Mackinac Center for Public Policy

Issues and Ideas Forum

"State-led Health Care Reforms"

Speaker:
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Health Care Policy Analyst, Washington Policy Center;
Author, *The Patient-Centered Solution: Our Health Care Crisis, How It Happened, and How We Can Fix It*

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Location: Radisson at the Capitol, Lansing, Michigan

Time: 12:00 p.m. EDT
Date: Wednesday, March 14, 2018

Transcript By
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MICHAEL VAN BEEK: Good afternoon. It just hit 12:00, so it is technically afternoon. Welcome to another Issues and Ideas Forum, hosted by the Mackinac Center. We want to begin by thanking one of our generous sponsors, Auto-Owners Insurance. They sponsor these events that we host in Lansing on a regular basis. So we thank them for their support.

Just a couple of housekeeping things before we get started. There will be a session of question and answers at the end of the presentation. If you have a question, please jot it down on one of the cars that's at your tables there, and one of my colleagues will come and pick that up. And then I'll ask questions to our speaker from your card. The reason we do that is because we're also – in addition to this meeting here tonight, we're also livestreaming this event. So that allows people viewing that – viewing this online to hear each question. And that livestream will be recorded and available on our website. So if you'd like to view this later or share it with a friend, you can get that at the Mackinac Center's website, which is at Mackinac.org.

So onto today's topic. Facing seemingly endless paralysis on health care reform from the federal government, a growing number of states are starting to consider reforms that they could enact to improve provision of health care for their residents. Although federal laws and rules typically dominate health care regulations, there are still several things that states can do themselves that would have the effect of lowering costs and increasing access for patients. And with us today we have an expert to speak about what some of those reforms are.

And his name is Dr. Roger Stark. He is the health care policy analyst at the Washington Policy Center and a retired physician. He is author of two books, including, "The Patient-Centered Solution: Our Health Care Crisis, How it Happened, and How We Can Fix It." Over a 12-month period in 2013 and 2014, Dr. Stark testified before three different congressional committees in Washington, D.C., regarding the Affordable Care Act. Dr. Stark graduated from the University of Nebraska's College of Medicine and was one of the cofounders of the open-heart surgery program at Overlake Hospital in Bellevue, Washington. He retired from private practice a few years ago and became actively involved in the hospital's foundation, serving as board chair and executive director.

Please join me in welcoming Dr. Stark. (Applause.)

ROGER STARK: Well, thanks very much, Mike. And thanks to the Mackinac Center for putting on this event – this luncheon event. Also, let me take this opportunity to thank each and every one of you for being interested in public policy, spending your luncheon with us here this afternoon. It seems that so many people in this country now receive their information from a soundbite, or from a Twitter account, or something like that. And my hat is really off to you folks for being interested in the issues as they apply to your community and to your state and to the nation.

One of my favorite humorists was Will Rogers. And Will has been quoted as saying: "I don't make political jokes. I just watch the government and report the facts." And that's basically what we do at the Washington Policy Center, at the Mackinac Center. We look at proposed legislation, we say how is this going to impact our community, what are the side

effects? If legislation has already been passed, we look at the legislation and we say, well, is this legislation meeting its goals? Is this what the architects designed this legislation to do? And that's kind of the task we have at think tanks.

We are state-based. The Washington Policy Center is state-based. But about 80-85 percent of what I do is actually at the federal level, simply because of Medicare, Medicaid, and now the Affordable Care Act and how that actually impacts state laws and members of our state and local communities. So what I want to do this afternoon actually is three things. First of all, a little bit of – historically of where the Affordable Care Act came from, what it's about. The second thing I want to do is what, within the confines, within the language of the Affordable Care Act can states actually do. And then the third thing I want to spend some time what – dealing with what states can actually do outside of het Affordable Care Act. What are other kinds of things that states can do to influence their health care policy to decrease costs and increase access for the citizens of their states?

So let's start out with another quote. This is probably the most famous quote associated with the ACA: "We have to pass the bill so you can find out what's in it." The ACA was probably the most complex pieces of legislation – social legislation ever passed in the history of this country. With amendments it runs to over 2,700 pages. And within the ACA, the language reads, the secretary shall, and that's over 1,400 times. And what that means is the secretary of Health and Human Services had a huge role in implementing the Affordable Care Act and then carrying out the Affordable Care Act.

Here's another famous quote from Jonathan Gruber, one of the – one of the architects of the Affordable Care Act: "Lack of transparency is a huge political advantage. The stupidity of the American voter was really critical to getting the Affordable Care Act passed." And he admitted this a couple years later. Remember, the ACA was passed along strict party lines. There were no Republicans that voted for the ACA in either the House or the U.S. Senate. And there were few Democrats actually in the U.S. house that voted against the Affordable Care Act.

