

# FOIA Marker

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Records Management, White House Office of (WHORM)

Subject Files - FG001-07 (Briefing Papers)

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Folder Title:

1222132

# Withdrawn/Redacted Material

## Obama Presidential Library

DOCUMENT NO.	FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
001	Schedule	Schedule of the President	5	01/06/2017	P6/b6;
002	Calendar	[Calendar]	5	01/2017	P6/b6;
003	Memorandum	Daily Economic Briefing - To: POTUS - From: Jeff Zients	4	01/05/2017	P5;
004	Memorandum	Vox Live Interview - From: Liz Allen, Kristie Canegallo	3	01/06/2017	P5; P6/b6;
005	Report	Updates on Health Care Debate	3	N.D.	P5; Transferred
006	Memorandum	Interview with George Stephanopoulos - From: Rob O'Donnell and Brooke Lillard	3	01/05/2017	P5;
007	Talking Points	Talking Points	7	N. D.	P5;

**COLLECTION TITLE:**

**Records Management, White House Office of (WHORM)**

**SERIES:**

**Subject Files - FG001-07 (Briefing Papers)**

**FOLDER TITLE:**

**1222132**

**FRC ID:**

**9828**

**RESTRICTION CODES**

**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P1 National Security Classified Information [(a)(1) of the PRA]**
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]**
- P3 Release would violate a Federal statute [(a)(3) of the PRA]**
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]**
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]**
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]**

**PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).**

**Deed of Gift Restrictions**

- A. Closed by Executive Order 13526 governing access to national security information.**
- B. Closed by statute or by the agency which originated the document.**
- C. Closed in accordance with restrictions contained in donor's deed of gift.**

**Freedom of Information Act - [5 U.S.C. 552(b)]**

- b(1) National security classified information [(b)(1) of the FOIA]**
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]**
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]**
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]**
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]**
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]**
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]**
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]**

**Records Not Subject to FOIA**

**Court Sealed - The document is withheld under a court seal and is not subject to the Freedom of Information Act.**

**Paul Raizk**

**1222132**

**FG001-07**

**Executive Office of The President  
Barcode Scanning Sheet**



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Collection Code:

**SECLOG**

**Scanned by  
ORM**

Staff Name:

Document Date:

**January 06, 2017**

Correspondent:

Subject/Description:

**BRIEFING PAPERS**



**SCHEDULE OF THE PRESIDENT**

**\*PRIVATE\***

**MEETING BREAKDOWN FOR PRESIDENT BARACK OBAMA  
FRIDAY, JANUARY 6, 2017  
WASHINGTON, DC**

*Back from the OVAL  
1/6/17*

10:00 – 10:30 am      **PRESIDENTIAL DAILY BRIEFING**  
Location:      The Oval Office  
PRESS:      CLOSED

- |                       |
|-----------------------|
| <b>Attendees:</b>     |
| 1. The Vice President |
| 2. Denis McDonough    |
| 3. Susan Rice         |
| 4. Avril Haines       |
| 5. Lisa Monaco        |
| 6. Colin Kahl         |
| 7. Ben Rhodes         |
| 8. Director Clapper   |
| 9. Suzanne Fry        |
| 10. Daniel Flynn      |

10:50 – 10:55 am      **EVENT PREP**  
Location:      The Oval Office  
POC:      Peter Velz  
PRESS:      CLOSED

- |  |
|--|
| <b>Attendees:</b>                        |
| 1. Kristie Canegallo                     |
| 2. Josh Earnest                          |
| 3. Liz Allen                             |
| 4. Katie Hill, Assistant Press Secretary |

10:55 – 11:00 am      **WALKING MOVEMENT EN ROUTE BLAIR HOUSE**

**NOTE:** The PRESS POOL and White House Videographer will capture **YOUR** walk to the Blair House

11:00 – 11:05 am      **ARRIVE BLAIR HOUSE // ARRIVAL GREET // MOVE TO THE LINCOLN ROOM (HOLD)**  
Location:      Blair Door, Blair House  
                         1651 Pennsylvania Ave. NW  
                         Washington, DC 20503  
Site:      Andrea Richter  
Hold:      Lincoln Room, First Floor  
Staff Hold:      Protocol Office, First Floor  
PRESS:      POOLED FOR OUTSIDE GREET // CLOSED FOR INSIDE GREET

**Greeted outside the Blair House by (POOLED PRESS):**  
- Randy Bumgardner, Blair House Manager



**Greeted in the Front Drawing Room by (CLOSED PRESS):**

- Ezra Klein, Editor-in-Chief, Vox.com
- Sarah Kliff, Senior Correspondent, Vox.com

11:05 – 11:10 am

**MAKEUP // MOVE TO OSA**

Location: Lincoln Room, First Floor, Blair House (Hold)  
 Site: Andrea Richter  
 PRESS: CLOSED

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**NOTE:** [redacted] YOU are lav'd at off-stage announce

11:10 – 11:55 am

**VOX LIVE INTERVIEW**

Location: Garden Room, First Floor, Blair House  
 POC: Liz Allen  
 Attendees: Approximately 85 participants, seated  
 Setup: **YOU** are seated on an 8-foot by 4-foot stage. Behind **YOU** is the Garden Room mantle with a Vox logo placed on top. Three chairs are positioned on the stage with water tables in between, and POTUS flags frame the stage edges.  
 Sound/Podium: Lav Mic // None  
 PRESS: POOLED // LIVESTREAMED ON WH.GOV AND VOX.COM

**Format:**

- Ezra Klein introduces **YOU** to stage
- **YOU** move to stage from stage LEFT and take **YOUR** seat
- **YOU** participate in a 40-minute interview with Ezra Klein (**NOTE:** Towards the end of the interview, Sarah Kliff takes a question for **YOU** from the audience)
- Interview concludes and **YOU** depart

11:55 – 12:05 pm

**WALKING MOVEMENT EN ROUTE THE OVAL OFFICE**

**NOTE:** The PRESS POOL and White House Videographer will capture **YOUR** walk back to the White House

12:10 – 12:20 pm

**OVAL OFFICE DROP-BY**

Location: The Oval Office  
 POC: Ferial Govashiri  
 PRESS: CLOSED

12:30 – 1:00 pm

**LUNCH**

Location: The Oval Office  
 PRESS: CLOSED

1:00 – 1:30 pm

**POTUS TIME**

Location: The Oval Office  
 PRESS: CLOSED

1:30 – 1:55 pm

**DESK TIME**



Location: The Oval Office  
PRESS: CLOSED

1:55 – 2:00 pm

**STAFF SECRETARY TIME**

Location: The Oval Office  
POC: Joani Walsh  
PRESS: CLOSED

**YOU sign:**  
1. S. 3084: American Innovation and Competitiveness Act

2:00 – 3:00 pm

**WHITE HOUSE DEPARTURE PHOTOS**

Location: The Oval Office  
POC: Tess Udall // Divya Kantamneni  
Attendees: 252 attendees // 57 clicks  
PRESS: CLOSED

**Format:**

- YOU welcome departing staff members and their families into the Oval Office
- YOU pose for a photograph with each group
- After each photo, the group departs and YOU repeat this process for approximately 56 clicks
- Following the last click, all guests depart

Attendees manifested in the event memo

3:15 – 3:45 pm

**WRAP UP**

Location: CoS Office  
POC: Jenny Wang  
PRESS: CLOSED

4:00 – 4:05 pm

**MOVE TO THE DOCTOR'S OFFICE**

4:05 – 4:15 pm

[Redacted]

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Location: The Doctor's Office  
POC: Peter Velz // Desiree Barnes  
PRESS: CLOSED

**Attendees:**  
1. Josh Earnest  
2. Jen Psaki  
3. Ben Rhodes  
4. Ned Price  
5. Denis McDonough (optional)

4:15 – 4:20 pm

**MOVE TO LOWER CROSS HALL**



4:20 – 4:30 pm

**WALK & TALK INTERVIEW WITH GEORGE STEPHANOPOULOS OF ABC THIS WEEK**

Location: Lower Cross Hall, The Residence  
POC: Rob O'Donnell  
Attendees: **YOU** + George Stephanopoulos, Host, ABC This Week  
Setup: Walk and Talk Interview (Path: Lower Cross Hall to the Palm Room, down the West Colonnade and concluding at the Oval Office)

Sound/Podium: Lav Mic // None

PRESS: CLOSED // TAPED TO AIR ON JANUARY 8

**Format:**

- **YOU** move to the bottom of the Public Staircase in the Lower Cross Hall
- **YOU** greet George Stephanopoulos (**NOTE:** This greet is ON CAMERA)
- **YOU** are fitted with a lav mic
- **YOU** participate in a 5-minute walk and talk interview with George Stephanopoulos
- **YOU** and George Stephanopoulos walk down the Lower Cross Hall towards the Palm Room and conclude at the Oval Office
- **YOU** move to the Oval Office

4:30 – 4:35 pm

**MOVE TO THE OVAL OFFICE**

4:35 – 5:15 pm

**SIT-DOWN INTERVIEW WITH GEORGE STEPHANOPOULOS**

Location: The Oval Office  
POC: Rob O'Donnell  
Attendees: **YOU** + George Stephanopoulos, Host, ABC This Week  
Setup: **YOU** are seated across from George Stephanopoulos in front of the Resolute Desk.

Sound/Podium: Lav Mic // None

PRESS: CLOSED // TAPED TO AIR ON JANUARY 8

**Format:**

- **YOU** take **YOUR** seat
- **YOU** participate in a 20-minute sit-down interview with George Stephanopoulos
- **YOU** conclude and bid farewell to George Stephanopoulos; George Stephanopoulos and the crew depart

5:30 – 5:50 pm

**OVAL OFFICE DROP-BY'S WITH THE FIRST LADY**

Location: The Oval Office  
POC: Ferial Govashiri  
PRESS: CLOSED

5:50 – 6:30 pm

**OVAL OFFICE DROP-BY'S**

Location: The Oval Office  
POC: Ferial Govashiri  
PRESS: CLOSED

[Redacted] P6/b(6)



	P6/b(6)
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9:25 – 9:30 pm

**MOVE TO THE STATE FLOOR WITH THE FIRST LADY**

9:30 – TBD pm

**PRIVATE EVENT**

Location: The State Floor  
POC: Kristina Broadie  
PRESS: CLOSED

RON

**THE WHITE HOUSE**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<p><b>HONOLULU, HI</b> <b>ON BOARD AFI</b></p> <p>Scheduler: Rothblum</p> <p>9:25-9:55 pm- En Route Joint Base Pearl Harbor-Hickam</p> <p>9:55-10:00 pm- Arrive//Load Air Force One</p> <p>10:00 pm- Wheels Up Joint Base Pearl Harbor-Hickam to Joint Base Andrews</p> <p>RON ON BOARD AFI</p>	<p><b>ON BOARD AFI</b> <b>WASHINGTON, DC</b></p> <p>Scheduler: Rothblum</p> <p>11:40-11:45 am- Arrive JBA//Load Marine One</p> <p>11:45-11:55 am- Lift from Joint Base Andrews to the South Lawn</p> <p>11:55-12:00 pm- Proceed to Residence // Down PM- No Schedule</p> <p>RON WH</p>	<p><b>WASHINGTON, DC</b></p> <p>Scheduler: Boyle</p> <p>10:00-10:30 am- PDB</p> <p>11:30-11:40 am- Oval Office Drop-By (Jackie Walker &amp; Family-FG)</p> <p>12:00-12:20 pm- (2) Oval Office Drop-Bys (Bob Bauer, daughter &amp; spouse; Bob Bauer + Atty's-FG)</p> <p>12:30-1:00 pm- Lunch</p> <p>1:00-1:05 pm- Foreign Leader Call Prep to President Erdogan of Turkey</p> <p>1:05-1:50 pm- Foreign Leader Call to President Erdogan of Turkey</p> <p>2:00-2:15 pm- Oval Office Drop-By (Nicola Green-BR)</p> <p>2:30-3:30 pm- WH Departure Photos</p> <p>3:45-3:55 pm- Prep</p> <p>3:55-4:00 pm-</p> <p>4:00-4:30 pm- Hold for Israeli TV Interview</p> <p>4:30-4:35 pm- Move to Oval Office</p> <p>4:50-4:45 pm- Move to the Residence</p> <p>4:55-5:10 pm- Group Photos</p> <p>5:10-5:15 pm- Move to the Oval Office</p> <p>5:30-6:00 pm- Wrap Up</p> <p>6:00-6:30 pm- Desk Time</p> <p>RON WH</p>	<p><b>WASHINGTON, DC</b></p> <p>Scheduler: Bollinger</p> <p>9:15-9:20 am- En Route Capitol Building</p> <p>9:20-9:25 am- Arrive//Arrival Greet</p> <p>9:25-9:30 am- Move to Green Room</p> <p>9:30-9:35 am- Greet with Stage Participants</p> <p>9:35-10:35 am- Meeting with House and Senate Dem Caucis</p> <p>10:40-10:45 am- En Route WH</p> <p>10:45-10:50 am- Arrive WH//Move to Oval Office</p> <p>11:00-11:05 am- Move to the Cabinet Room</p> <p>11:05-11:15 am - POOL SPRAY</p> <p>11:15-12:30 pm- Meeting w/Joint Chiefs of Staff and Combatant Commanders</p> <p>12:30-12:35 pm- Move to the Oval Office</p> <p>12:35-1:05 pm- Lunch</p> <p>1:05-1:30 pm- POTUS Time</p> <p>1:30-1:50 pm- Desk Time</p> <p>1:50-2:00 pm- Make-A-Wish Visit</p> <p>2:05-2:20 pm- En Route Joint Base Myer-Henderson</p> <p>2:20-2:25 pm- Arrive Joint Base Myer - Henderson//Arrival Greet</p> <p>2:25-2:30 pm- Move to Off-Stage Announce</p> <p>2:30-3:45 pm- DoD Farewell Parade</p> <p>3:40-4:00 pm- En Route WH</p> <p>4:00-4:05 pm- Arrive the WH // Move to the Oval Office</p> <p>4:10-4:40 pm- Meeting per ADB</p> <p>4:40-4:45 pm- Move to the Residence</p>	<p><b>WASHINGTON, DC</b></p> <p>Scheduler: Bollinger</p> <p>10:00-10:30 am- PDB</p> <p>10:55-11:00 am- Move to the Map Room</p> <p>11:00-11:30 am- OPSQ Time</p> <p>11:30-11:35 am- Move to the Oval Office</p> <p>11:35-11:55 am- ROTUS Time</p> <p>11:55-12:15 pm- PRO Recognition Photos</p> <p>12:25-12:55 pm- Lunch</p> <p>1:00-2:00 pm- NSC Time</p> <p>2:05-2:10 pm- Move to the Doctor's Office</p> <p>2:20-2:55 pm- Live from the WH: Regional TV Interviews</p> <p>2:55-3:00 pm- Move to the Oval Office</p> <p>3:15-3:20 pm- Move to the Roosevelt Room</p> <p>3:20-3:45 pm- Weekly Address &amp; Video Taping (VR, Farewell Trailer)</p> <p>4:00-4:05 pm- Meeting Prep</p> <p>4:05-4:10 pm- Move to the China Room</p> <p>4:10-5:00 pm- PCAST Meeting</p> <p>5:00-5:10 pm- Group Photo w/PCAST Members</p> <p>5:10-5:15 pm- Move to Oval Office</p> <p>5:30-6:00 pm- Wrap Up</p> <p>6:00-6:30 pm- Desk Time</p> <p>RON WH</p>	<p><b>WASHINGTON, DC</b></p> <p>Scheduler: Bollinger/Rothblum</p> <p>10:00-10:30 am- PDB</p> <p>10:50-10:55 am- Event Prep</p> <p>10:55-11:00 am- Walking Movement En Route Blair House</p> <p>11:00-11:05 am- Arrive Blair House //Arrival Greet//Move to Hold</p> <p>Announce</p> <p>11:10-11:55 am- VOX Live Interview</p> <p>11:55-12:05 pm- En Route the Oval Office</p> <p>12:10-12:20 pm- Oval Office Drop-By (Cornell's Family-FG)</p> <p>12:30-1:00 pm- Lunch</p> <p>1:00-1:30 pm- POTUS Time</p> <p>1:30-1:55 pm- Desk Time</p> <p>1:55-2:00 pm- Move to the Doctor's Office</p> <p>2:10-2:15 pm- Move to Lower Cross Hall</p> <p>2:15-2:25 pm- Walk and Talk Interview with George Stephanopoulos</p> <p>2:25-2:30 pm- Move to the Oval Office</p> <p>2:30-2:55 pm- Sit-Down Interview with George Stephanopoulos</p> <p>3:05-4:05 pm- WH Departure Photos</p> <p>4:20-5:00 pm- (4) Oval Office Drop-By's (RT Rybak; Mai Lassiter &amp; son Jay; Devin Parekh; Margo Lion; Eddie Vedder-FG)</p> <p>5:00-5:20 pm- Oval Office Drop-By's w/the First Lady (Kerry Washington &amp; Family; Kristen Jarvis &amp; Family)</p>	<p><b>WASHINGTON, DC</b> <b>JACKSONVILLE, FL</b> <b>WASHINGTON, DC</b></p> <p>Scheduler: Rothblum</p> <p><b>DOMESTIC TRAVEL</b></p> <p>3:30-3:35 pm- Load Marine One</p> <p>3:35-3:45 pm- Lift from the South Lawn to JBA</p> <p>3:45-3:50 pm- Arrive JBA // Load AF-1</p> <p>3:50-5:50 pm- Wheels Up JBA to Jacksonville Int'l Airport</p> <p>5:50-5:55 pm- Arrive Jacksonville Int'l Airport // Load Motorcade</p> <p>6:50-7:00 pm- Hold for Photos // Departure Greet</p> <p>7:05-7:30 pm- En Route Jacksonville Int'l Airport</p> <p>7:30-7:35 pm- Arrive Jacksonville Int'l Airport//Load AF-1</p> <p>7:35-9:20 pm- Wheels Up Jacksonville Int'l Airport to JBA</p> <p>9:20-9:25 pm- Arrive JBA // Load Marine One</p> <p>9:25-9:35 pm- Lift from JBA to the South Lawn</p> <p>9:35-9:40 pm- Arrive the South Lawn // Down</p> <p>RON WH</p>

