

## **Mackinac Center for Public Policy**

### **Issues and Ideas Forum**

**“After Obamacare: How Michigan Can Deliver on Patient-Centered Health Care”**

**Speaker:**

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**Introduction and Moderator:**

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*Transcript By  
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(Begin video presentation.)

VOICEOVER: Dani Valassis thought her health insurance woes were over when Michigan expanded Medicaid and a state worker told her she was eligible.

DANI VALASSIS: And I literally hugged the guy, and he was a little taken aback. But I just was grateful because I am sort of a red-flag patient, and I need to have some kind of coverage for catastrophic issues.

VOICEOVER: Dani has a history of health problems, including cancer, and needs frequent access to a doctor to stay out of the emergency room. But Medicaid did not provide that.

MS. VALASSIS: Some doctors weren't available. They weren't taking new patients. And the ones that were were having so many people that they lost the personal touch of taking care of an individual person like that.

VOICEOVER: When she did get in to see a doctor, visits lasted a few minutes, and no one seemed to have the time to appreciate her medical history.

MS. VALASSIS: It was just frustrating. I felt like I was cattle.

VOICEOVER: The experience was affecting her health. She went back to her physician of 15 years, but learned he didn't accept Medicaid – and, to her surprise, any insurance. She thought there was no way that she could afford the charges until she learned –

MS. VALASSIS: You pay a flat fee, you can see him as often as you want, and we can communicate on the internet, and it's amazing.

VOICEOVER: Dani's physician, internist Dr. Chad Savage, now practices medicine under a new billing model known as direct primary care. For all of those unlimited primary visits, Dani pays \$49 a month. Dr. Savage can offer that price because he saves money by not having to process insurance claims.

CHAD SAVAGE, M.D. (YourChoice Direct Care): No one has exact numbers, but I can tell you that all the numbers I've heard are too low – that, when I left the insurance-based system, my cost of operating my practice dropped by more than half.

VOICEOVER: Direct primary care provides just that, primary care – treatment for chronic and acute health problems. Patients can also get deep discounts on things like imaging, basic prescriptions, and medical supplies, which Dr. Savage purchases directly, saving patients the middleman charges.

DR. SAVAGE: So this here was 214 bucks.

VOICEOVER: Take these supplies for diabetes, which one of his patients received under Medicare and saved a record of the claim.

DR. SAVAGE: I looked to see what we can purchase them for through a direct approach, and the entire thing's about \$32, versus \$246.

VOICEOVER: By not having to process claims, Dr. Savage can spend more time with his patients. Patients come in earlier because they don't fear a bill for an unnecessary visit. Dr. Savage can sometimes manage patients over the phone or computer.

DR. SAVAGE: This is not something that can easily be done in the insurance-based system because they can't figure out how to bill and code it.

VOICEOVER: Because of its promise to both doctors and patients, direct primary care has captured the attention of lawmakers – not just for Medicaid, which costs taxpayers billions, but health insurance for government workers.

MICHIGAN STATE SENATOR PATRICK COLBECK (R): If we can find a way to go off and provide better care for less money, that's where you start.

VOICEOVER: Michigan State Senator Patrick Colbeck wants to test direct primary care with a small group of Medicaid patients. Not only could it be instructive for state government, but anyone who pays for health insurance. Michigan's private sector spends over \$35 billion a year on health care. If a new pay model could save just 18 percent, that would be significant.

SEN. COLBECK: If you freed up about \$6 billion for employers in the state of Michigan, that can go to higher-paying jobs, that can go to more jobs, that can go to being more competitive in the marketplace. Businesses will flock to Michigan. As a matter of fact, we'd probably have a lot of friends in Canada that are going to come on over for medical tourism over to Michigan because we will be the center of a free-market health care revolution.

VOICEOVER: In a flat-fee-based model, both patient and doctor have an incentive for keeping costs down. Patients want to avoid having to use expensive catastrophic insurance they would carry, and doctors won't want to lose their members if they discover direct primary care isn't keeping them out of the hospital.

Michigan may have to act soon. Federal funding for expanded Medicaid starts phasing out in 2017. If the program fails to reach projected savings, Michigan law calls for it to end, perhaps leaving tens of thousands without health coverage.

Dani says if she's willing to pay out of her own pocket for direct primary care, it says a lot about the Medicaid system today. And she's grateful that people like Dr. Savage have found a way to make it work.

MS. VALASSIS: He's very, very thorough. Comforting to know that he's there. It's perfect for me. It would help a lot of people.

(End video presentation.)

(Applause.)

JOHN C. MOZENA: Thank you, everyone. Thank you. Welcome to the Issues and Ideas from the Mackinac Center for Public Policy.

I have been informed that since we shot that video by Jack McHugh, who MichiganVotes online site, that both the House and Senate have placed a direct primary care funding pilot into the Medicaid budgets for this year. So, with any luck and with a little bit of some more shovel work by Senator Colbeck, maybe we'll actually have a chance to see how that works this year, so.

My name is John Mozena. I am the vice president for marketing and communications at the Mackinac Center for Public Policy. On behalf of all of us, I want to thank you all for joining us.