And then finally – this is a famous quote from president – former President Obama: "I've got a pen and a phone, and I can use that pen to sign executive orders and take executive actions without Congress." And I think at the time President Obama was very frustrated with the lack of Congress to move on his proposed legislation. And this essentially set up the president for administrative actions outside of Congress to deal with health care reform. If we remember back last year, 2017, the United States House passed a piece of legislation in the summer – reform legislation. And at that time, there were four, five, or six potential bills floating around the United States Senate.

The critical issue was there were not really 51 votes to pass any Senate bill. And consequently, it looked like Congress was going to be unable last year, 2017, to pass meaningful health care reform. And that was sort of the impetus of this project that I'm going to present here this afternoon. Now, I'm almost embarrassed to tell you that I looked at those 1,400 passages in the ACA that says, the secretary shall. And you want to talk about boring. It's almost like, Stark, you need to get a life. But I actually looked at all 1,400 of them. And once you do, there are a couple things that come out.

The experience that we've had with the Affordable Care Act – remember the goals of the Affordable Care Act. That's kind of the way I like to look at this. It was going to reduce our health care costs. That was goal number one. Goal number two was to provide universal health insurance – in other words, increase access. The Affordable Care Act has not been able to do either of those things. I think everyone outside of the Medicaid program has seen their premiums go up. When the Affordable Care Act passed for one reason or another there were 50 million uninsured in this country, who had no health insurance.

To date, somewhere a little over 20 million people have found health insurance through the Affordable Care Act. And fully one half of those are in the expanded Medicaid program. In the state of Washington, 80 percent of people in the expanded – 80 percent of those with new insurance under the Affordable Care Act are actually in the expanded Medicaid program. And then, as I mentioned, Congress has been unable to pass meaningful health care reform. So that's kind of where we stand now with the Affordable Care Act. There is absolutely no question that the ACA has helped some people. Don't get me wrong. But it has come nowhere near the goals that the architect set when it passed in 2010.

Now, one thing about the current administration, different than the Obama administration, is they're very open to any kind of changes, innovations that the states can come up with. They have said on multiple occasions: We welcome these kinds of innovations coming from the states. They're encouraging creative solutions. Now, as I mentioned, there are these 1,400 passages, the secretary shall. If you actually drill down on those, there are basically very few things—very little leeway that the secretary or the administration has. The language of the ACA is pretty specific regarding those 1,400 passages, except for two areas. And those areas deal with waivers – state-applicable waivers.

Section 1332 deals with the sort of statewide state-based waivers. And Section 1115A deals with Medicaid waivers. So let's look at those for just a second here. Section 1332, there are some requirements – some stipulations in the ACA as far as states applying for these. And I've listed those here. First of all, they've got to be cost neutral. They can't increase the federal deficit or the federal debt. Interestingly enough, if a state is going to apply for a 1332 waiver, legislatures have to pass laws – it has to be in statute that the state is applying for that waiver. Obviously public input, it's important for any piece of legislation, but certainly for these waivers.

The health insurance that's offered through the waiver must be at least as comprehensive as the insurance plans offered or required in the ACA. It can cost no more than the exchange plans. And if you look at the total number of citizens in this state, the waiver and the waiver request has to ensure the same number as are already insured under the ACA. So what are some of the potential uses for these 1332 waivers? Well, first of all, refining – redefining essential health benefits. Now, as most of you are aware, the ACA has 10 essential health benefits within it. And these are for important things, don't get me wrong, major medical and so forth.

But a number of these are not applicable to everyone purchasing health insurance. For example, I can guarantee you I do not need obstetrical coverage. I might need mental health and alcohol rehabilitation, but I don't need obstetrical coverage. And yet, if I purchase a plan

through the exchange, I'm paying for that essential health benefit. So those are the kinds of things that potentially a 13332 waiver could get around.

Changing your insurance market. Changing the products that an insurance company offers. And what I mean by that is offering more health savings accounts, emphasizing those kinds of tools, emphasizing high-deductible catastrophic kinds of benefits. And then two plans or two waivers that states are already looking at, high-risk pools and reinsurance. Now, briefly, what they can do is they can take your high-cost, high-user patients out of your general, individual, and small-group markets, and they can provide the financing and the access that that relatively small group of patients need. And they can leave other members in the individual and small group markets in a situation where they're not paying as much for their insurance premiums.

We tried to do this in the state of Washington this year with a reinsurance program. It was unsuccessful. The legislation was unsuccessful simply because of the funding mechanism. And there are two or three or four different ways to fund this, but each method of funding has its own constituency. And that can become a political issue. But these are the kinds of things that states are looking at within the language of the Affordable Care Act.

Now, 1115A waivers – 1115 waivers in the Medicaid program have been around for over 50 years. And states have applied and have received hundreds of 1115 waivers over the last 50-some years. What the ACA does is it provides billions of dollars for states to try innovative pilot programs in their Medicaid expansion and their existing Medicaid program as well. To date, there have been sort of four broad categories dealing with 1115A waivers. Probably the most popular is a delivery system change. And what I mean by that is going from a fee for service kind of model into a health maintenance or accountable care model.