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			4:45-5:15 pm- Reception w/Ambassadors 5:15-5:20 pm- Move to the Oval Office 5:25-5:35 pm- Oval Office Drop-By (Franco Harris-MD) 5:40-6:00 pm- Wrap Up 6:00-6:30 pm- Desk Time  RON WH		5:25-5:30 pm- Staff Secretary Time 5:30-6:00 pm- Wrap Up 6:00-6:30 pm- Desk Time [Redacted] 9:25-9:30 pm- Move to the State Floor [Redacted]  RON WH	

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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<p>8</p> <p>WASHINGTON, DC</p> <p>Scheduler: Rothblum</p>	<p>9</p> <p>WASHINGTON, DC</p> <p>Scheduler: Bollinger</p> <p>10:00-10:30 am- PDB</p> <p><i>Note: Hold time for Group Photos</i></p> <p>[Redacted]</p> <p>1:45-2:00 pm- Oval Office Drop-By (Tom Wheeler-FG)</p> <p>[Redacted]</p> <p>2:30-3:30 pm- WH Departure Photos</p> <p>[Redacted]</p> <p>3:55-4:00 pm- Move to TBD</p> <p>4:00-5:15 pm- Steve Kroft 60 Minutes Interview</p> <p>5:15-5:20 pm- Move to the Oval Office</p> <p>5:30-6:00 pm- Wrap Up</p> <p>6:00-6:30 pm- Desk Time</p> <p>RON WH</p>	<p>10</p> <p>WASHINGTON, DC</p> <p><b>CHICAGO, IL</b></p> <p>WASHINGTON, DC</p> <p>FYI: FLOTUS in NYC (following Chicago)</p> <p><b>DOMESTIC TRAVEL</b></p> <p>Scheduler: Boyle</p> <p>10:00-10:30 am- PDB</p> <p><i>Note: Hold time for Group Photos</i></p> <p>12:05-12:15 pm- Oval Office Drop-By (Tory Burch)</p> <p>12:30-1:00 pm- POTUS Lunch</p> <p>1:00-2:00 pm- Desk Time</p> <p>2:00-2:10 pm- Make-A-Wish</p> <p>2:20-2:25 pm- Move to TBD</p> <p>2:25-2:45 pm- Hold for Residence Toast &amp; Group Photo</p> <p>2:45-2:50 pm- Move to the Oval Office</p> <p>3:00-3:05 pm- Load Marine One</p> <p>3:05-3:15 pm- Lift from the South Lawn to JBA</p> <p>3:15-3:20 pm- Arrive JBA//Movement to TBD Hanger</p> <p>3:20-3:50 pm- Hold for PAG Farewell Event</p> <p>3:50-4:05 pm- Brief Hold</p> <p>4:05-4:10 pm- Movement to AFI</p> <p>4:20-5:15 pm- Wheels Up JBA to Chicago O'Hare Int'l Airport</p> <p>5:15-5:20 pm- Arrive Chicago O'Hare Int'l Airport // Load Marine One</p> <p>5:20-5:35 pm- Lift from Chicago O'Hare Int'l Airport to Soldier Field LZ</p>	<p>11</p> <p>WASHINGTON, DC</p> <p>FYI: FLOTUS in NYC</p> <p>Scheduler: Boyle</p> <p>1:15-1:20 am- Wheels Down JBA//Load Marine One</p> <p>1:20-1:30 am- Lift from JBA to South Lawn</p> <p>1:30-1:35 am- Arrive South Lawn//Proceed to Residence</p> <p>RON WH</p> <p>11:30-12:00 pm- PDB</p> <p>12:00-12:15 pm- Oval Office Drop-By (Rob Fisher &amp; Family-FG)</p> <p>12:15-12:30 pm- Oval Office Drop-By (Kelly Starett &amp; Spouse-FG)</p> <p>[Redacted]</p> <p>1:30-2:00 pm- POTUS Time</p> <p>2:00-2:30 pm- Oval Office Drop-By (Lee Bollinger-FG)</p> <p>[Redacted]</p> <p>3:15-4:00 pm- Hold Per Ferial</p> <p>4:15-5:15 pm- WH Departure Photos</p> <p>5:30-6:00 pm- Wrap Up</p> <p>6:00-6:30 pm- Desk Time</p> <p>RON WH</p>	<p>12</p> <p>WASHINGTON, DC</p> <p>Scheduler: Rothblum</p> <p>10:00-10:30 am- PDB</p> <p><i>Note: Hold time for Group Photos</i></p> <p>[Redacted]</p> <p>1:30-2:00 pm- POTUS Time</p> <p>2:15-2:30 pm- Oval Office Drop-By (Chris Sautter-FG)</p> <p>2:30-2:45 pm- Oval Office Drop-By (Kathy Ruemmler-FG)</p> <p>2:55-3:00 pm- Move to the Residence</p> <p>3:00-3:30 pm- Biden Family &amp; Friends End of Administration Tribute</p> <p>3:30-3:35 pm- Move to the Oval Office</p> <p>3:50-4:00 pm- Prep</p> <p>4:00-5:15 pm- Roundtable w/Conservative Columnists</p> <p>5:30-6:00 pm- Wrap Up</p> <p>6:00-6:30 pm- Desk Time</p> <p>6:30-8:10 pm- POTUS Time</p> <p>8:10-8:15 pm- Move to the Residence</p> <p>8:15-10:00 pm- East Room Event</p> <p>RON WH</p>	<p>13</p> <p>WASHINGTON, DC</p> <p>Scheduler: Bollinger</p> <p>10:00-10:30 am- PDB</p> <p>11:00-11:15 am- Milaide Ceremony &amp; Departure Photo for LTC Drew Steadman</p> <p>11:30-11:50 am- Oval Office Drop-By (Tony Robbins-FG)</p> <p>12:00-12:20 pm- Oval Office Drop-By (Reid Hoffman-FG)</p> <p>[Redacted]</p> <p>1:35-1:40 pm- Prep</p> <p>1:40-2:00 pm- Interview w/Michiko Kakutani</p> <p>2:15-2:30 pm- Oval Office Drop-By (Charles Rivkin-FG)</p> <p>2:45-2:50 pm- Move to TBD</p> <p>2:50-3:15 pm- Weekly Address &amp; Video Taping w/the First Lady</p> <p>3:15-3:30 pm- Joint Taping w/the First Lady</p> <p>3:30-3:35 pm- Move to the Oval Office</p> <p>3:50-4:50 pm- WH Departure Photos</p> <p>5:05-5:20 pm- Oval Office Drop-By of U.S. Mint Representatives</p> <p>5:30-6:00 pm- Wrap Up</p> <p>6:00-6:30 pm- Desk Time</p> <p>RON WH</p>	<p>14</p> <p>WASHINGTON, DC</p> <p>Scheduler: Boyle</p>

P6/b(6)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		<p>5:35-5:40 pm- Arrive Soldier Field LZ // Load Motorcade 5:40-5:50 pm- En Route Valois 5:50-5:55 pm- Arrive Valois</p> <div data-bbox="638 321 877 418" style="border: 2px solid black; width: 114px; height: 60px; margin: 5px 0;"></div> <p>6:10-6:55 pm- Hold for Interview with Lester Holt (sit-down followed by walk &amp; talk) 6:55-7:00 pm- Move to TBD 7:00-7:20 pm- POTUS Dinner 7:20-7:25 pm- Load Motorcade 7:25-7:40 pm- En Route McCormick Place 7:40-7:45 pm- Arrive McCormick Place // Greet 7:45-7:55 pm- Motorcade Driver &amp; Law Enforcement Photos 7:55-8:00 pm- Move to Off- Stage Announce 8:00-8:30 pm- Hold for Remarks 8:30-8:50 pm- Hold for Rope Line and Signing Table 8:50-8:55 pm- Move to TBD 8:55-9:05 pm- Hold for CNN Standing Interview (t) 9:05-9:10 pm- Move to TBD 9:10-9:55 pm- Hold for Clutch Per ADB 10:00-10:15 pm- En Route Soldier Field LZ 10:15-10:20 pm- Arrive Soldier Field LZ//Load Marine One 10:20-10:35 pm- Lift from Soldier Field LZ to Chicago O'Hare Int'l Airport 10:35-10:40 pm- Arrive Chicago O'Hare Int'l Airport//Load AF1 10:40 pm- Wheels Up Chicago O'Hare Int'l Airport to JBA</p>				

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<p>15 <b>WASHINGTON, DC</b></p> <p>Scheduler: Boyle</p> <p><i>Note: Hold 20-30 min this week for "Keeping It 1600" Interview (RR)</i></p> <p><i>Note: Hold for In-Town</i></p> <p><i>Note: Hold time for Group Photos this week</i></p>	<p>16 <b>WASHINGTON, DC</b> FYI: MLK Day</p> <p>Scheduler: Boyle</p> <p><b>Note:</b> Hold for Make-A-Wish Visit</p> <p>12:30-1:00 pm- Lunch</p> <p>1:00-1:05 pm- Move to Blue Room</p> <p>1:05-1:35 pm- Hold for Cubs Visit</p> <p>1:35-1:40 pm- Move to Oval Office</p> <p>1:40-2:10 pm- Desk Time</p> <p>2:15-2:30 pm- En Route TBD</p> <p>2:30-2:35 pm- Arrive TBD//Arrival Greet//Move to TBD</p> <p>2:35-3:25 pm- Hold for Service Project</p> <p>3:30-3:45 pm- En Route WH</p> <p>[Redacted]</p> <p>RON WH</p>	<p>17 <b>WASHINGTON, DC</b> FYI: FLOTUS' Birthday</p> <p>Scheduler: Rothblum</p> <p>10:00-10:30 am- PDB</p> <p>12:00-12:15 pm- Oval Office Drop-By (Penny Pritzker &amp; Family-FG)</p> <p>[Redacted]</p> <p>1:30-2:30 pm- Oval Office Drop-By (Bob Bauer &amp; Attorneys-FG)</p> <p>[Redacted]</p> <p>3:50-4:00 pm- Prep</p> <p>4:00-5:15 pm- Roundtable w/Progressive Columnists</p> <p>5:30-6:00 pm- Wrap Up</p> <p>6:00-6:30 pm- Desk Time</p> <p>[Redacted]</p> <p>RON WH</p>	<p>18 <b>WASHINGTON, DC</b></p> <p>Scheduler: Bollinger</p> <p><b>Note:</b> Hold time for Press Conference (Location TBD)</p> <p>10:00-10:30 am- PDB</p> <p>12:30-1:00 pm- Lunch</p> <p>1:00-1:30 pm- POTUS Time</p> <p>1:30-2:00 pm- Desk Time</p> <p>5:30-6:00 pm- Wrap Up</p> <p>6:00-6:30 pm- Desk Time</p> <p>6:30-6:40 pm - Make-A-Wish Visit</p> <p>RON WH</p>	<p>19 <b>WASHINGTON, DC</b></p> <p>Scheduler: Rothblum</p> <p>10:00-10:30 am- PDB</p> <p>12:30-1:00 pm- Lunch w/the VP</p> <p>1:00-1:30 pm- POTUS Time</p> <p>1:30-2:00 pm- Desk Time</p> <p>5:30-6:00 pm- Wrap Up</p> <p>6:00-6:30 pm- Desk Time</p> <p>[Redacted]</p> <p>RON WH</p>	<p>20 <b>WASHINGTON, DC</b> FYI: Inauguration Day</p> <p>Scheduler: Rothblum</p> <p>[Redacted]</p> <p>TBD-TBD am- TBD Morning Schedule</p> <p>10:00-10:05 am- Move to TBD//Greet President-Elect Trump &amp; Mrs. Trump</p> <p>10:05-10:35 am- Pre-Inaugural Coffee</p> <p>10:35-10:45 am- Brief Hold//Load Motorcade</p> <p>10:45-10:55 am- En Route Capitol Building</p> <p><i>Note: Hold for In-Town</i></p>	