I'd also like to thank our Issues and Ideas event sponsors, Auto-Owners Insurance. They make all of this possible, and we certainly appreciate their support. Since this topic does touch on insurance today, we do want to make clear that they do not have input on the content of the event.

If you have questions during the event, we have these question-and-answer cards. Please fill them out. I or one of my colleagues will pick them up, and we will make sure that we leave plenty of time for Naomi to answer all of your good questions. We appreciate all the great questions that we get at these events, and they're often some of the highlight(s).

So, health care. I'm a marketing and communications guy, but I joked on Twitter the other day that if I ever get a tattoo, it will probably say "health insurance and health care are not the same thing." (Laughter.) And that's because this is a bit of an old home week for me: I started off my career 20 years ago as a reporter covering health care policy here in the state and was a press corps credentialed member here. And it was a different time. It was before term limits, so dinosaurs stalked the earth and often had committee chairmanships – (laughter) – Cadillac plans were what UAW members had when they were building the Cadillacs, and that HMOs were going to solve all our problems, which didn't end up happening.

It was a simpler time, but now we're living in interesting times. Most notably, something is going to happen to the Affordable Care Act, whether it's a change or repeal or replace. Whatever form that takes, that's going to have huge implications for the states. And whatever happens to that, we also have opportunities at the state level for innovation, for creativity, for good policy that makes a difference in people's lives.

To help us identify and navigate what those challenges and opportunities are, we are privileged to have one of the finest state-level health care policy experts in the nation today. Naomi Lopez-Bauman is an adjunct scholar for us at the Mackinac Center. She's also the

director of health care policy at the Goldwater Institute in Arizona. Her past work includes extensive research on federal and state health care programs. She served on a California Senate Bipartisan Task Force on homelessness, as a special policy adviser to the state of Michigan's Secchia Commission under Governor Engler, and much more. She's the author of more than a hundred studies and commentaries, and makes frequent media appearances, including on "Politically Incorrect," PBS, CNN, CNBC, Fox News and NBC. She is emphatically not fake news. (Laughter.)

Please join me in welcoming Naomi Lopez-Bauman. (Applause.)

NAOMI LOPEZ-BAUMAN: Hello. Thank you so much for having me today. I really appreciate being here, and I always enjoy working with my fellow liberty fighters at the Mackinac Center.

So today I'm going to be talking about health care. I work – I've done a lot of work on both the federal and the state level of health care policy, and it is never a dull moment. And that's particularly true right now.

So if you want to know what's happening in health care, you need to only see this. And we can actually wrap up right here. (Laughter.)

So Republicans have been running against the Affordable Care Act for eight years. And it was actually quite a big surprise, I think, to a lot of people that Trump won. And so now Republicans are in the position where there's not – they have not coalesced around a single plan, as we know, and there's a lot of disagreement about what to do next. But more importantly, politically, a lot of Republicans in Congress, in the Senate, are in a position where they actually don't want to roll back the ACA, and that's creating a lot of political problems in terms of moving forward on any kind of reform.

I'm not actually clear that we will have a reform anytime soon. I would put even money on the – on the potential that summer rolls around, the individual market is collapsing around the country, and that is used as leverage to bring Democrats to the table. If you want to wait until summer and bring Democrats to the table, we know that any kind of possible reform is going to actually move left of where we are today.

So that's the bad news. The good news is that at the state level there is still enormous potential and opportunity to actually move towards a consumer-driven, free-market health care system.

But before we move into that, I want to just point out John's point, and that is there are really three important things to remember whenever we're talking about health care.

The first is that insurance is a financial product. It is not care. It is a backup catastrophic payment in case something goes wrong. Unfortunately, we've moved very far away from that. But our goal should always be to move back towards that kind of a model.

The second thing is that you can repeal and replace the ACA and still protect the sick. This is something that lawmakers in Washington don't seem to have a good grasp on. The idea is that if you were to repeal the ACA, people would be left uninsured, people would be dying in the streets. You know, of course, as a society, we have reached a consensus that we should have some kind of safety net. And we do have a safety net. But the bottom line is that it doesn't have to be the ACA that provides that safety net. We can have a lot of different types of models that look a lot of different ways and involve a lot less government.

And the third most important lesson I think that we need to draw as people who work on the state level is that the calamity that's the ACA should never be repeated again. The biggest problem with the ACA is that it took control from the states and sent it to Washington. That's never a recipe for success, it's never worked, and it's never going to work. We know that states know how to do this better. We will do a better job. We will be more accountable to the people that we're trying to serve. And that is probably the most important lesson.

And that's actually the crux of the fight that's going on right now on Capitol Hill, is should states be allowed to have that control? We know right now, unfortunately, that states are going to have to go to Washington and beg permission to get out of the ACA. That's basically a done deal already. The question is, from here forward, what are we going to do about this question?

So the great news about health care is that we've got 50 laboratories to experiment in. Some states will do it really well. Some states will do it very poorly. We know that Colorado and Vermont will always be failures, same with California. But we also have the potential for really great innovations from states like Michigan and Wisconsin and Texas and Arizona and Florida. And so the idea that – anytime that you take control away from the states, you're taking away the options. You're taking away the examples of how to do it right.

