow transition to a replacement program.

The road ahead is likely to be complex as the draft versions of legislation discussed in this paper, and other versions yet to come, make their way through the legislative process and potentially to the President's desk. Wakely will monitor the debate and weigh in to bring relevant facts to light.

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[19] http://www.rand.org/content/dam/rand/pubs/research_reports/RR700/RR708/RAND_RR708.pdf