P6/b(6)



# Withdrawal Marker

## Obama Presidential Library

FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Memorandum	Daily Economic Briefing - To: POTUS - From: Jeff Zients	4	01/05/2017	P5;

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#### COLLECTION:

Records Management, White House Office of (WHORM)

#### SERIES:

Subject Files - FG001-07 (Briefing Papers)

#### FOLDER TITLE:

1222132

#### FRC ID:

9828

#### OA Num.:

#### NARA Num.:

#### FOIA IDs and Segments:

22-26844-F

#### RESTRICTION CODES

##### Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

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##### Records Not Subject to FOIA

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# Withdrawal Marker

## Obama Presidential Library

FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Memorandum	Vox Live Interview - From: Liz Allen, Kristie Canegallo	3	01/06/2017	P5; P6/b6;

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FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Report	Updates on Health Care Debate	3	N.D.	P5; Transferred

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### FOLDER TITLE:

1222132

### FRC ID:

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22-26844-F

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**B**

## Q&A

### **Q: How would you assess the ACA now? What is working? What is not?**

While it hasn't always been easy, the facts are clear: by any measure, health care in America is better than it was before the ACA. We have a record-low rate of uninsured Americans. And insured Americans are benefiting from real consumer protections. We have had record-low health care price inflation and a system that is more efficient and effective. Medicare will last longer and has better benefits. And Medicaid has been strengthened and expanded to millions more low-income adults – people who are now getting needed mental health care or treatment for opioid addiction.

But we can do more to improve the ACA. Our work implementing the ACA has been iterative and it's been rooted in data and facts. I meet with my team regularly so that we can kick the tires and troubleshoot, and adjust where we need to. In late 2015, I asked my team to conduct a rigorous analysis of this law: where was it over-performing, where was it under-performing, and why. And we came up with ideas about what could we do to make it better, which led to me authoring a piece in the *Journal of the American Medical Association*. This includes introducing a public plan fallback in areas with limited competition, increasing financial assistance for low- and moderate-income families, and taking action to reduce prescription drug costs. Where we could, we've made adjustments along the way where we could administratively, informed by what we are hearing from industry groups, consumer groups, and the American people.

But we can always do more to improve health care in America.

### **Q: What did you do wrong? Is your Administration at fault for because you drove the ACA through in a partisan way / had your head in the sand when issuers were giving you warning signs of problems / did not sell the ACA effectively enough?**

We're sitting in the very place where I hosted a summit nearly seven years ago to put all health reform ideas on the table, and to do so in a transparent way so that Americans could participate in the process. Remember: we're talking about the health care of every American in this country. The stakes were high then, and they're even higher now. We had hoped to find a willing partner across the aisle and that largely hasn't been the case for the ACA – in contrast to the process with other health care bills like the Cures legislation and MACRA. These bills were the result of years-long negotiations between Democrats and Republicans on the Hill and between the White House and Congress. So it's clear that bipartisanship can still happen, but Republicans drew a line in the sand on the ACA. In fact, a big reason why it took so long to move health reform legislation through Congress in 2009 and 2010 was that Democrats were doing everything they could to incorporate Republican ideas and get Republicans on board.

More broadly, our work implementing the ACA has been iterative and it's been rooted in data and facts. We've made adjustments along the way where we could administratively, informed by what we are hearing from industry groups, consumer groups, and the American people. And we put forward other ideas which require legislation and which Congress could act on right now.

One other point often lost in this debate: the ACA might be the only landmark bill in modern history in which Congress has abdicated its responsibility in passing subsequent legislation and technical corrections to improve it. When President Bush enacted Medicare Part D, the prescription drug plan, Congress made improvements over the years. The same was true for the Children's Health Insurance Program under President Clinton. This failure to even make technical fixes has enabled Congressional Republicans to complain that it's not living up to its full potential. And this is just one of many examples of how Congress is not carrying out its basic duties on behalf of the American people.

I'd also note that with Medicare Part D, a lot of Democrats were critical of what's called the "donut hole" when it was passed. And as part of the ACA, we came in as a Democratic Administration and we fixed that, and the donut hole will be completely closed by 2020 if the ACA is not repealed. So we took our objections, and we built on the law that existed and strengthened it – we didn't burn it all down and say we need to start this entire years-long exercise from scratch. We would have never dreamed of just repealing it right away, with some IOU that we would do something better years later.

**Q: Why do you think the law remains as unpopular as it does, and what could you have done differently to sell it to the American people?**

I said this to the Democratic Caucus earlier this week: I wish we had been more effective making the case to the American people how much the ACA can help working families. So that's on us. If you look at the polling data, it's been remarkably consistent over the years. The fact that the law remains roughly as popular as it is unpopular – despite misleading attack ads since Day One – is a testament to how much people value good health insurance that protects them from discrimination and bankruptcy. And that hasn't changed in almost seven years.

Yet, it seems like we may be seeing a shift in how Republican voters view repeal for the first time – with more of them now saying, wait a minute, don't take my health care away. Let's improve this law instead. To some extent, with me leaving office, people may start to take a more clear-eyed view of the law.

**Q: What specific lessons have you learned over the years from drafting, passage and implementation of the ACA, and what wisdom would you impart to your successor?**

One thing is that when you're dealing with health care, the stakes are high. It's one-fifth of the American economy, but the stakes are also infinitely high for every family that is dealing with a tragic or chronic illness. It's not something to just repeal or undermine through executive action in order to spike a political football. And it will need constant attention long after legislation is signed into law, because you need to look out for those families and for the economy and for the health care industry.

**Q: What did you and the President-elect talk about regarding the ACA: can't the two of you go off and fix it? Is your sense that he actually wants to repeal the entire law? How would you assess his knowledge of the ACA and our health care system?**

The President-elect has said publicly that he wants to maintain protections for the 133 million Americans with pre-existing conditions, and I'll take him at his word. At the same time, though, Republicans in Congress want to repeal the individual responsibility portion of the law. I was initially against this Republican idea, but we learned from Massachusetts that individual responsibility, alongside financial assistance, is the only proven way to provide affordable, private, individual insurance to every American. Maintaining protections for people with pre-existing conditions without requiring individual responsibility would cost millions of Americans their coverage and cause dramatic premium increases for millions more. This is just one of the many complex tradeoffs in health reform, and a good example of how undoing some of the ACA may undo all of it.

I also understand he and his team have talked publicly about handling repeal and replace simultaneously, which would be far preferable to repeal and delay for the millions of people who are relying on this care. In that case any replacement plan should be assessed for whether it moves our health system forward, toward more affordability and quality care for all Americans.

**Q: Do you agree with Senator Schumer's strategy of scorched earth / no lifeline for Republicans should they repeal the law?**

For years, Democrats have indicated a willingness to work with Republicans to improve upon the system we have, and so have I. We have put forward ideas about how to do this. And we'll continue to be open to that. But what we won't do is negotiate with Republicans who are holding Americans' health care hostage and chilling one-fifth of our economy, just so they can prove a political point. This isn't a game or a talking point – this is people's health care and lives are at stake. There is no need for Republicans to pursue such a dangerous strategy. I can't speak to how Democrats should conduct themselves after I've left office, but if Republicans continue to pursue a hardline partisan repeal strategy, I don't think the American people will hold Democrats responsible for the consequences.

**Q: Do you think that Republicans will be able to repeal the ACA?**

I think even a lot of conservative commentators, and even those who have been critical of the ACA, have started to see how ill-advised the current Republican plan is. Taking away health coverage from people who may never have had it in their lives – and taking away the health and financial security that comes with it – is not who we are as a country. And this is not just about the 20 million Americans who may lose life-saving coverage provided by the ACA. It is also the 260 million Americans with pre-ACA coverage who may pay more for worse benefits than before. It is doctors and nurses who may no longer be paid to care for a patient after a hospitalization or in a coordinated way. And, it is hospital workers that may be laid off if uncompensated care surges. Taking all that away will be much harder than providing it in the first place. Unlike their previous votes to repeal the ACA, this one will have real consequences for Republicans. They will have to own their actions and – like I did for the past six years – own the health care system, warts and all.

**Q: What do you view as the top concerns with the Congressional Republicans' "repeal and delay" strategy?**

I know that Republicans say they will use the two or three years of a “repeal and delay” bill to develop something better than the ACA and that no one will be hurt during that transition period. But let’s talk about what will really happen on the Congressional Republicans’ irresponsible path. Repeal and delay will put the health care system and millions of hard-working Americans on the edge of a cliff. This will result in uncertainty that will drive up health care costs, drag down the economy, and bring back the worst practices of providers and insurers of avoiding patients who need care the most.

And we know how unlikely it is that there will be a second vote to replace what has been taken away. In fact, the most likely reason why Republicans are pursuing this strategy is precisely because after six years of promises, they are still no closer to having a serious replacement plan. Health reform is hard. These are complex issues. Undoing some of the ACA may undo all of it.

The stakes could not be higher – not just for the 20 million people who have gained coverage but for every American, and for our economy.

**Q: What role will you play in defending the ACA after you are out of office? Is this something you think you will devote significant time to? If not, why not?**

As I've always said, while I plan to give the President-elect a wide berth, the same as President Bush did with me, I will preserve my ability to weigh in if I think policies are being enacted that go against who we are as Americans.

C

## ACA REFERENCE FACTS

After nearly 100 years of talk, and decades of trying, we finally made affordable, quality health care for all a reality for America. In more than six years since the Affordable Care Act was passed, here is where we stand and what is at risk if Republicans take us backwards and repeal the ACA.

### Expanded and Improved Insurance Coverage

#### *Topline Points*

- 20 million more adults have health insurance thanks to the ACA. On top of that, more than 3 million additional children have health insurance than in 2008, thanks in large part to the ACA and other actions taken by this Administration. The nation's uninsured rate now stands at its lowest level ever.
- As many as half of non-elderly Americans—133 million people—have some type of pre-existing health condition, including as many as 17 million children. They are now protected from coverage denials, higher premiums, and reduced benefits, practices that were routine before the law's enactment.
- 105 million Americans, including 39.5 million women and nearly 28 million children, are benefiting from the elimination of lifetime limits on insurance coverage. Insurers are also now prohibited from placing annual limits on insurance coverage and must cap enrollees' annual out-of-pocket spending. These protections did not exist before the ACA.
- 137 million Americans now have a right to coverage of critical preventive services with no out-of-pocket costs, like flu shots, yearly check-ups for women, and birth control. These benefits were not guaranteed before the ACA.
- The share of Americans forgoing health care due to cost has fallen by more than one-third since 2010. A range of other evidence shows that recent improvements in insurance coverage are also improving financial security and health.

#### *Additional Points*

- Medicaid expansion: The 31 States and the District of Columbia that have expanded their Medicaid programs to more low-income adults have seen particularly rapid progress in expanding coverage. If the remaining states expand Medicaid, over 4 million more uninsured people would gain coverage.
- Marketplace: More than 10 million people have health insurance coverage through the Health Insurance Marketplace. 84 percent of Marketplace enrollees are receiving financial assistance that makes their monthly premiums affordable.
- Young adults: 6.1 million young Americans gained coverage thanks to the ACA. Of these, 2.3 million have coverage because they now have the option to stay covered on their parents' plans until they turn 26 – a benefit that did not exist before the law.
- Part D “donut hole”: More than 11 million Medicare beneficiaries have saved an average of more than \$2,100 per beneficiary on prescription drugs (over \$23.5 billion in total) since the ACA became law due to the phase out of the “donut hole.”

- Mental health and substance use: The ACA created the largest expansion of mental health and substance use disorder coverage in a generation. It expanded mental health and substance use disorder benefits and parity protections to more than 60 million people.
- Uncompensated care: Hospitals delivered an estimated \$10.4 billion less in uncompensated care in 2015 than if uncompensated care had remained at its 2013 level.

### Lower Costs and Better Quality Care

#### *Topline Points*

- Health care prices have risen at the lowest rate in 50 years since the ACA became law.
- The average premium for a family with job-based coverage is nearly \$3,600 lower in 2016 than if premium growth since 2010 had matched the decade before the ACA. Adding in out-of-pocket costs brings these savings to \$4,400.
- The typical Medicare beneficiary with traditional Medicare will incur around \$700 less in premiums and cost sharing in 2016 than if Medicare spending had matched projections issued in 2009, even before counting out-of-pocket savings on prescription drugs.
- The ACA provides incentives to medical providers to improve quality of care. The rate of hospital-acquired conditions like infections has fallen 21 percent since 2010, saving 125,000 lives and nearly \$28 billion in health care costs.
- The ACA has greatly improved the nation's fiscal outlook, reducing deficits by more than \$3 trillion over the next two decades. The ACA and broader trends in the health care system have added 11 years to the life of the Medicare Trust Fund since 2009.
- The country as a whole is now on track to spend \$2.6 trillion less on health care than was projected without the ACA back in 2010, despite dramatically higher insurance coverage.

#### *Additional Points*

- Alternative Payment Models: More than 30 percent of Medicare payments now flow through alternative payment models that reward the delivery of efficient, high-quality care, rather than just a high quantity of care.
- Medicare Advantage: Medicare Advantage plans are paid more accurately and are required to spend at least 85 percent of Medicare revenue on patient care, while enrollment has grown by over 60 percent and average premiums have dropped by 13 percent since passage of the ACA.