But, fortunately, we have some tools: We've got state constitutions, we've got capitols, and we've got courtrooms. This is where the policy fight will take place. This is where we will win these victories on health care. We have opportunities to legislate and litigate for health care freedom in a number of areas.

So, when I talk to lawmakers around the country – and I've written about this a lot – there are basically 10 areas where state lawmakers have the authority still to do something about health care impacting affordability and accessibility. But in order to lay the groundwork for a fertile health care market, in order to lay the groundwork for moving forward post-ACA, I think there are 10 important steps that states need to be looking at. And not every state will do every single one of these 10 items, but these are really the places where health care efforts need to be focused on the state level.

The first is establishing accountability and transparency. We're always in the position of playing defense on health care. If there's someone who's uninsured, the media is out there saying, oh, you know, we've got to expand Medicaid because someone's uninsured. But the bottom line is that we will always have uninsured amongst us. The reasons are very complicated

and complex, but that's just a reality. What we need to do is put the people who would expand Medicaid, the people who would expand government into the health care system, on the defense.

We need to come back to them with a list of all of the federal dollars and all of the state dollars that a state is spending. There is no lack of commitment to health care. There's no lack of resources. Any state around the country is easily spending five figures on every uninsured person in their state, easily spending four figures on every poor person in their state just for health care delivery. But the reality is that we know that only about 20 to 40 cents of each dollar is actually meeting – is actually reaching the patient and actually providing care. We need to change that. And we need to change the conversation. We need to ask – we need to ask the people who would expand government care to defend these numbers, defend these programs, and show us what you're going to do, how you're going to do it better with the resources that we're already spending.

The second issue is to regain control over insurance markets. The ACA took control from states over the regulation of insurance, for the most part, and so states really are left with Washington mandates and edicts on this. This is not going to be easy, and this is – this is right now one of the areas where there's a lot of fighting going on on Capitol Hill and in Washington, because a lot of Republican lawmakers don't want to cede that authority back to the states.

Fortunately, Michigan did not pass laws implementing the Affordable Care Act. This was one of the great victories that's an untold victory in the state, but that is that lawmakers here did not pass laws basically saying that we're going to forever do ACA. And this is going to be very helpful because any rollback of the ACA will mean that you will not have to go back to the legislature to repeal those laws that are on the books. And, unfortunately, a lot of states did do that, and they're going to be in a much more – they're going to have a much harder time moving towards a free-market health care system and one free of Washington mandates.

So the next big area is Medicaid. And this is one of the – unfortunately, one of the areas where Michigan did not do so well. So, as we know, you've got about 600,000 people on the rolls, on Medicaid. Many of them are able-bodied adults – the vast majority, in fact. And you've also got a – you've also got a situation where we know that you're paying for a lot of people who aren't actually eligible for that care.

So the next area that states need to move, particularly states like Michigan that expanded Medicaid, is to verify Medicaid eligibility. Particularly amongst able-bodied adults, eligibility is short. You might have a three-, five-month spell, and people go on and off the rolls very quickly. It's a very fluid population in terms of eligibility for Medicaid. But you're still paying for them to get that care. Under managed care in Medicaid you're paying a flat rate for everyone who is supposedly eligible, so you're paying a lot of money for people who either aren't getting care or shouldn't be getting that care from taxpayer dollars. And so that's going to be a very important issue. States need to be doing this more frequently. They can even move to onsite verification, if possible.

The next area is going to be unwinding Medicaid expansion. There's a lot of fear about this, and particularly in state capitals of states where they did expand Medicaid. And certainly

your governor is one of poster boys for this, where they go to Washington and they cry buckets of tears talking about how they can't possibly roll back Medicaid expansion. But the reality is that it's actually very easy to do so.

If you were to do an enrollment freeze today, in two years you'd have 80 percent of the population – the expansion population off the rolls just by natural attrition. Because this is such a fluid population, because their eligibility changes so frequently, they'd be off the rolls. And this is a very easy way to do it.

So, for the first time in almost a decade, there's an administration that's open to Medicaid innovation. Secretary Price has communicated with all of the governors around the country that they want states to innovate. They want states to apply to Washington for permission to get out of some of the most onerous Medicaid regulations and rules. It's a different day.

In the past, states have asked for very, very modest cost-sharing provisions, for example, penalties for unnecessary use of ERs, penalties for missed appointments, and they've been told no. These are all very common-sense types of reforms that would actually have a big impact on the program, but they've been – but states have been told no over and over.

But now is the time for states to think big. There are enormous opportunities, and it's – it may only be a short window. We don't really know. But right now states need to be looking at ways of really reimagining their Medicaid system.

For example, work requirements. Very simple: you can – you can require 80 hours per month of some kind of work activity for able-bodied adults to maintain eligibility. You can have health savings vehicles that would allow people to move from Medicaid to private – to private coverage. You can have lockout periods where if someone is not truly eligible but they're participating, you can lock them out of the program. If they're not paying premiums, you can lock them out of the program. There are a lot of innovations that would really impact Medicaid participation and really encourage people to not fall into the Medicaid trap, where if they earn one dollar more they lose eligibility for the program. So these are the kind of reforms that state lawmakers should be developing and designing, and sending to Washington to reform their program.