D

## REPEALING THE ACA WITHOUT A REPLACEMENT – THE RISKS TO AMERICAN HEALTH CARE

**Barack H. Obama, J.D.**

Health care policy often shifts when the country's leadership changes. That was true when I took office, and it will likely be true with President-elect Donald Trump. I am proud that my administration's work, through the Affordable Care Act (ACA) and other policies, helped millions more Americans know the security of health care in a system that is more effective and efficient. At the same time, there is more work to do to ensure that all Americans have access to high-quality, affordable health care. What the past 8 years have taught us is that health care reform requires an evidence-based, careful approach, driven by what is best for the American people. That is why Republicans' plan to repeal the ACA with no plan to replace and improve it is so reckless. Rather than jeopardize financial security and access to care for tens of millions of Americans, policymakers should develop a plan to build on what works before they unravel what is in place.

Thanks to the ACA, a larger share of Americans have health insurance than ever before.<sup>1</sup> Increased coverage is translating into improved access to medical care – as well as greater financial security and better health. Meanwhile, the vast majority of Americans still get their health care through sources that predate the law, such as a job or Medicare, and are benefiting from improved consumer protections, such as free preventive services.

We have also made progress in how we pay for health care, including rewarding providers who deliver high-quality care rather than just a high quantity of care. These and other reforms in the ACA have helped slow health care cost growth to a fraction of historical rates while improving quality for patients. This includes better-quality and lower-cost care for tens of millions of seniors, individuals with disabilities, and low-income families covered by Medicare, Medicaid, and the Children's Health Insurance Program. And these benefits will grow in the years to come. That being said, I am the first to say we can make improvements. Informed by the lessons we've learned during my presidency, I have put forward ideas in my budgets and a July 2016 article<sup>2</sup> to address ongoing challenges – such as a lack of choice in some health insurance markets, premiums that remain unaffordable for some families, and high prescription-drug costs. For example, allowing Medicare to negotiate drug prices could both reduce seniors' spending and give private payers greater leverage. And I have always welcomed others' ideas that meet the test of making the health system better. But persistent partisan resistance to the ACA has made small as well as significant improvements extremely difficult.

Now, Republican congressional leaders say they will repeal the ACA early this year, with a promise to replace it in subsequent legislation – which, if patterned after House Speaker Paul Ryan's ideas, would be partly paid for by capping Medicare and Medicaid spending. They have yet to introduce that “replacement bill,” hold a hearing on it, or produce a cost analysis – let alone engage in the more than a year of public debate that preceded passage of the ACA. Instead, they say that such a debate will occur after the ACA is repealed. They claim that a 2- or 3-year delay will be sufficient to develop, pass, and implement a replacement bill. This approach of “repeal first and replace later” is, simply put, irresponsible – and could slowly bleed the health care system that all of us depend on. (And, though not my focus here, executive

actions could have similar consequential negative effects on our health system.) If a repeal with a delay is enacted, the health care system will be standing on the edge of a cliff, resulting in uncertainty and, in some cases, harm beginning immediately. Insurance companies may not want to participate in the Health Insurance Marketplace in 2018 or may significantly increase prices to prepare for changes in the next year or two, partly to try to avoid the blame for any change that is unpopular. Physician practices may stop investing in new approaches to care coordination if Medicare's Innovation Center is eliminated. Hospitals may have to cut back services and jobs in the short run in anticipation of the surge in uncompensated care that will result from rolling back the Medicaid expansion. Employers may have to reduce raises or delay hiring to plan for faster growth in health care costs without the current law's cost-saving incentives. And people with preexisting conditions may fear losing life-saving health care that may no longer be affordable or accessible.

Furthermore, there is no guarantee of getting a second vote to avoid such a cliff, especially on something as difficult as comprehensive health care reform. Put aside the scope of health care reform – the federal health care budget is 50% bigger than that of the Department of Defense.<sup>3</sup> Put aside how it personally touches every single American – practically every week, I get letters from people passionately sharing how the ACA is working for them and about how we can make it better. “Repeal and replace” is a deceptively catchy phrase – the truth is that health care reform is complex with many interlocking pieces, so that undoing some of it may undo all of it. Take, for example, preexisting conditions. For the first time, because of the ACA, people with preexisting conditions cannot be denied coverage, denied benefits, or charged exorbitant rates. I take my successor at his word: he wants to maintain protections for the 133 million Americans with preexisting conditions. Yet Republicans in Congress want to repeal the individual-responsibility portion of the law. I was initially against this Republican idea, but we learned from Massachusetts that individual responsibility, alongside financial assistance, is the only proven way to provide affordable, private, individual insurance to every American. Maintaining protections for people with preexisting conditions without requiring individual responsibility would cost millions of Americans their coverage and cause dramatic premium increases for millions more.<sup>4</sup> This is just one of the many complex tradeoffs in health care reform. Given that Republicans have yet to craft a replacement plan, and that unforeseen events might overtake their planned agenda, there might never be a second vote on a plan to replace the ACA if it is repealed. And if a second vote does not happen, tens of millions of Americans will be harmed. A recent Urban Institute analysis estimated that a likely repeal bill would not only reverse recent gains in insurance coverage, but leave us with more uninsured and uncompensated care than when we started.

Put simply, all our gains are at stake if Congress takes up repealing the health law without an alternative that covers more Americans, improves quality, and makes health care more affordable. That move takes away the opportunity to build on what works and fix what does not. It adds uncertainty to lives of patients, the work of their doctors, and the hospitals and health systems that care from them. And it jeopardizes the improvements in health care that millions of Americans now enjoy.

Congress can take a responsible, bipartisan approach to improving the health care system. This was how we overhauled Medicare's flawed physician payment system less than 2 years ago. I

will applaud legislation that improves Americans' care, but Republicans should identify improvements and explain their plan from the start – they owe the American people nothing less.

Health care reform isn't about a nameless, faceless "system." It's about the millions of lives at stake – from the cancer survivor who can now take a new job without fear of losing his insurance, to the young person who can stay on her parents' insurance after college, to the countless Americans who now live healthier lives thanks to the law's protections. Policymakers should therefore abide by the physician's oath: "first, do no harm."

Disclosure forms provided by the author are available at NEJM.org.

Mr. Obama is President of the United States.

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## UNITED STATES HEALTH CARE REFORM

Progress to Date and Next Steps

Barack Obama, JD<sup>1</sup>

Abstract

**Importance** The Affordable Care Act is the most important health care legislation enacted in the United States since the creation of Medicare and Medicaid in 1965. The law implemented comprehensive reforms designed to improve the accessibility, affordability, and quality of health care.

**Objectives** To review the factors influencing the decision to pursue health reform, summarize evidence on the effects of the law to date, recommend actions that could improve the health care system, and identify general lessons for public policy from the Affordable Care Act.

**Evidence** Analysis of publicly available data, data obtained from government agencies, and published research findings. The period examined extends from 1963 to early 2016.

**Findings** The Affordable Care Act has made significant progress toward solving long-standing challenges facing the US health care system related to access, affordability, and quality of care. Since the Affordable Care Act became law, the uninsured rate has declined by 43%, from 16.0% in 2010 to 9.1% in 2015, primarily because of the law's reforms. Research has documented accompanying improvements in access to care (for example, an estimated reduction in the share of nonelderly adults unable to afford care of 5.5 percentage points), financial security (for example, an estimated reduction in debts sent to collection of \$600-\$1000 per person gaining Medicaid coverage), and health (for example, an estimated reduction in the share of nonelderly adults reporting fair or poor health of 3.4 percentage points). The law has also begun the process of transforming health care payment systems, with an estimated 30% of traditional Medicare payments now flowing through alternative payment models like bundled payments or accountable care organizations. These and related reforms have contributed to a sustained period of slow growth in per-enrollee health care spending and improvements in health care quality. Despite this progress, major opportunities to improve the health care system remain.

**Conclusions and Relevance** Policy makers should build on progress made by the Affordable Care Act by continuing to implement the Health Insurance Marketplaces and delivery system reform, increasing federal financial assistance for Marketplace enrollees, introducing a public plan option in areas lacking individual market competition, and taking actions to reduce prescription drug costs. Although partisanship and special interest opposition remain, experience with the Affordable Care Act demonstrates that positive change is achievable on some of the nation's most complex challenges.

### Introduction

Health care costs affect the economy, the federal budget, and virtually every American family's financial well-being. Health insurance enables children to excel at school, adults to work more productively, and Americans of all ages to live longer, healthier lives. When I took office, health care costs had risen rapidly for decades, and tens of millions of Americans were uninsured. Regardless of the political difficulties, I concluded comprehensive reform was necessary.

The result of that effort, the Affordable Care Act (ACA), has made substantial progress in addressing these challenges. Americans can now count on access to health coverage throughout their lives, and the federal government has an array of tools to bring the rise of health care costs under control. However, the work toward a high-quality, affordable, accessible health care system is not over.

In this Special Communication, I assess the progress the ACA has made toward improving the US health care system and discuss how policy makers can build on that progress in the years ahead. I close with reflections on what my administration's experience with the ACA can teach about the potential for positive change in health policy in particular and public policy generally.

### Impetus for Health Reform

In my first days in office, I confronted an array of immediate challenges associated with the Great Recession. I also had to deal with one of the nation's most intractable and long-standing problems, a health care system that fell far short of its potential. In 2008, the United States devoted 16% of the economy to health care, an increase of almost one-quarter since 1998 (when 13% of the economy was spent on health care), yet much of that spending did not translate into better outcomes for patients.<sup>1-4</sup> The health care system also fell short on quality of care, too often failing to keep patients safe, waiting to treat patients when they were sick rather than focusing on keeping them healthy, and delivering fragmented, poorly coordinated care.<sup>5,6</sup>

Moreover, the US system left more than 1 in 7 Americans without health insurance coverage in 2008.<sup>7</sup> Despite successful efforts in the 1980s and 1990s to expand coverage for specific populations, like children, the United States had not seen a large, sustained reduction in the uninsured rate since Medicare and Medicaid began (Figure 1<sup>8-10</sup>). The United States' high uninsured rate had negative consequences for uninsured Americans, who experienced greater financial insecurity, barriers to care, and odds of poor health and preventable death; for the health care system, which was burdened with billions of dollars in uncompensated care; and for the US economy, which suffered, for example, because workers were concerned about joining the ranks of the uninsured if they sought additional education or started a business.<sup>11-16</sup> Beyond these statistics were the countless, heartbreaking stories of Americans who struggled to access care because of a broken health insurance system. These included people like Natoma Canfield, who had overcome cancer once but had to discontinue her coverage due to rapidly escalating premiums and found herself facing a new cancer diagnosis uninsured.<sup>17</sup>

In 2009, during my first month in office, I extended the Children's Health Insurance Program and soon thereafter signed the American Recovery and Reinvestment Act, which included temporary support to sustain Medicaid coverage as well as investments in health information technology, prevention, and health research to improve the system in the long run. In the summer of 2009, I signed the Tobacco Control Act, which has contributed to a rapid decline in the rate of smoking among teens, from 19.5% in 2009 to 10.8% in 2015, with substantial declines among adults as well.<sup>7,18</sup>

Beyond these initial actions, I decided to prioritize comprehensive health reform not only because of the gravity of these challenges but also because of the possibility for progress. Massachusetts had recently implemented bipartisan legislation to expand health insurance

coverage to all its residents. Leaders in Congress had recognized that expanding coverage, reducing the level and growth of health care costs, and improving quality was an urgent national priority. At the same time, a broad array of health care organizations and professionals, business leaders, consumer groups, and others agreed that the time had come to press ahead with reform.<sup>19</sup> Those elements contributed to my decision, along with my deeply held belief that health care is not a privilege for a few, but a right for all. After a long debate with well-documented twists and turns, I signed the ACA on March 23, 2010.

#### Progress Under the ACA

The years following the ACA's passage included intense implementation efforts, changes in direction because of actions in Congress and the courts, and new opportunities such as the bipartisan passage of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015. Rather than detail every development in the intervening years, I provide an overall assessment of how the health care system has changed between the ACA's passage and today.

The evidence underlying this assessment was obtained from several sources. To assess trends in insurance coverage, this analysis relies on publicly available government and private survey data, as well as previously published analyses of survey and administrative data. To assess trends in health care costs and quality, this analysis relies on publicly available government estimates and projections of health care spending; publicly available government and private survey data; data on hospital readmission rates provided by the Centers for Medicare & Medicaid Services; and previously published analyses of survey, administrative, and clinical data. The dates of the data used in this assessment range from 1963 to early 2016.

#### Expanding and Improving Coverage

The ACA has succeeded in sharply increasing insurance coverage. Since the ACA became law, the uninsured rate has declined by 43%, from 16.0% in 2010 to 9.1% in 2015,<sup>7</sup> with most of that decline occurring after the law's main coverage provisions took effect in 2014 (Figure 1<sup>8-10</sup>). The number of uninsured individuals in the United States has declined from 49 million in 2010 to 29 million in 2015. This is by far the largest decline in the uninsured rate since the creation of Medicare and Medicaid 5 decades ago. Recent analyses have concluded these gains are primarily because of the ACA, rather than other factors such as the ongoing economic recovery.<sup>20,21</sup> Adjusting for economic and demographic changes and other underlying trends, the Department of Health and Human Services estimated that 20 million more people had health insurance in early 2016 because of the law.<sup>22</sup>

Each of the law's major coverage provisions – comprehensive reforms in the health insurance market combined with financial assistance for low- and moderate-income individuals to purchase coverage, generous federal support for states that expand their Medicaid programs to cover more low-income adults, and improvements in existing insurance coverage – has contributed to these gains. States that decided to expand their Medicaid programs saw larger reductions in their uninsured rates from 2013 to 2015, especially when those states had large uninsured populations to start with (Figure 2<sup>23</sup>). However, even states that have not adopted Medicaid expansion have seen substantial reductions in their uninsured rates, indicating that the ACA's other reforms are increasing insurance coverage. The law's provision allowing young adults to stay on a parent's

plan until age 26 years has also played a contributing role, covering an estimated 2.3 million people after it took effect in late 2010.<sup>22</sup>

Early evidence indicates that expanded coverage is improving access to treatment, financial security, and health for the newly insured. Following the expansion through early 2015, nonelderly adults experienced substantial improvements in the share of individuals who have a personal physician (increase of 3.5 percentage points) and easy access to medicine (increase of 2.4 percentage points) and substantial decreases in the share who are unable to afford care (decrease of 5.5 percentage points) and reporting fair or poor health (decrease of 3.4 percentage points) relative to the pre-ACA trend.<sup>24</sup> Similarly, research has found that Medicaid expansion improves the financial security of the newly insured (for example, by reducing the amount of debt sent to a collection agency by an estimated \$600-\$1000 per person gaining Medicaid coverage).<sup>26,27</sup> Greater insurance coverage appears to have been achieved without negative effects on the labor market, despite widespread predictions that the law would be a “job killer.” Private-sector employment has increased in every month since the ACA became law, and rigorous comparisons of Medicaid expansion and nonexpansion states show no negative effects on employment in expansion states.<sup>28-30</sup>

The law has also greatly improved health insurance coverage for people who already had it. Coverage offered on the individual market or to small businesses must now include a core set of health care services, including maternity care and treatment for mental health and substance use disorders, services that were sometimes not covered at all previously.<sup>31</sup> Most private insurance plans must now cover recommended preventive services without cost-sharing, an important step in light of evidence demonstrating that many preventive services were underused.<sup>5,6</sup> This includes women’s preventive services, which has guaranteed an estimated 55.6 million women coverage of services such as contraceptive coverage and screening and counseling for domestic and interpersonal violence.<sup>32</sup> In addition, families now have far better protection against catastrophic costs related to health care. Lifetime limits on coverage are now illegal and annual limits typically are as well. Instead, most plans must cap enrollees’ annual out-of-pocket spending, a provision that has helped substantially reduce the share of people with employer-provided coverage lacking real protection against catastrophic costs (Figure 3<sup>33</sup>). The law is also phasing out the Medicare Part D coverage gap. Since 2010, more than 10 million Medicare beneficiaries have saved more than \$20 billion as a result.<sup>34</sup>

### **Reforming the Health Care Delivery System**

Before the ACA, the health care system was dominated by “fee-for-service” payment systems, which often penalized health care organizations and health care professionals who find ways to deliver care more efficiently, while failing to reward those who improve the quality of care. The ACA has changed the health care payment system in several important ways. The law modified rates paid to many that provide Medicare services and Medicare Advantage plans to better align them with the actual costs of providing care. Research on how past changes in Medicare payment rates have affected private payment rates implies that these changes in Medicare payment policy are helping decrease prices in the private sector as well.<sup>35,36</sup> The ACA also included numerous policies to detect and prevent health care fraud, including increased scrutiny prior to enrollment in Medicare and Medicaid for health care entities that pose a high risk of fraud, stronger penalties for crimes involving losses in excess of \$1 million, and additional funding for antifraud

efforts. The ACA has also widely deployed “value-based payment” systems in Medicare that tie fee-for-service payments to the quality and efficiency of the care delivered by health care organizations and health care professionals. In parallel with these efforts, my administration has worked to foster a more competitive market by increasing transparency around the prices charged and the quality of care delivered.

Most importantly over the long run, the ACA is moving the health care system toward “alternative payment models” that hold health care entities accountable for outcomes. These models include bundled payment models that make a single payment for all of the services provided during a clinical episode and population-based models like accountable care organizations (ACOs) that base payment on the results health care organizations and health care professionals achieve for all of their patients’ care. The law created the Center for Medicare and Medicaid Innovation (CMMI) to test alternative payment models and bring them to scale if they are successful, as well as a permanent ACO program in Medicare. Today, an estimated 30% of traditional Medicare payments flow through alternative payment models that broaden the focus of payment beyond individual services or a particular entity, up from essentially none in 2010.<sup>37</sup> These models are also spreading rapidly in the private sector, and their spread will likely be accelerated by the physician payment reforms in MACRA.<sup>38,39</sup>

Trends in health care costs and quality under the ACA have been promising (Figure 4<sup>1,40</sup>). From 2010 through 2014, mean annual growth in real per-enrollee Medicare spending has actually been *negative*, down from a mean of 4.7% per year from 2000 through 2005 and 2.4% per year from 2006 to 2010 (growth from 2005 to 2006 is omitted to avoid including the rapid growth associated with the creation of Medicare Part D).<sup>1,40</sup> Similarly, mean real per-enrollee growth in private insurance spending has been 1.1% per year since 2010, compared with a mean of 6.5% from 2000 through 2005 and 3.4% from 2005 to 2010.<sup>1,40</sup>

As a result, health care spending is likely to be far lower than expected. For example, relative to the projections the Congressional Budget Office (CBO) issued just before I took office, CBO now projects Medicare to spend 20%, or about \$160 billion, less in 2019 alone.<sup>41,42</sup> The implications for families’ budgets of slower growth in premiums have been equally striking. Had premiums increased since 2010 at the same mean rate as the preceding decade, the mean family premium for employer-based coverage would have been almost \$2600 higher in 2015.<sup>33</sup> Employees receive much of those savings through lower premium costs, and economists generally agree that those employees will receive the remainder as higher wages in the long run.<sup>43</sup> Furthermore, while deductibles have increased in recent years, they have increased no faster than in the years preceding 2010.<sup>44</sup> Multiple sources also indicate that the overall share of health care costs that enrollees in employer coverage pay out of pocket has been close to flat since 2010 (Figure 5<sup>45-48</sup>), most likely because the continued increase in deductibles has been canceled out by a decline in co-payments.

At the same time, the United States has seen important improvements in the quality of care. The rate of hospital-acquired conditions (such as adverse drug events, infections, and pressure ulcers) has declined by 17%, from 145 per 1000 discharges in 2010 to 121 per 1000 discharges in 2014.<sup>49</sup> Using prior research on the relationship between hospital-acquired conditions and mortality, the Agency for Healthcare Research and Quality has estimated that this decline in the

rate of hospital-acquired conditions has prevented a cumulative 87 000 deaths over 4 years.<sup>49</sup> The rate at which Medicare patients are readmitted to the hospital within 30 days after discharge has also decreased sharply, from a mean of 19.1% during 2010 to a mean of 17.8% during 2015 (Figure 6; written communication; March 2016; Office of Enterprise Data and Analytics, Centers for Medicare & Medicaid Services). The Department of Health and Human Services has estimated that lower hospital readmission rates resulted in 565 000 fewer total readmissions from April 2010 through May 2015.<sup>50,51</sup>

While the Great Recession and other factors played a role in recent trends, the Council of Economic Advisers has found evidence that the reforms introduced by the ACA helped both slow health care cost growth and drive improvements in the quality of care.<sup>44,52</sup> The contribution of the ACA's reforms is likely to increase in the years ahead as its tools are used more fully and as the models already deployed under the ACA continue to mature.

#### Building on Progress to Date

I am proud of the policy changes in the ACA and the progress that has been made toward a more affordable, high-quality, and accessible health care system. Despite this progress, too many Americans still strain to pay for their physician visits and prescriptions, cover their deductibles, or pay their monthly insurance bills; struggle to navigate a complex, sometimes bewildering system; and remain uninsured. More work to reform the health care system is necessary, with some suggestions offered below.

First, many of the reforms introduced in recent years are still some years from reaching their maximum effect. With respect to the law's coverage provisions, these early years' experience demonstrate that the Health Insurance Marketplace is a viable source of coverage for millions of Americans and will be for decades to come. However, both insurers and policy makers are still learning about the dynamics of an insurance market that includes all people regardless of any preexisting conditions, and further adjustments and recalibrations will likely be needed, as can be seen in some insurers' proposed Marketplace premiums for 2017. In addition, a critical piece of unfinished business is in Medicaid. As of July 1, 2016, 19 states have yet to expand their Medicaid programs. I hope that all 50 states take this option and expand coverage for their citizens in the coming years, as they did in the years following the creation of Medicaid and CHIP.

With respect to delivery system reform, the reorientation of the US health care payment systems toward quality and accountability has made significant strides forward, but it will take continued hard work to achieve my administration's goal of having at least half of traditional Medicare payments flowing through alternative payment models by the end of 2018. Tools created by the ACA—including CMMI and the law's ACO program—and the new tools provided by MACRA will play central roles in this important work. In parallel, I expect continued bipartisan support for identifying the root causes and cures for diseases through the Precision Medicine and BRAIN initiatives and the Cancer Moonshot, which are likely to have profound benefits for the 21st-century US health care system and health outcomes.

Second, while the ACA has greatly improved the affordability of health insurance coverage, surveys indicate that many of the remaining uninsured individuals want coverage but still report

being unable to afford it.<sup>53,54</sup> Some of these individuals may be unaware of the financial assistance available under current law, whereas others would benefit from congressional action to increase financial assistance to purchase coverage, which would also help middle-class families who have coverage but still struggle with premiums. The steady-state cost of the ACA's coverage provisions is currently projected to be 28% below CBO's original projections, due in significant part to lower-than-expected Marketplace premiums, so increased financial assistance could make coverage even more affordable while still keeping federal costs below initial estimates.<sup>55,56</sup>

Third, more can and should be done to enhance competition in the Marketplaces. For most Americans in most places, the Marketplaces are working. The ACA supports competition and has encouraged the entry of hospital-based plans, Medicaid managed care plans, and other plans into new areas. As a result, the majority of the country has benefited from competition in the Marketplaces, with 88% of enrollees living in counties with at least 3 issuers in 2016, which helps keep costs in these areas low.<sup>57,58</sup> However, the remaining 12% of enrollees live in areas with only 1 or 2 issuers. Some parts of the country have struggled with limited insurance market competition for many years, which is one reason that, in the original debate over health reform, Congress considered and I supported including a Medicare-like public plan. Public programs like Medicare often deliver care more cost-effectively by curtailing administrative overhead and securing better prices from providers.<sup>59,60</sup> The public plan did not make it into the final legislation. Now, based on experience with the ACA, I think Congress should revisit a public plan to compete alongside private insurers in areas of the country where competition is limited. Adding a public plan in such areas would strengthen the Marketplace approach, giving consumers more affordable options while also creating savings for the federal government.<sup>61</sup>

Fourth, although the ACA included policies to help address prescription drug costs, like more substantial Medicaid rebates and the creation of a pathway for approval of biosimilar drugs, those costs remain a concern for Americans, employers, and taxpayers alike—particularly in light of the 12% increase in prescription drug spending that occurred in 2014.<sup>1</sup> In addition to administrative actions like testing new ways to pay for drugs, legislative action is needed.<sup>62</sup> Congress should act on proposals like those included in my fiscal year 2017 budget to increase transparency around manufacturers' actual production and development costs, to increase the rebates manufacturers are required to pay for drugs prescribed to certain Medicare and Medicaid beneficiaries, and to give the federal government the authority to negotiate prices for certain high-priced drugs.<sup>63</sup>

There is another important role for Congress: it should avoid moving backward on health reform. While I have always been interested in improving the law—and signed 19 bills that do just that—my administration has spent considerable time in the last several years opposing more than 60 attempts to repeal parts or all of the ACA, time that could have been better spent working to improve our health care system and economy. In some instances, the repeal efforts have been bipartisan, including the effort to roll back the excise tax on high-cost employer-provided plans. Although this provision can be improved, such as through the reforms I proposed in my budget, the tax creates strong incentives for the least-efficient private-sector health plans to engage in delivery system reform efforts, with major benefits for the economy and the budget. It should be preserved.<sup>64</sup> In addition, Congress should not advance legislation that undermines the

Independent Payment Advisory Board, which will provide a valuable backstop if rapid cost growth returns to Medicare.

#### Lessons for Future Policy Makers

While historians will draw their own conclusions about the broader implications of the ACA, I have my own. These lessons learned are not just for posterity: I have put them into practice in both health care policy and other areas of public policy throughout my presidency.

The first lesson is that any change is difficult, but it is especially difficult in the face of hyperpartisanship. Republicans reversed course and rejected their own ideas once they appeared in the text of a bill that I supported. For example, they supported a fully funded risk-corridor program and a public plan fallback in the Medicare drug benefit in 2003 but opposed them in the ACA. They supported the individual mandate in Massachusetts in 2006 but opposed it in the ACA. They supported the employer mandate in California in 2007 but opposed it in the ACA—and then opposed the administration’s decision to delay it. Moreover, through inadequate funding, opposition to routine technical corrections, excessive oversight, and relentless litigation, Republicans undermined ACA implementation efforts. We could have covered more ground more quickly with cooperation rather than obstruction. It is not obvious that this strategy has paid political dividends for Republicans, but it has clearly come at a cost for the country, most notably for the estimated 4 million Americans left uninsured because they live in GOP-led states that have yet to expand Medicaid.<sup>65</sup>

The second lesson is that special interests pose a continued obstacle to change. We worked successfully with some health care organizations and groups, such as major hospital associations, to redirect excessive Medicare payments to federal subsidies for the uninsured. Yet others, like the pharmaceutical industry, oppose any change to drug pricing, no matter how justifiable and modest, because they believe it threatens their profits.<sup>66</sup> We need to continue to tackle special interest dollars in politics. But we also need to reinforce the sense of mission in health care that brought us an affordable polio vaccine and widely available penicillin.

The third lesson is the importance of pragmatism in both legislation and implementation. Simpler approaches to addressing our health care problems exist at both ends of the political spectrum: the single-payer model vs government vouchers for all. Yet the nation typically reaches its greatest heights when we find common ground between the public and private good and adjust along the way. That was my approach with the ACA. We engaged with Congress to identify the combination of proven health reform ideas that could pass and have continued to adapt them since. This includes abandoning parts that do not work, like the voluntary long-term care program included in the law. It also means shutting down and restarting a process when it fails. When HealthCare.gov did not work on day 1, we brought in reinforcements, were brutally honest in assessing problems, and worked relentlessly to get it operating. Both the process and the website were successful, and we created a playbook we are applying to technology projects across the government.

While the lessons enumerated above may seem daunting, the ACA experience nevertheless makes me optimistic about this country’s capacity to make meaningful progress on even the biggest public policy challenges. Many moments serve as reminders that a broken status quo is not the nation’s destiny. I often think of a letter I received from Brent Brown of Wisconsin. He

did not vote for me and he opposed “ObamaCare,” but Brent changed his mind when he became ill, needed care, and got it thanks to the law.<sup>67</sup> Or take Governor John Kasich’s explanation for expanding Medicaid: “For those that live in the shadows of life, those who are the least among us, I will not accept the fact that the most vulnerable in our state should be ignored. We can help them.”<sup>68</sup> Or look at the actions of countless health care providers who have made our health system more coordinated, quality-oriented, and patient-centered. I will repeat what I said 4 years ago when the Supreme Court upheld the ACA: I am as confident as ever that looking back 20 years from now, the nation will be better off because of having the courage to pass this law and persevere. As this progress with health care reform in the United States demonstrates, faith in responsibility, belief in opportunity, and ability to unite around common values are what makes this nation great.