The next big area of reform is supply-side health care. This is very controversial. It's usually a pretty big lift, but it's actually doable, and it's a really important one. The idea is that health care professionals should be allowed to practice at the top of their medical education and professional training. There are a lot of areas where a state can expand scope of practice: nurse practitioners, certified registered nurse anesthetists, pharmacists.

The health system is based on a decades-old model that is no longer relevant. We have people who monitor a lot of aspects of their health care and wellness. We have people who use telemedicine; they're able to hail over the internet a physician's appointment immediately, in real time, 24/7. So the idea that we're going to maintain the same scope-of-practice model that we had decades ago doesn't make any sense for today's 21<sup>st</sup>-century health care. And, by changing



scope-of-practice laws, you're actually increasing the availability of providers, and you're actually able to impact the cost.

I would say, though, on scope of – whenever you're going to address scope of practice, to be very careful about supervision. Supervision in these laws is very important. It's a question of does a doctor have to be in the room watching over the shoulder of the health care provider, or can they be doing consultations within, say, 24 hours with that provider. And so the question is, you know – and I think my recommendation is always to use a general supervision model so that the provider can be as free as possible to meet needs in rural areas, for example, to go to places where patients are located, and to actually be able to charge less money.

What we've seen in a lot of states that expand scope of practice is that, with direct supervision, they actually now in some states are actually, for example, requiring nurse practitioners to pay the practice to just participate and practice there. And so we have to be very careful whenever we look at these – look at these rules, but this is a really important area to look at.

The next area for reform basically is utilizing what's happening in the private sector, the innovations that are going on. Too often, lawmakers get caught in the trap of looking at where the federal dollars are, where the state dollars are, and looking at metrics such as the uninsured rate only, without looking beyond that: what is happening in the private sector.

The great news is that the private sector is ignoring what's going on in Washington, ignoring what's going on in state houses, and innovating anyway, without waiting for lawmakers to act. One of the most important areas is telemedicine, where it is possible in real time to get an appointment. You don't have to wait a week. If you've got something simple, you can – you can use Teladoc. You can use all kinds of – all kinds of smartphone applications that would hook you up to a physician in real time. Direct primary care, which has been discussed and I know is really important issue right now in this legislative session, is an area that can absolutely impact access and affordability in the state. It is already working in other states, and we've already seen some preliminary evidence that it working in a couple of Medicaid programs around the country. It's also going to be used in some state employee benefit programs. And so this really is an area that is not only attractive to patients, but is also attractive to providers. So the more fertile you make the state for this kind of practice, the better off the state will be.

The reason that this works so well is that you're cutting out the middle man. You're cutting out the administration that goes along with all of these health care programs and all of these health care rules. The dirty little secret of the ACA is that it was a jobs program. And direct primary – and whenever you look at how many more administrators, hospitals and physicians' offices are required in order to operate their practice, that's where job growth has been. It's been ACA-related. Direct primary care eliminates that, and allows to – allows the physician to restore the doctor-patient relationship, and get out of all the huge administrative burden that they now face in regular practices.

Another area is expanding access to voluntary care. So volunteer care can be done in a number of ways. One of the most interesting ways that it's – that it was just passed in Ohio in

the last session was to basically allow continuing medical education credits to be used towards providing free care for indigent patients. But the more that you encourage and allow and make it easy, and minimize any liability concerns, the better off your state will be, not only in terms of providing care to those who need it most, but also to just encouraging the reinvigoration of civil society in the health care sector, which unfortunately has been severely damaged by government intervention over the decades.

So one of my favorite areas is state employee health. And the reason that I really like looking at state employee health plans is because a lot of states have self-insured plans. That means that it's very easy to implement change. You don't have to go through a whole lot of rigmarole in order to get something implemented in a state employee health plan if you're self-insured. So if you're able to infuse health plans with free market health options – for example, direct primary care in the state employee health plan – you're going to be much better off down the road, not only because you're providing a benefit that state employees will truly value and will make – will make their lives better, but you're also able to then export that kind of reform into Medicaid.

A lot of times, whenever we to innovate in Medicaid, we're accused of providing second-tier care, trying to cheapen health care. But if you've got something implemented already, like telemedicine or direct primary care in a state employee health plan, you really make it a lot easier to move it to Medicaid, because you've got a natural constituency for it and you're also providing something that's a pretty good benefit. You don't have to go back and argue that it's not second-tier care. You know that it's good, and your constituency of state employees also know that it's good, and in demand, and something that they like.

And the last area is protecting taxpayers from the Affordable Care Cadillac tax. The Cadillac tax is a 40 percent excise tax under the Affordable Care Act which is based on a CPI, not health inflation, adjusted threshold. Every dollar you go above that threshold is a 40 percent tax. So basically, it is a very steep tax that doesn't provide one penny of care to patients. So the Cadillac tax – we've got a lot of strange bedfellows in health care reform. The unions are very much against this, not surprisingly. (Laughs.) But basically, this tax – the implementation of this has been delayed over and over. And even though it's been delayed, there will be some incarnation of the Cadillac tax in any health care reform, I believe. Republicans are very much in favor of moving from an open-ended – open-ended tax rate benefit to something like a Cadillac tax or capping the employer exclusion on health care.