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## RECENT VOX ACA ARTICLES

*Ezra Klein and Sarah Kliff*

### Trump's "if you like your insurance, you can keep it" moment

#### One of Trump's top advisers just made repealing Obamacare much, much harder.

*Updated by Ezra Klein@ezraklein Jan 4, 2017, 2:00pm EST*

On Monday, Trump adviser Kellyanne Conway was on Morning Joe and was asked about Obamacare. Her recitation of her boss's position likely filled congressional Republicans with dread.

JOE SCARBOROUGH: If Americans have health care today under the Affordable Care Act, will they have health care --it sounds like Donald Trump is saying they will have health care under whatever replaces it?

KELLYANNE CONWAY, TRUMP TRANSITION: Yes. That is correct.

**We don't want anyone who currently has insurance to not have insurance.** Also, we are aware that the public likes coverage for pre-existing conditions. There are some pieces of merit in the current plan...

**Sahil Kapur** [Verified account](#) @sahilkapur

This is simply not realistic under any conceivable Obamacare replacement, as Republicans who work on health care policy understand.

This raises one of the central unanswered questions about Donald Trump. We know he wants to repeal Obamacare. But why does he want to repeal it? And how much of a political price is he willing to pay to repeal it?

Congressional Republicans are willing to pay a huge political price to repeal Obamacare, just as congressional Democrats paid a political price for enacting it. They're willing to pay this price because they think repealing Obamacare is important; for years, they have heard, and said, that Obamacare is socialism, it's a job killer, it's a government takeover, it's endless debt, it's the ruination of the best health care system in the world, it's free stuff that will create a dependent underclass permanently loyal to the Democratic Party.

Yes, taking health insurance from tens of millions of people will be unpopular, but it needs to be done. Sacrifices must be made.

With Trump, it's less clear. Sometimes he seems like a standard-issue Republican here. He says Obamacare is a disaster that he wants repealed, the plan his campaign released is an orthodox conservative repeal plan, and his pick for secretary of health and human services is one of the House's most ardent Obamacare foes.

But there's always been a divergence between Trump's official actions and his off-the-cuff rhetoric. In the past, Trump praised Canada's single-payer system. In an interview with 60 Minutes, he said he believe that "everybody's got to be covered" and under Trumpcare, "the

government's gonna pay for it." And now we have Conway saying, "We don't want anyone who currently has insurance not to have insurance" — a principle that wipes out every Republican repeal plan, including Trump's own.

Republicans think Obamacare is bad, and Trump thinks Obamacare is bad. But it's possible they don't think it's bad for the same reasons. Republicans think Obamacare is bad because it's a liberal approach to health reform — it raises taxes on the rich to give subsidies to the poor, heavily regulates the private insurance industry, and uses the IRS to penalize anyone who doesn't buy coverage that meets the government's standards.

Donald Trump, by contrast, might think Obamacare is bad mainly because it's unpopular, and because people at his rallies cheer when he says it's bad. And if that's the case, he is not going to want to replace it with something that's less popular, that leaves fewer people uninsured, and that creates nationwide chaos that he gets blamed for. But that's going to put him at odds with Republicans who want to roll back the law for ideological reasons, and who are willing to pay the price.

Or it's possible Trump will go along with his HHS pick and his party on this one and pass a law that rips health insurance from tens of millions of people and throws state health systems into chaos. But if he does that, then this clip of Conway, and his own words on 60 Minutes, is going to haunt him.

### **Why Obamacare enrollees voted for Trump**

In Whitley County, Kentucky, the uninsured rate declined 60 percent under Obamacare. So why did 82 percent of voters there support Donald Trump?

*Updated by Sarah Kliffsarah@vox.com Dec 13, 2016, 8:10am EST*

CORBIN, Kentucky — Kathy Oller is so committed to her job signing up fellow Kentuckians for Obamacare that last Halloween, she dressed up as a cat, set up a booth at a trick-or-treat event, and urged people to get on the rolls. She's enrolled so many people in the past three years that she long ago lost count.

"Must be somewhere in the thousands," she said to me one morning at a local buffet restaurant where she'd just finished an enrollment event with the staff.

The health care law has helped lots of people in Whitley County, where Oller works. The uninsured rate has fallen from 25 percent in 2013 to 10 percent today, according to data from the nonprofit Enroll America. Overall, Kentucky is now tied with West Virginia for the biggest increase in health coverage.

But Obamacare's success in Whitley County and across Kentucky hasn't translated into political support for the law. In fact, 82 percent of Whitley voters supported Donald Trump in the presidential election, even though he promised to repeal it.

Oller voted for Trump too.

“I found with Trump, he says a lot of stuff,” she said. “I just think all politicians promise you everything and then we’ll see. It’s like when you get married — ‘Oh, honey, I won’t do this, oh, honey, I won’t do that.’”

I spent last week in southeastern Kentucky talking to Obamacare enrollees, all of whom supported Trump in the election, trying to understand how the health care law factored into their decisions.

Many expressed frustration that Obamacare plans cost way too much, that premiums and deductibles had spiraled out of control. And part of their anger was wrapped up in the idea that other people were getting even better, even cheaper benefits — and those other people did not deserve the help.

There was a persistent belief that Trump would fix these problems and make Obamacare work better. I kept hearing informed voters, who had watched the election closely, say they did hear the promise of repeal but simply felt Trump couldn’t repeal a law that had done so much good for them. In fact, some of the people I talked to hope that one of the more divisive pieces of the law — Medicaid expansion — might become even more robust, offering more of the working poor a chance at the same coverage the very poor receive.

The political reality in Washington, however, looks much different: Republicans are dead set on repealing the Affordable Care Act. The plans they have proposed so far would leave millions of people without insurance and make it harder for sicker, older Americans to access coverage. No version of a Republican plan would keep the Medicaid expansion as Obamacare envisions it.

The question is not whether Republicans will end coverage for millions. It is when they will do it. Oller’s three years of work could very much be undone over the next three years.

In southeastern Kentucky, that idea didn’t seem to penetrate at all — not to Oller, and not to the people she signed up for coverage.

“We all need it,” Oller told me when I asked about the fact that Trump and congressional Republicans had promised Obamacare repeal. “You can’t get rid of it.”

### **“I’m really having a problem with the people that don’t want to work”**

Corbin is a small town in southeastern Kentucky, a place where cross-country truckers driving up and down I-75 will stop for the night. Its biggest tourist attraction is the first Kentucky Fried Chicken restaurant, which boasts an impressive collection of Harland Sanders memorabilia.

Oller has traveled around Corbin enrolling residents in health care plans since the coverage expansion started in 2014. And lately, she says, she’s watched the plans get more and more expensive.

“I like being able to give people good news, but it’s not always good news with Healthcare.gov, with the amount that premiums went up and the larger deductibles,” she says.

Premiums for midrange plans increased 22 percent nationally this year. That is, however, before the premium subsidies, which 80 percent of marketplace enrollees use — and which significantly lower the cost of coverage.

Narrow networks have become a problem in the area too. When Oller hosted an enrollment event at a hospital, she had to warn the enrollees that they couldn't use their insurance at that particular facility.

Oller renewed a 59-year-old woman's coverage (who asked her personal information be left out of this story) just after lunchtime on a Tuesday. She and her husband received a monthly tax credit that would cover most of their premium. But they would still need to contribute \$244 each month — and face a \$6,000 deductible.

The woman said she had insurance before the Affordable Care Act that was significantly more affordable, with \$5 copays and no deductible at all. She said she paid only \$200 or \$300 each month without a subsidy.

The deductible left her exasperated. "I am totally afraid to be sick," she says. "I don't have [that money] to pay upfront if I go to the hospital tomorrow."

Her plan did offer free preventive care, an Obamacare mandate. But she skips mammograms and colonoscopies because she doesn't think she'd have the money to pay for any follow-up care if the doctors did detect something.

The woman said she only buys insurance as financial protection — "to keep from losing my house if something major happened," she says. "But I'm not using it to go to the doctor. I've not used anything."

The woman was mad because her costs felt overwhelmingly expensive. These are some of the most common frustrations with the Affordable Care Act. Surveys show that high deductibles are the top complaint; 47 percent of enrollees told the Kaiser Family Foundation they were dissatisfied with their deductible.

A study from the Commonwealth Fund earlier this year found that four in 10 adults on Affordable Care Act plans didn't think they could afford to go to the doctor if they got sick. Fewer than half said it was easy to find an affordable plan.

But her frustration isn't just about the money she has to pay. She sees other people signing up for Medicaid, the health program for the poor that is arguably better coverage than she receives and almost free for enrollees. She is not eligible for Medicaid because her husband works and they are above the earnings threshold.

Medicaid is reserved for people who earn less than 138 percent of the poverty line — about \$22,000 for a couple. This woman understood the Medicaid expansion is also part of Obamacare, and she doesn't think the system is fair.

“They can go to the emergency room for a headache,” she says. “They’re going to the doctor for pills, and that’s what they’re on.”

She felt like this happened a lot to her: that she and her husband have worked most their lives but don’t seem to get nearly as much help as the poorer people she knows. She told a story about when she used to work as a school secretary: “They had a Christmas program. Some of the area programs would talk to teachers, and ask for a list of their poorest kids and get them clothes and toys and stuff. They’re not the ones who need help. They’re the ones getting the welfare and food stamps. I’m the one who is the working poor.”

Oller, the enrollment worker, expressed similar ideas the day we met.

“I really think Medicaid is good, but I’m really having a problem with the people that don’t want to work,” she said. “Us middle-class people are really, really upset about having to work constantly, and then these people are not responsible.”

Oller had told me earlier that she had enrolled on Medicaid for a few months, right before she started this job. She was taking some time off to care for her husband, who has cancer and was in chemotherapy treatment. I asked how she felt about enrolling in a program she sometimes criticizes.

“Oh, no,” she said quickly. “I worked my whole life, so I know I paid into it. I just felt like it was a time that I needed it. That’s what the system is set up for.”

“I guess I thought that, you know, he would not do this”

Before I went to Kentucky, I did about half a dozen interviews with experts on why the state had voting so resoundingly for politicians who want to dismantle Obamacare.

I kept hearing the same theory over and over again: Kentuckians just did not understand that what they signed up for was part of Obamacare. If they had, certainly they would have voted to save the law.

Kentucky had been deliberate in trying to hide Obamacare’s role in its coverage expansion. The state built a marketplace called Kynect where consumers could shop for the law’s private plans, in part to obscure the fact that it had anything to do with the unpopular federal law.

“We wanted to get as far away from the word Obamacare as we could,” Steve Beshear, the former Kentucky governor who oversaw the effort, says. “Polls at the time in Kentucky showed that Obamacare was disapproved of by maybe 60 percent of the people.”

I heard from Obamacare enrollment counselors who had seen this confusion play out firsthand, too. “When we’re approaching people about getting signed up on health care, one of the first questions they have is, ‘Is this Obamacare?’” says Michael Wynn, one of Oller’s co-workers. “So we would tell them, ‘No, this is not Obamacare. This is a state-run plan.’”

This was a story I heard a lot, but it was not the one that fit the Obamacare enrollees I met. All but one knew full well that the coverage was part of Obamacare. They voted for Trump because they were concerned about other issues — and just couldn't fathom the idea that this new coverage would be taken away from them.

"I guess I thought that, you know, he would not do this, he would not take health insurance away knowing it would affect so many peoples lives," says Debbie Mills, an Obamacare enrollee who supported Trump. "I mean, what are you to do then if you cannot pay for insurance?"

Mills and her husband run a furniture store. They used to buy their own health insurance in the early 2000s, but the premiums became unaffordable, surpassing \$1,200. They had gone without coverage for two years, paying cash for doctor visits, until the Affordable Care Act began.

"It's made it affordable," Mills says of Healthcare.gov. This year, she received generous tax credits and paid a \$115 monthly premium for a plan that covered herself, her husband, and her 19-year-old son.

Earlier this year, Mills's husband was diagnosed with non-alcoholic cirrhosis of the liver. He is now on the waiting list for a liver transplant. Obamacare's promise of health coverage, she says, has become absolutely vital in their lives.

Her enrollment process wasn't seamless; there were calls back and forth to different insurance companies and hospitals to make sure certain providers were in network. But she ultimately finished the process pretty happy, selecting a more robust plan for 2017 with a \$280 monthly premium for herself, her husband, and her son.

As Mills waited to fill out the enrollment paperwork, we began to talk about her vote for Donald Trump one month earlier.

"We were wanting change," she said. "We're in an area with a lot of coal. When people aren't in the coal mines, they're not spending and buying in our area." She said she thought Trump, a successful businessman, would have a better shot at fixing all that.

I asked her if she had followed the campaign and heard the candidates talk about repealing Obamacare. "I did, yeah," she said. "That was the only thing I did not like about him."

This was the conversation that followed, beginning with another question I asked:

Are you surprised how much Republicans are talking about repeal?

No.

Did you expect — do you think they'll do it, or do you think it'll be too hard?

I'm hoping that they don't, 'cause, I mean, what would they do then? Would this go away?

Yes, possibly.

The insurance?

It will go, if they repeal it. I mean, that's what they promised to do in so many elections.

Right ... so ... I don't know. ...

We spoke a good deal longer about the Affordable Care Act, and the possibility of repeal. Mills said she had gone into the voting booth confident that Republicans wouldn't dismantle the law, despite their promises. How could they, when people like her had become so reliant on it?

Mills's expectation that Trump would keep the Affordable Care Act, on the one hand, feel unrealistic: Of course Republicans would dismantle the law they spent six years campaigning against.

But it is also understandable: Legislators typically don't dismantle large health coverage programs that serve millions. Since their creation in 1965, Medicare and Medicaid have certainly faced some opposition but never threats of outright repeal.

"I assumed it was impossible to repeal the ACA with 20 million people covered," Larry Levitt, a health policy expert at the Kaiser Family Foundation, recently tweeted. "I may have been wrong about that."