So regardless of what happens, just keep an eye on this particular area. It is really helpful to run bills on the Cadillac tax basically saying that state taxpayers are not going to pay an excise tax that doesn't provide a penny of care. And that will help to encourage more reforms on the state employee health care, on the health care system, and the retiree system because you will be exposing the fact that absent reform your taxpayers will be sending money to Washington for absolutely no reason.

So one of the mistakes that we often make in health care reform is looking at metrics like the number of uninsured. This is really, I think, one of the most fundamental challenges that we face in terms of moving from our current system to a more free-market system. And this is

exactly what we're seeing politically from Congress, is that a lot of lawmakers are afraid to repeal the ACA because they know that the uninsured rate will go up, and it will. But the bottom line is that we're talking about the wrong – we're talking about the wrong issue. We're talking about the wrong metric.

Whenever the private sector does in and innovates – for example, in the northwest – in the Pacific Northwest of the U.S., you have springing up now what are basically genius bars for health care, where a patient can go in, they oftentimes pay a flat fee – like direct primary care. They go in, they see a doctor, they get treated very well, and they have a really great experience. So they have access and they have affordability. We don't talk about that when we talk about health care reform.

We're only talking about metrics and things that really don't matter to the – things that fundamentally don't matter to the patient. They don't matter to the person who lives in a rural area who's paying \$20,000 in premiums and deductibles before they actually can use a dollar of their actual health insurance coverage. They're not talking – they're not talking to people who have a Medicaid card but can't get an appointment. They're not talking to – they're not talking about the people who are actually being hurt by the current law, and people that have not necessarily been helped by the status quo, even pre-ACA.

So what we need to be talking about is the consumer-centric health care experience. What does it mean to change health care? What does it mean to have direct primary care, to have more telemedicine, to have more innovations? It means that the patient has access and affordable health care options. Not everyone will use them, not everyone will need them. But you will be moving in the right direction when you start focusing on the consumer, on the patient, instead of focusing on the hospital market share, on which benefits are going to be required in your insurance market. This is what matters. The patient matters. The consumer matters. And this is the metric that is the only winning one if we're going to move forward.

Oops, wrong direction.

So this is a really tiny slide, and I can certainly send it out. But the next steps for states are going to be really critical. We are dealing with a moving target right now. We don't know exactly what's going to happen with health care reform. But there are some important things that states can do. As I mentioned, I just gave you a list of 10 things that state lawmakers can do today that don't require a government permission slip from Washington. But there are also other things that you can do.

You can go back to the drawing board on your current insurance regulations and take a look and see, now that – you know, now that the public really does understand what insurance regulations mean in terms of costs, in terms of being able to afford their premiums, it's a good opportunity to go back and figure out: Do we have the right regulatory framework for selling insurance, or should it be more open? Should people – shouldn't it be legal for people to buy a high-deductible, catastrophic policy?

Also, states should be looking at pursuing Medicaid waivers, as I mentioned before, thinking big on Medicaid, and also looking forward to possible using 1332 waivers. This was part of the Affordable Care Act that allows states to get out of a lot of the essential health benefits that are required as part of the law. There will be a string to this, probably, based on the negotiations that are going on right now in Washington, where states will be required to have some kind of high-risk pool or some kind of mechanism at the state level to manage risk to underwrite those patients who can't – who cannot be underwritten through the regular insurance market in order to move forward with a 1332 waiver.

But what this does is it would allow – it would allow you to move people from Medicaid seamless to private insurance coverage. And that should always be the goal – private coverage. It would also allow you to get out of a lot of the regulations that now currently are imposing a very high cost on consumers who don't have a subsidy in the insurance market. So you've got a lot of tools at your disposal. You've got Medicaid waivers, you can use state plan amendments to revise your Medicaid – your Medicaid program. The 1332 waivers, it's a little bit early. They're not quite ripe yet. We're waiting for new guidance to come out of HHS that basically makes it easier for you to innovate and get out of the – get out of the ACA insurance market regulations. But that will be coming, I believe. And you can go back to the drawing board on your state insurance regulations, and you can also think big on Medicaid.

These are going to be the – this is going to be a lot of heavy lifting. It is going to be very, very difficult to move these. But it is absolutely essential that states do this. Otherwise, we're going to be left with Washington basically saying: Oh, we gave you an opportunity and you didn't take it. Michigan is in the very unique position to move forward. You've innovated on welfare reform in the past. Now it's your turn to do the same thing on health care.

I know that this is a very deep and complex issue, and the old Chinese curse, may you live in interesting times, is certainly true today. I would be happy to answer any questions that you have, or to follow up later. I can be reached through email, through Twitter, or through phone. And I'm happy to share my slides with you. And I'm happy to take questions.

MR. MOZENA: Thank you very much, Naomi. (Applause.) As we said before, we'd appreciate it if folks could ask questions off the comment cards, just so we have a chance to try to collect it and make sure that sort of all the themes gets touched one at a time. I'm going to start off with one.

One of the things that you and your colleagues at the Goldwater Institute have done some really interesting work on is right to try, which isn't exactly in this role but it's related. So I wanted to make sure that you had a chance to touch on that for folks here.

MS. LOPEZ-BAUMAN: Yeah, so the Goldwater Institute has a right to try model legislation, that is now law, I believe, in 34 states. And it's sitting on the governors' desks of three more states, I believe. Basically, we've seen – we've seen people trying to reform the FDA, people who have tried to make them less risk-averse, more willing to speed up the approval process, and the – you know, the FDA used to basically just evaluate drugs based on safety. But now they do it on safety and efficacy. And they continue to move the bar higher and

higher, so that you might have a drug or treatment that actually does a great job for 12 percent of the population, but it's rejected because of that bar continuing to move higher and higher.

So the Goldwater Institute basically – our very smart litigators used the state constitutions, that basically – that basically takes the – uses the position that if you have a right to die, you certainly have a right to try to save your own life, and you also have a right to medical self-defense. So the idea is that using state constitutions and state legislations, individuals don't have to go to the FDA and beg for permission to save their own lives. It should be legal. And that's what we've done in the states around the country. We know that there's Dr. Delpassand in Texas, who has treated more than 80 cancer patients and is saving lives. We know of other doctors around the country who have – who have used it. And we are also working on national – on federal legislation that would also protect states that have this law in places.

Using that same model, and – this is a – this is a model that we're using a whole lot in health care – we take constitutional protections which go above and beyond federal constitutional protections. The federal constitution is a floor not a ceiling on individual liberty. So we use the state protections. One of those is free speech. And in health care I'm really happy to report that we ran an off-label bill in Arizona, which basically allows for the free communication between pharmaceutical manufacturers and doctors, basically telling them about how they're using their drug and how they're seeing it being used effectively.

In fact, I spoke to a woman from Michigan about a month ago. Her name was Laura. And she was covered under the Federal Employee Health Benefits Plan. She has – she has – she has cancer. And she also knows, through genetic testing, that she has – that she has two genetic – can't think of the word – mutations – two genetic mutations that are similar to a lot of different kind of cancers that some researchers at an Ivy League medical research institute have been researching, and that their treatment is FDA approved, it's already been approved by the FDA for another particular kind of cancer. But they've been testing this treatment on cancers that appear in all parts of the body, but the thing that these cancers have in common are these same two genetic mutations.

Well, Laura's insurance rejected it. And it's been very difficult for her to get covered for this treatment, even though her doctor and the medical researchers at this Ivy League medical research institute believe that it would really help her, and possibly cure her. But she can't, because it's illegal, even though this is an approved treatment, it's illegal for them to tell the insurance company about this treatment that would be off-label for a different indication than it was approved for. So our legislation passed by chambers and was signed by Governor Ducey two weeks ago and is the first state in the nation that allows for the free exchange of communication between pharmaceutical companies and physicians. And so we are using state constitutions to develop the model legislation to promote liberty at the state level on health care.

MR. MOZENA: Speaking of liberty at the state level on health care, a question about what states, besides Washington, have deployed direct primary care as part of the Medicaid reforms. And I'll add on, are there any results coming out yet that look worthwhile, interesting, meaningful?

MS. LOPEZ-BAUMAN: So Qliance was the big player in Washington state. And their results have been a little bit mixed, but overall positive. And we've got I think two or three more states that have – that are now applying for permission to use direct primary care in their states. So and I guess what was it – I'm sorry, what was the –

MR. MOZENA: What are those states, if you don't mind?

MS. LOPEZ-BAUMAN: I believe that you've got – I believe it's Oklahoma. And I'm not thinking of the other one. And then you've also gotten –

MR. MOZENA: Tennessee, maybe.

Q: Tennessee.

MS. LOPEZ-BAUMAN: OK, maybe so.

And then – and then you've also got state employee health plans that are now looking at it. You've got New Jersey running a DPC pilot as well. So the – so it's still very early, but this is an innovation that if you're able to get around – wrap around essential health benefits that are required under – that have been typically required under the Medicaid program, there is a – there is very upside potential on saving a lot of money and actually increasing patient access to care, which is something that the General Accounting Office has been tracking. And we know that virtually every state does have difficulty in meeting those metrics under the – under the Medicaid program.

MR. MOZENA: On Medicaid, another segue, a lot of hospitals and other providers say that they need that Medicaid expansion money, because otherwise uncompensated care is killing them. And uncompensated care is always the monster under the bed when it comes to health care reform. Sort of for folks who can't participate in the market because they don't have the resources, how do we deal with that in such a way without just putting more people back on Medicaid?

MS. LOPEZ-BAUMAN: (Laughs.) So uncompensated care is one of the most interesting areas, because whenever you take a look at hospitals' financial disclosures and their income tax disclosures, you find that glossy educational materials, that look a lot more like marketing products, are actually counted and charity care. So hospitals are always crying poor. And some of them really do face a lot of financial difficulty due to uncompensated care. Meanwhile, others will, you know, be crying the same crocodile tears. Meanwhile, they have eight cranes building several new wings on their hospital. (Laughs.) So.