Donald Trump, meanwhile, made promises during campaign interviews that sharply diverged from his actual campaign stances. He promised, "I am going to take care of everybody," during an interview with 60 Minutes — even though his health plan would leave 21 million without coverage.

The day after talking to Mills, I started to think about a headline I wrote for Vox a few years ago.

It was right after the Supreme Court upheld the health law in the *King v. Burwell* decision. "Obamacare's final test: it survived the Supreme Court, and is here to stay," the headline read. I quoted experts who said that because Obamacare had so many enrollees, of course Republicans wouldn't dare dismantle it. One leading Obamacare advocate promised that "the ACA is a permanent part of the American health care system."

We used the same logic that Mills did. We thought, of course you can't take away a program that millions of Americans rely on.

I spent election night frantically reporting and calling sources, trying to understand what parts of Obamacare Republicans could and couldn't dismantle. I didn't know at the time, nor had I devoted the necessary time to learn, until election night.

Mills was wrong about what Republicans would do to Obamacare. But then again, I write about it for a living. And I was wrong too.

“It was Russian roulette, but I felt that we needed change”

The Kentucky voters I spoke with constantly mentioned “change” as a reason they supported Trump.

“That man has a head for business,” one enrollee said. “He will absolutely do his best to change things.”

Still, Oller acknowledged she took a leap of faith with Trump.

“It was Russian roulette,” Oller said of her vote. “But I felt that we needed change.”

Trump will almost certainly bring change to Obamacare. Republicans are moving quickly on repealing Obamacare and replacing it with a new policy. The current proposals suggest that policy will be better for the young, rich, and healthy — but worse for the poor, sick, or old. The type of people I spoke with in Kentucky are those at risk of being disadvantaged by some of the replacement ideas.

Consider the case of the 59-year-old who was frustrated with the cost of coverage under Obamacare.

The Republican plans might do some things that would be good for her. They would likely stop requiring insurers to cover a specific set of benefits, like the preventive care that she doesn’t use. That would drive down her premiums, but wouldn’t get her any closer to better health care access.

And there are plenty of changes that make it more likely her premiums would go up.

Right now she and her husband will receive \$8,496 in subsidies toward their insurance premiums in 2017. Under the plan proposed by Rep. Tom Price, the Georgia Congress member whom Trump has selected to run the Health and Human Services Department, their subsidy would drop to \$6,000.

Obamacare increases her tax credit if her income goes down. But the Republican plans don’t do that. The Price plan, for example, gives everyone over the age of 50 — whether that is this woman in Kentucky or Bill Gates out in Seattle — the exact same tax credit on the individual market.

Obamacare currently limits how much insurers can charge older patients like Ruby. It says that insurance companies can only charge its oldest patients three times as much as the youngest ones. But the Price plan would get rid of that requirement and let insurers charge older patients — who tend to need more health care — whatever they want.

Debbie Mills and I spoke for about an hour about Obamacare. By the end of the conversation, it had moved from me interviewing her to her asking a few questions about what might change and whether the coverage she would sign up for in a few minutes would still be valid.

I ended up reassuring Mills that nothing would change for her coverage in 2017, and likely not 2018 — but that wasn't a guarantee. I didn't know what would happen either.

Our interview began to make her a bit nervous.

"You're scaring me now on the insurance part," she said. "I'm afraid now that the insurance is going to go away and we're going to be up a creek."

### **What we've learned from our Facebook community for Obamacare enrollees**

*Last month, Vox launched a Facebook group for enrollees to talk about their shared experience.*

*Updated by [Lauren Katz](mailto:Lauren.Katz@vox.com) [lauren.katz@vox.com](mailto:lauren.katz@vox.com) Jan 4, 2017, 1:50pm EST*

The day after the election, Vox health reporter Sarah Kliff sent out [a tweet](#) with a request: She wanted to talk to people who relied on Obamacare coverage and were worried about what the law's repeal could mean for them.

The 250-plus responses she got came from all over the country. It quickly became clear that not only is there a large group of Americans who are unsure of what will happen next with their health coverage, but they wanted to talk about it.

9 Nov



**Sarah Kliff**

✓ [@sarahkliff](#)

Do you have Obamacare? Are you worried about losing your coverage? Tell me what you're thinking. [sarah@vox.com](mailto:sarah@vox.com)

**Follow**



**Elayne C. Burke** [@chatelainedc](#)

[@sarahkliff](#) [@chrishayes](#) a week ago I panicked about a higher premium, now panicked that I won't be insurable bc of a pre-existing condition

6:00 PM - 9 Nov 2016 · [Washington, DC](#)

9 Nov



**Navy Mom** [@USNavyMomPA](#)

[@sarahkliff](#) Sent you an email, Sarah. I have Obamacare and I'm terrified.

**Follow**

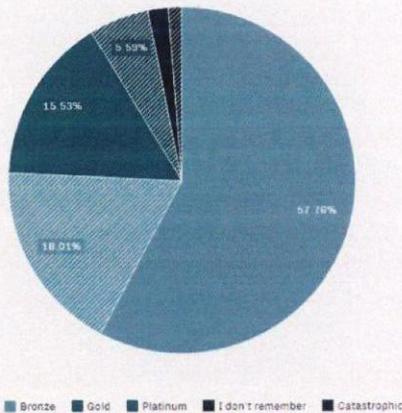


**Jo Kaur** [@SikhFeminist](#)

[@USNavyMomPA](#) [@sarahkliff](#) Ditto. My parents are on Obamacare and are in their late 50s, early 60s. They are petrified.

If you purchased coverage on the marketplace, what level of coverage did you buy in 2016?

6:08 PM - 9 Nov 2016



Source: <https://www.facebook.com/groups/youandme/>  
 Credit: Data collection by Lauren Katz and Sarah Kliff

Last month, we launched a [Facebook group](#) for Obamacare enrollees. The group has grown to more than 1,000 members. We've stepped back and watched group members make this space their own, a place where they share their stories and interesting articles, ask questions about health plans, and generally support one another in this uncertain time.

We've learned that a Facebook community can be an incredibly productive space for our readers to go through a shared experience together — and for us at Vox to

interact with our audience in a completely new way.

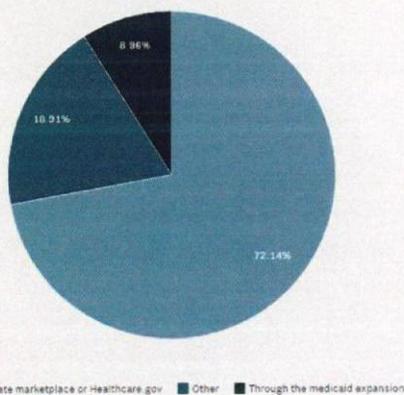
On our website, our roles are very defined: We write stories, and our audience reads them. Information flows from our writers to our readers. But in our Facebook community, roles are much more fluid: All of us are sharing and commenting on stories, with information flowing both ways.

### Who are the group members?

We collected data using a Google survey with 195 responses from the 1,046-member group. The average age of the respondents is 46.5 years. The group is geographically diverse: We received responses from people living in 42 states and the District of Columbia (New York is most heavily represented in our data).

Most respondents are using the Obamacare marketplace — and buying coverage for themselves:

Where do you get your health insurance?

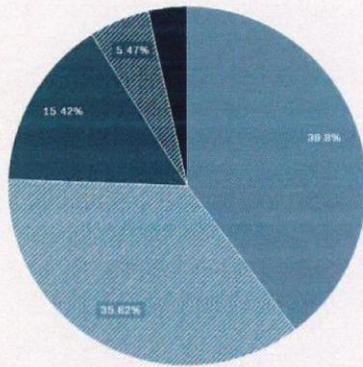


Source: [What's next? A community for Obamacare enrollees by Vox](#)  
 Credit: Data collection by Lauren Katz and Sarah Kliff

About half of our marketplace enrollees use tax credits; most use silver plans:

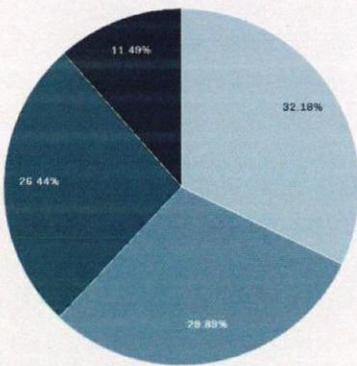
Enrollees experience frustration with deductibles and premiums:

Generally, are you satisfied with your current health insurance coverage?



■ I am very satisfied ■ I am somewhat satisfied ■ I am somewhat dissatisfied ■ I am neither satisfied or dissatisfied  
■ I am very dissatisfied

If you answered that you are "somewhat" or "very" dissatisfied with your plan, can you tell us why?



■ The cost-sharing like deductibles and co-pays is too high ■ Other ■ The premiums are too expensive  
■ I can't see the doctors I want to see because my network is too narrow

Data like this is only part of story we are getting from the community. Concerns about the future of their coverage and current challenges with premiums are personal and important to understanding the state of health care in America. With those concerns come personal questions that need addressing. So we recently polled the group to see what kinds of people they're most interested in hearing from. Shortly after, we hosted a [Facebook Live Q&A with Ron Pollack](#), the executive director of Families USA. We asked him questions we received from our Obamacare Facebook group about states initiating their own single-payer health insurance, whether or not subsidies for low-income Americans will be reduced, and the options for covering existing health conditions — including how to prevent insurance being dropped when an expensive condition develops.

### Finding a safe space on social media is rare

Mary Baker Eaton, a 64-year-old from

Massachusetts and a member of the Facebook group, recently explained to Vox by phone why she appreciates the community and feels protective of the space.

"The only ideology that the group has is that we don't want to die. We're a bunch of people, and this is life or death for us. This is not Republican, this is not independent, this is not Democrat," she said.

BEFORE JOINING THE GROUP, EATON DIDN'T TALK ABOUT HEALTH CARE ON FACEBOOK AT ALL

Before joining the group, Eaton didn't talk about health care on Facebook at all. There's so much misinformation out there, she says, which can make it difficult to have an intelligent and informed conversation online.

"This is the first place I can talk about — and have other people talk about — the Affordable Care Act where, at least in the first month, it feels like a welcoming place, and a safe place."

### Building a mutually-beneficial community

It's not always easy to find a group of people to geek out with you over health care policy. But that's what we've found here. And we're having a lot of fun.

Sarah and I are constantly experimenting with ways to engage the audience and provide them with valuable information they are looking for. Sarah often drops in interesting resources she comes across while researching stories with a note about why it's important:



**Sarah Kliff** shared a link.

December 20, 2016 at 4:17pm

Here's a report that I think will become important in the health care debate. The Congressional Budget Office is the agency here in D.C. that will "score" any replacement legislation, tell Congress how much it costs and how many people it will cover.

CBO put out a memo today that I found quite interesting. They said that, if the new health insurance plans under GOP replacement plans don't "provide enough financial protection against high medical costs" then they won't count those plans as insurance coverage. This means that it will be harder for Republicans to say that their plans cover lots of people.

Here's a link to the memo:

### **Challenges in Estimating the Number of People With Nongroup Health Insurance Coverage Under Proposals for Refundable Tax Credits**

What are the challenges in estimating the number of people who would purchase health insurance in the nongroup (or individual) market under proposals to replace the current tax-based subsidies with refundable tax credits?

CBO.GOV

And the community also gets to go behind-the-scenes of the reporting process:



**Sarah Kliff**

December 9, 2016 at 2:43pm

The guy you see on the right of this photograph is an Obamacare enrollment counselor who works in a very conservative area of Kentucky, one that voted heavily for Trump. I spent most of this week following him around, trying to understand why an area that had benefited so much from the Affordable Care Act had voted against it so strongly in this election.

A few observations from the road:

- Lots of Obamacare enrollees I talked to said they wanted change. They expected that Trump would change Obamacare for the better, not the worse.
- Most Obamacare enrollees I spoke with said they did hear Republicans' promises to repeal the law — but thought it was all campaign bluster. They thought that the law was so ingrained in society at this point, it couldn't possibly disappear.
- Lots of frustration with high premiums and deductibles. Deductibles came up \*a ton.\* One woman I spoke with didn't use preventive care because, even if they found anything, she couldn't afford to pay for it.

That's a quick download - but happy to answer questions in comments, — and the story should be out on Vox sometime this week.



This is only the beginning. We have some big plans for the group in 2017. Our goal for this group is to create a community, and we're thrilled to see that community is thriving.

Next Friday, we'll sit down with President Barack Obama to discuss Obamacare. We'll be conducting the interview in front of an audience that we've partly selected from our Facebook community.

### **The Congressional Budget Office has some bad news for Obamacare repealers**

*Updated by Sarah Kliff@sarah@vox.com Dec 28, 2016, 2:20pm EST*

The Congressional Budget Office has stepped into the Obamacare repeal fight, issuing a fierce warning to Republicans in the form of ... a sternly worded blog post.

CBO is the government's nonpartisan scorekeeper, the agency that tells Congress how much new programs cost and who they'll cover. Their analysts will estimate how many people get insurance under any Republican replacement plan.

And CBO, in its new blog post, says it won't let Republicans count especially skimpy coverage as health insurance. They argue that health insurance needs to provide "financial protection against high medical costs" for CBO to count the people who buy it as covered.

This is important, because in principle you could provide insurance coverage to everyone while spending practically nothing if you were willing to make the insurance totally worthless. Imagine a government program offering everyone a government-run insurance plan with a \$1 million deductible, 85 percent copays, and no coverage of preventative care. You could say that's a health insurance plan — just a really terrible one.

### **Republicans want skimpier insurance coverage**

That's an extreme example, of course, but one frequent Republican complaint about the Affordable Care Act is that the law mandates an excessively generous benefits package. This drives up premiums, they argue, and scares off some healthy and young enrollees who want to buy a skimpier plan.

Most Republican replacement plans aim to change this by repealing the Obamacare's "essential health benefits" provision, which mandates that all insurers cover a set of 10 different types of care including maternity services and pediatric care. The House GOP's "Better Way" plan would allow insurers to cut whatever benefits they no longer want to cover — a move that will likely benefit healthy people, who generally want less robust coverage.

Most Republican plans also allow insurance plans to set annual and lifetime limits on how much they'll pay out for medical care, a practice that the Affordable Care Act outlawed. Before the health care law, there were some "mini-med" plans that would cap annual health benefits at \$5,000 — an amount you can easily blow through after a few days in the hospital.