So the issue of uncompensated care is very complicated because we don't actually have a good baseline of knowing exactly what uncompensated care means. And they use their rack rate as – you know, as their own measurement. So, in other words, if you go into a department store and you see the tag, that's basically the price that they're telling us that the care – that that's the

actual cost, when it's not. We know that, you know, you wait for your coupon in the mail or you wait for a sale and it's automatically 25 percent off.

So there have been – there have been some mixed studies that have been coming out recently that are basically discussing this issue of how, surprise, the ACA is not actually going to be fixing the uncompensated care issue for hospitals. And here's – you know, if you – and if you just step back and think about it a little bit, they basically say that Medicaid reimbursement doesn't cover their costs. But you expand Medicaid reimbursement for a bigger population, and you know that that population is going to see – going to use their services more – and, surprise, you know, they're still making the same claim.

Under the – under the current negotiations that are going on with the ACA right now, we do know that the last incarnation that we saw, which may or may not be the final – the final package that is actually signed by the president, but that uncompensated care funds would still – would go to states that did not expand Medicaid while the Medicaid expansion money would continue to flow to the hospitals and expansion states. But I do think that ultimately – and I don't think this is something that's going to change anytime soon – but I think ultimately we're going to need to go to a different model, because this model is terribly unfair to – in many cases, to rural hospitals. It's unfair to smaller hospitals. And it's not a transparent system by any stretch. And so we've really got to go back to the drawing board on how we treat this.

And I think that, you know, one of the big moves that you see in a lot of states is the move towards hospital price transparency. I think that that's – you know, that's not a terrible thing, but it's not actually solving the problem. I think that we need to empower patients more to actually go out and shop for care. Obviously, it's not possible in an ER situation, you know, if there's a traumatic event. But in other cases, it is possible. And Michigan is also in the good position where you don't have the same restrictions on establishing, for example, free market ERs or surgery centers, where a lot of that care can be delivered at a much lower price and, quite frankly, as academic literature shows over and over, at a much higher quality.

MR. MOZENA: Real quick follow up on that. You talked about restrictions on establishment certificate of need programs. What do you think of those?

MS. LOPEZ-BAUMAN: Oh. (Laughs.) So basically – you know, since we don't require a grocery store to go and ask their competitors for permission to open up a store across the street, we shouldn't require the same thing in health care. A lot of people will argue that health care is different, but it's really not. This was a – this was a system that was set in place many decades ago based on an outdated payment model that no longer exists. And yet, you still have players in the health care market who want government muscle to protect them from competition. We are in the year 2017. There is absolutely no need for these outdated laws. And we should really let the market decide.

MR. MOZENA: I'm shocked you would say that. Please, folks, if you have questions just hold them up over your head and my colleagues will grab them for you.

It's not a pure health care issue, but one of the things that's a policy issue, especially at the federal level, is the growth of the number of people on some form of long-term disability benefit. I've seen arguments that that's part of behind the growth in the opioid epidemic and other things. Have you looked at that topic, and how we address that?

MS. LOPEZ-BAUMAN: Sure. I focus primarily on health care, but over the years I've done a lot of work in a lot of different policy areas. So whenever you talk about disability, you've got to define which disability program because, like many government programs, there's more than one covering the same issue. But whenever you take a look at one of the things – one of – one of the unintended consequences of welfare reform was that you actually did move people to the disability rolls. And this has not only happened with middle aged adults who are – either have some physical limitations or who are basically just long-term unemployed, but it's also happening in the schools.

And we're seeing this more and more trending in some of the states. For kids, very sadly and unfortunately, are being encouraged to be, you know, disabled so that they can continue – their family can continue to draw down the higher disability payments for their families. And also, disability triggers automatic eligibility – categorical eligibility for other programs, such as – such as Medicaid. So this is a really important issue that has not yet reached a crisis level, but is an important one to address because if you're able to address this and fix it, you're able to impact a lot of other programs around, plus improve people's lives.

So one of the – one of the most interesting ways of addressing this would be through something that was in the Cures Act. The Cures Act, as many people know, addressed a lot of FDA changes and innovations. But one of the things it also did was it tacked on – they tacked on a bunch of different types – different types of legislation at the bottom of the bill. And I think it's in Title 21, where there's a pay after performance model that was part of the Cures Act. What this proposes to do it allows states, and actually community providers and all kinds of different players, to apply to the federal government – and it can be across agency – to develop pilot programs and models that would be paid for – basically you'd be reimbursed after you show success.

So, for example, in the area of foster care, you've got a lot of kids who don't graduate. And you're spending a whole lot of money. And this is really, you know, a huge government failure. So what you could do is you could have a model that pays once the kids graduate. You've got a lot of social service providers out here that are drawing down government money and not actually delivering on what they're supposed to be delivering. You could do the same thing with disability.