These changes, taken together, get rid of a lot of definitions Obamacare set up for health insurance. They will near certainly drive down the cost of insurance, but it's important to keep in mind: These are not the same plans currently offered under Obamacare. Enrollees will pay less but also get fewer benefits. Comparing premiums for the two is a bit like comparing the coach seats on an airplane to first class ones — or, for especially skimpy plans, getting strapped to the plane's wing.

### **CBO says it will set minimum standards for coverage**

CBO says, in this memo, that it's not going to consider these things to be the same: It won't count a plan that doesn't really insure against the high cost of medical bills as health insurance. This is the key sentence:

If there were no clear definition of what type of insurance product people could use their tax credit to purchase, everyone who received the tax credit would have access to some limited set of health care services, at a minimum, but not everyone would have insurance coverage

that offered financial protection against a high-cost or catastrophic medical event; CBO and JCT would not count those people with limited health benefits as having coverage.

CBO doesn't go as far in its blog post to outline what does count as "financial protection." Mini-med plans with annual limits of \$5,000 likely would not fit the CBO's definition, but what about a plan that sets a higher annual limit, above \$100,000 or so? Is that enough financial protection? Will plans that offer fewer benefits, those that decide to exclude maternity care, for example, count?

We don't quite know yet. But we do know that CBO is kicking off this discussion, and telling Republicans that some plans that could be offered under their proposals might not count as coverage in their eyes.

Asked to comment on the CBO blog post, AshLee Strong, a spokeswoman for House Speaker Paul Ryan (R-WI) said "Congressional leaders are working hand-in-glove with the incoming administration to lower health care costs and put families back in charge of choosing what kind of coverage best fits their needs. We will share more on our plans in the near future."



THE WHITE HOUSE

Washington

January 5, 2017

**WHITE HOUSE DEPARTURE PHOTOS**

DATE: January 6, 2017  
LOCATION: Oval Office  
TIME: 2:00 – 3:00 PM  
FROM: Anita Breckenridge

**I. PURPOSE**

To take photographs with 56 current staffers and 1 former staffer who are departing the White House.

**II. PARTICIPANTS**

- Attached at Tab A

**III. PRESS PLAN**

CLOSED Press.

**IV. SEQUENCE OF EVENTS**

- Staff members and their families enter the Oval Office one-by-one, pose for a photograph with YOU, and depart.

**V. REMARKS**

N/A.

**VI. ATTACHMENT**

- A. List of Participants



## LIST OF PARTICIPANTS

### **Sara Aviel**

Current Position: Executive Associate Director, Office of Management and Budget

Guests:

- Martin DiMarzio, husband
- Abraham DiMarzio, son

### **Matthew Beck (Departed WH Staffer)**

Previous Position: Confidential Assistant to the U.S. Chief Acquisition Officer and the U.S. Intellectual Property Enforcement Coordinator in OMB

Current Position: Graduate Student at the University of Cambridge

Guests:

- Marleen Beck, mother
- James Beck, father
- Jamie Beck, sister
- Rose Davich, grandmother

### **Christa Bowers**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Christman Bowers, brother
- Andrea Bowers, mother
- Tom Bowers, father
- Christian Bowers, brother
- Angel Williams, sister

### **Katherine Branch**

Current Position: Director of Special Projects and Events and Special Assistant to the Sen Advisor and Assistant to the President for Intergovernmental Affairs and Office of Public Engagement

Guests:

- Rebecca Murdock, mother
- Frankie Murdock, brother
- Natalie Borges, daughter
- Darrell Lyons, son
- Mikaela Lyons, granddaughter
- Willie Murdock, father

### **Crystal Brown**

Current Position: Senior Advisor in the Office of Management and Budget

Guests:

- Marcia Brown, mother
- Delores Sessoms, grandmother

**Shannon Buckingham**

Current Position: Associate Director for Communications, Office of Management and Budget

Guests:

- Stephen Buckingham, husband
- Lila Buckingham, daughter
- Daniel Buckingham, son

**Jessica Butherus**

Current Position: Special Assistant and Advisor to the Director, Office of Administration

Guests:

- Erin Resimius, sister
- Rita Butherus, mother
- Martin Butherus, father
- Katherine Weathers, sister

**Beth Cobert**

Current Position: Acting Director of the Office of Personnel Management

Guests:

- Adam Cioth, husband
- Talia Cioth, daughter
- Peter Cioth, son

**Iiona Cohen**

Current Position: General Counsel in the Office of Management and Budget

Guests:

- Mark Donnelly, husband
- Maya Donnelly Cohen, daughter
- Jack Donnelly Cohen, son
- Malcolm Cohen, father
- Judith Cohen, mother

**Elizabeth Cooke**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Gregory Cooke, father
- Karen Cooke, mother
- Owen Cooke, brother

**Shavonnia Corbin-Jonson**

Current Position: Advisor and Assistant to the Director

Guests:

- Roberta Johnson, grandmother

**Christopher Crosbie**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Courtney McLarnon Silk, partner
- Sharon Crosbie, mother
- Michael Crosbie, father
- Brigit Crosbie, sister
- Sean Crosbie, brother

**Lisa Danzig**

Current Position: Associate Director for Performance Management in the Office of Management and Budget

Guests:

- Alexander Downes, husband
- Amelia Downes, daughter
- Claire Downes, daughter

**Carolyn Dee**

Current Position: Deputy to the Associate Director for Legislative Affairs in the Office of Management and Budget

Guests:

- Constance Dee, mother
- Robert Dee, father

**Michael Dickerson**

Current Position: Administrator of the U.S. Digital Service

Guests:

- Mollie Dickerson, sister
- William Dickerson, father
- Debora Dickerson, mother
- Megan Busath, sister
- Evan Dickerson, brother

**Shaun Donovan**

Current Position: Director of the Office of Management and Budget

Guests:

- Elizabeth Eastman, wife
- Miles Donovan, son
- Lucas Donovan, son

**Mark Dowd**

Current Position: Senior Advisor in the Office of Management and Budget

Guests:

- Amanda Faye Dowd, wife
- Hope Faye Dowd, daughter
- Rian Faye Dowd, son

**Adaeze Enekwechi**

Current Position: Associate Director for Health in the Office of Management and Budget

Guests:

- Emmanuel Enekwechi, father
- Patricia Enekwechi, mother
- Chetachi Akamigbo, child
- Adanna Akamigbo, child

**Tamara Fucile**

Current Position: Associate Director for Legislative Affairs, Office of Management and Budget

Guests:

- Todd Watterson, husband
- Caroline Watterson, daughter
- Bridget Watterson, daughter
- Ryan Watterson, son

**Stephanie Gaither**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Jerry Gaither, father
- Miles Gaither, nephew
- Chanda Gaither, sister

**Marc Groman**

Current Position: Senior Advisor to the Director, Office of Management and Budget

Guests:

- Jared Reitman, son
- David Reitman, husband

**Abdullah Hasan**

Current Position: Press Assistant in the Office of Management and Budget

Guests:

- Nabila Hasan, sister
- Rafat Fahim, mother
- Fahim Hasan, father

**Jelani Hayes**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Kimberly Hayes, mother
- Brooke Hayes, sister
- Timothy Hayes, father

**William Jenkins**

Current Position: Chief of Staff and Senior Advisor, Office of Management and Budget

Guests:

- Adora Jenkins, wife
- William Jenkins, son

**Luis Jimenez**

Current Position: Counselor to the Ambassador, United States Trade Representative

**Katherine Johnson**

Current Position: Counselor to the Administrator, Office of Management and Budget

Guests:

- Laurie Richardson, friend
- Robert Klaus, friend

**Amanda Keammerer**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Diana Keammerer, grandmother
- Matthew Keammerer, brother
- Nancy Keammerer, mother
- Richard Keammerer, parent
- Luciano Garcia Jr., grandparents

**Clifton Kellogg**

Current Position: Senior Advisor in the Office of Management and Budget

Guests:

- Tamara Kellogg, sister
- Elizabeth Cavendish, wife
- Patricia Kellogg, mother
- Amitai Etzioni, family
- Lucy Kellogg, daughter

**Jonathan Lachman**

Current Position: Associate Director of National Security Programs in the Office of Management and Budget

Guests:

- Sherry Orbach Lachman, wife
- Ozzie Orbach, father-in-law
- Frances Gutterman, aunt

**Kristine Lam**

Current Position: Deputy to the Associate Director for Legislative Affairs

Guests:

- Michael Barnes, partner
- Phil Lam, brother
- Daniel Lam, brother

**Rayden Llano**

Current Position: Special Assistant to the Deputy Director for Management, Office of Management and Budget

Guests:

- Javier Romero, brother
- Rayda Llano, aunt
- Josefa Llano, grandmother
- Maria Castellanos, mother
- Johannie Llano, sister

**Charles Luftig**

Current Position: Deputy General Counsel in the Office of Management and Budget

Guests:

- Melissa Garrett, sister
- Patrick Garrett, brother
- Jillian Garrett, uncle
- Leo Garrett, uncle

**Andrew Mayock**

Current Position: Senior Advisor for the Office of Management and Budget

Guests:

- Cindy Huang, wife
- Anne Mayock, mother-in-law
- Marilan Huang, father-in-law
- Steel Huang, child
- Mariella Mayock, child
- Tai Mayock, child

**Jane McDermott**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Erin Roth, sister
- Bradley Roth Jr., brother-in-law
- Beverly McDermott, mother
- Hayley McDermott, sister

**Tara McGuinness**

Current Position: Senior Advisor to the Director, Office of Management and Budget

Guests:

- Mary McGuinness, mother
- Terence McGuinness, father
- Damian Murphy, husband
- Eleanor Murphy, daughter

**Justin Meservie**

Current Position: Senior Advisor in the Office of Management and Budget

Guests:

- Samantha Slater, wife
- Joseph Meservie, father
- Andrea Meservie, mother
- Lauren Meservie, sister
- Michele Montecalvo, sister

**Shahrzad Mohtadi**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Tara Mohtadi, sister
- Hamid Mohtadi, father
- Fahimeh Zarrin, mother

**Niyat Mulugheta**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Abel Mulugheta, brother
- Zewdi Ghebremichael, mother
- Mulugheta Ghebremichael, father
- Minab Mulugheta, brother
- Dawit Mulugheta, brother

**Scott Nathan**

Current Position: Associate Director for General Government Programs, Office of Management and Budget

Guests:

- Laura DeBonis, wife
- Lia Nathan, daughter
- Asher Nathan, son

**Devin O'Connor**

Current Position: Associate Director for Economic Policy in the Office of Management and Budget

Guests:

- Arlene O'Connor, mother
- Rebecca O'Connor, wife
- Margaret Rose, parent
- Thomas O'Connor, son
- Desmond O'Connor, son

**Brandon Ona**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Karen Ona, mother
- Brice Ona, brother

**Allison Orris**

Current Position: Associate Administrator, Office of Information and Regulatory Affairs (OIRA)

Guests:

- Barbara Orris, mother
- Richard Orris, brother

**Sharon Parrott**

Current Position: Associate Director for Education, Income Maintenance & Labor

Guests:

- Ralph Parrott, father
- Betty Parrott, mother
- Ari Blumenthal, husband
- Miriam Blumenthal, daughter
- Adira Blumenthal, daughter

**Angeli Patel**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Ashish Patel, mother
- Deviyaniben Patel, brother

**Daniel Roberts**

Current Position: Legislative Analyst in the Office of Management and Budget

Guests:

- Debra Roberts, mother
- Ruben Roberts, father

**Caroline Ross**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- John Lykins, partner
- Shelley Ross, mother
- Richard Ross, father
- Charles Ross, brother

**Preeya Saikia**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Gini Saikia, mother
- Prabhat Saikia, father

**Philippa Scarlett**

Current Position: Deputy Intellectual Property Enforcement Coordinator

Guests:

- David Wakelyn, husband
- Natalie Wakelyn, daughter
- Alia Wakelyn, daughter
- Earle Scarlett, father
- Barbara Scarlett, mother

**Anthony Scott**

Current Position: Associate Director for General Government Programs, Office of Management and Budget

Guests:

- Laura DeBonis, wife
- Lia Nathan, daughter
- Asher Nathan, son

**Max Sgro**

Current Position: Confidential Assistant in the Office of Management and Budget

**Howard Shelanski**

Current Position: Administrator, Office of Information and Regulatory Affairs

Guests:

- Nicole Soulanille, partner
- Isaac Shelanski, child
- Vivien Shelanski, mother
- Michael Shelanski, father

**Gregory Touhill**

Current Position: U.S. Chief Information Security Officer

Guests:

- Katherine Touhill, daughter
- Andrew Touhill, son
- Charlene Touhill, wife

**Haley Van Dyck**

Current Position: Deputy Administrator, U.S. Digital Service

Guests:

- Jonathan Van Dyck, brother
- Thomas Van Dyck, father
- Jean Barnes, grandmother
- Janet Castle, mother

**Janelle Watson**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Janice Watson, mother
- Lonnie Watson, father
- Lonnie Watson, brother

**Carl Young**

Current Position: Confidential Assistant in the Office of Management and Budget

Guests:

- Elizabeth Young, aunt
- April Robinson, aunt
- Julia Young, sister

**Ali Zaidi**

Current Position: Associate Director for Natural Resource Programs in the Office of Management and Budget

Guests:

- Syed Zaidi, father
- Afroz Zaidi, mother
- Danish Zaidi, brother
- Syed Rizvi, grandmother



# Withdrawal Marker

## Obama Presidential Library

FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Memorandum	Interview with George Stephanopoulos - From: Rob O'Donnell and Brooke Lillard	3	01/05/2017	P5;

**This marker identifies the original location of the withdrawn item listed above.  
For a complete list of items withdrawn from this folder, see the  
Withdrawal/Redaction Sheet at the front of the folder.**

### COLLECTION:

Records Management, White House Office of (WHORM)

### SERIES:

Subject Files - FG001-07 (Briefing Papers)

### FOLDER TITLE:

1222132

### FRC ID:

9828

### OA Num.:

### NARA Num.:

### FOIA IDs and Segments:

22-26844-F

### RESTRICTION CODES

#### Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

#### Deed of Gift Restrictions

- A. Closed by Executive Order 13526 governing access to national security information.
- B. Closed by statute or by the agency which originated the document.
- C. Closed in accordance with restrictions contained in donor's deed of gift.

#### Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

#### Records Not Subject to FOIA

Court Sealed - The document is withheld under a court seal and is not subject to the Freedom of Information Act.



# Withdrawal Marker

## Obama Presidential Library

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Talking Points	Talking Points	7	N. D.	P5;

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