One of the other reforms too is – one of the other reforms too that you could do is you could theoretically apply to use – to use SSI money that would be a pilot program based on – you know, disability is – there's a threshold. But you – where if you're disabled, you get all the money. But there are actually people who are disabled who actually want to work, but maybe they can't work full time. You could have a lower threshold that would be a partial payment that would allow them, for example, to perhaps work remotely part time in a job – in a private sector job.



So there are opportunities for reform. This one is a very obscure one – the Cures Act, I think, Title 21, as I mentioned. But it is one that is worth looking at, because it is – that one would be a game changer, even though it was not noticed and a lot of people didn't write about it. You could address disability from a pilot program such as that. That can also be translated into a lot of other programs where you actually want the service provider to deliver, but they're not required to do so at this point.

MR. MOZENA: OK. This almost might be more of a question for the marketing guy than for the policy wonk, but we'll ask it to you anyways. People are used to prepaid health care. How do we convince them to take charge of their care – HSAs, high-deductible plans, all those sorts of things?

MS. LOPEZ-BAUMAN: So I think that one of the ways that you convince them is that you provide more options that are distinct and separate from employer-sponsored health care. So one of the possibilities down the road – this is more long-term thinking. And this is – these are – these are actually discussions that have been taking place in Washington when we've been talking about ACA repeal and replace. But one of them is that you would allow individuals to take the value of the open-ended, tax-free benefit that you get from your employer and deposit it into your own health savings account. That would be a huge step in the right direction.

I think that there's been a lot more interest lately in the idea that you don't have to have employer-sponsored health care. You can actually do it yourself. And the rise of things like health sharing ministries and direct primary care have really been, I think, some of the best examples of how you – of how you do that and how you get people to do that. So automatically now you have millions of people who are big advocates of this kind of approach that isn't traditional it's an innovation. It wasn't something – it wasn't an edict that was – that was deemed from Washington. This was something that happened to the market.

And so those are – that's probably the best way to do it, is just to have more and more people experiencing – having that daily experience with something that is not employer-sponsored health care. And you know, I really – when I talk to lawmakers, as I've been doing today, it really is astonishing to me, even though I've been doing this for a long time, how limited their experience is with some of these innovations that are happening. And in fact, I was even in D.C. recently talking to a group of doctors who didn't know about direct primary care. And they were astonished at the cost differentials, and actually very enthusiastic and excited about the possibility that they could get out of the administration burden that they now face.

MR. MOZENA: OK, last question, quick one. On a scale of one to 10, how optimistic are you that our health care system is going to look better in 10 years?

MS. LOPEZ-BAUMAN: So I'm extremely optimistic that some states will look better. So I would say a nine, but that's not across the board. That is in the states that are going to be the most innovative, that are going to protect free market health care, consumer-driven care, and actually go big with Medicaid reforms. And so I'm actually extremely, extremely optimistic. But I don't think it's going to come from Washington. And I don't think it's going to be in every

state. And I'm not afraid of that. I think we need the good examples in order to – in order to export those reforms to the remaining states that have not yet seen the light and adopted a free market, consumer-driven health care system.

MR. MOZENA: Excellent. Thank you very much. (Applause.)

Thank you, Naomi, for joining us today. Very much appreciate it.

I would like to thank the crew here at Troppo for the wonderful lunch.

I would like to thank, again, Auto-Owners Insurance, the series sponsor, for these events.

And we'd like to thank all of our supporters who make everything we do possible. It's important to have people out here talking about these kinds of ideas, because there's the opportunities. And if we don't grab onto them, nobody will.

If you are interested in these events – if this is your first time joining us, welcome and thank you very much for joining us. We do these on a regular basis. You can sign up for them. Kristin Anderson back there, our wonderful events manager, will be happy to take all the information you need and you can sign up for these events. The next one is on May 11<sup>th</sup>. And we have Mark Perry of our Board of Scholars, of the University of Michigan-Flint, and of the American Enterprise Institute, with the interestingly titled: Why Trump is Wrong About Trade. So that'll be fun. And Mark is awesome, having heard him speak a number of times. He's an economist that you can actually listen to at length.

We also have, and I would like to invite anyone who is able to make it on May 13<sup>th</sup>, the Detroit Children's Business Fair, which this is the second annual event that we are doing. It's a partnership that we do with Junior Achievement of Southeastern Michigan. And it is basically a lemonade stand on steroids for kids. We'll be having it at the Detroit Historical Museum in the Streets of Old Detroit Exhibit. And it is just a wonderful time where kids start up a business, they figure out what they're going to do, they make the products, they figure out the finances. My son did it last year and made \$50 net profit selling caramel corn and wanted to do it again this year, but unfortunately is not able to. But it is a – anybody who loves entrepreneurship, just watching these kids fall in love with it, it's a wonderful thing.

This event was streaming live on our Facebook page. We encourage all of you sign up for our social media and see everything that's going on. We're just back and forth with – chatting live with Chad Livengood at Crain's Detroit Business while I was sitting here about tax credit tomfoolery. And we thank you all for your time. We hope you found it worthwhile. And we'll be happy – we'll be around for a little while afterwards if anyone wants to chat. Thanks, folks.

(END)