That's what we did in the state of Washington. We applied for a waiver in 1115. It was granted in 2016. We placed all of our Medicaid patients – or almost 90 percent of our Medicaid patients into some sort of an accountable care organization plan rather than a fee for service plan. States have also used these to modify their long-term care program. They've also used them in behavioral and mental health. And then they've also tried to expand Medicaid in fairly creative ways using these 1115A waivers.

So potentially what else could you do? Well, you could prioritize your Medicaid dollars to those that truly need it. When Medicaid began in 1965, it was literally – it was a government-funded, taxpayer-funded safety net for children of low-income families. And over the last 53 years, it has changed dramatically now such that one in every Americans are in the Medicaid program. In my state of Washington, one of every four in the state of Washington are in Medicaid. And half the kids in Washington state are in the Medicaid program. So we need to drop this back to a true safety net program. We can't afford to expand it the way it is now. Last year, we spent about $545 billion on Medicaid. By the year 2020 it's estimated we're going to be spending over $700 billion that year in Medicaid. Something's got to be done.

Other things that states are looking at. Work requirement. There are now three states that have applied for 1115A waivers for a work requirement and have received it. Premium

charges, drug testing, limiting the duration – the amount of time that a person can be in Medicaid. In other words, it should be a bridge to individual insurance or to employer insurance. It shouldn't be an insurance plan for someone when they turn 18 and then they go into Medicaid when they – or Medicare when they turn 65. And then some states have actually talked about combining 1115A waivers with 1332 waivers and changing their entire health care delivery system. This is one of the ways that California potentially could arrive at a single payer system, is through a combination of these two wavier programs.

So the third thing we want to discuss this afternoon are what are specific actions that states can take above and beyond the Affordable Care Act. These are things that states can do right now. And options for states that have already expanded Medicaid, as has Michigan, as has Washington. What we did in Washington last year – and this was a bipartisan effort, actually – we passed legislation that said in 2010 state taxpayers are not going to be on the hook for any more than 10 percent of the costs of the expanded Medicaid.

Now, as probably everybody in this room understand, when Medicaid expansion began in 2014, the federal government picked up 100 percent of the cost. They did that for three years. And then starting 2017, 2018, 2019, that percent gradually changed from 100 – it gradually drops down to 90 percent in 2020 and states have to pick up 10 percent of the costs of Medicaid in the expansion Medicaid. So states can limit that to 10 percent forever. The other option is to pick a target year, like 2020 or 2021, figure out what the state spent during that year, and then pass legislation that says: Our state taxpayers are not going to be responsible for any more than that fixed amount of money.

So that's two things that states can do, really, to put at least a partial lid on the expanded Medicaid costs. Another thing states can look at is certificate of need. Now, this may be a topic that some of you are not familiar with. Back in the late '70s, early 1980s, the federal government looked around and said: We're paying for all this health care through Medicare and Medicaid. And so let's pass a law that states can't expand their hospitals, their kidney dialysis centers, and their clinics without government approval. They needed a certificate of need for that community.

Within about four or five years, the federal government found it wasn't decreasing cost and it was certainly decreasing access for patients. And the federal government – Congress actually repealed that law. So we've now had 30, 40 years' experience on a state-by-state level. States passed individual laws at the same time. And over a dozen of them have repealed those laws, again because they don't decrease costs but they do decrease access for patients. So repealing your C of N law is one thing to get around these two issues.

Tort reform, this is a very controversial thing. States have done it, and states have been successful at doing it. The data – if you look at research based on how much tort costs are to our overall health care system the research is really – it's all over the map. It could be as low as 2 or 3 percent. It could be as high as 20 percent. What we can look at are court costs, attorneys' fees, things like that. What's really hard to get a handle on is defensive medicine and the cost that we're spending – that providers spend in defensive medicine to order that extra test or that extra procedure and so forth, and how much of those costs actually add up.

Now, states – two examples are California and Texas. And what they have done is they put reasonable limits on non-economic damages – in other words, pain and suffering. There's absolutely no one that wants to limit economic damages for any kind of a malpractice situation, but if you put a limit – a reasonable limit on these pie in the sky jury awards as far as pain and suffering is concerned, that's a very good way to keep premiums – malpractice premium costs down, and to keep providers in your state.

Providers – especially in Texas, for example. This was about 18, 20 years ago. Doctors down in Texas were fleeing the state, simply because of the tort situation down there. they passed meaningful tort reform. And now they have plenty of doctors and nurses in the state. As I mentioned, the experience in California and Texas absolutely suggests that tort reform does work in holding down costs and, again, increasing access.

Then decrease the number of benefits. We've already talked about that with 1332 waivers. That's dealing with the Affordable Care Act. But every state has legislated a series of benefit mandates that are required in every insurance plan sold. For example, the state of Washington has 58 benefit mandates sort of above and beyond the 10 in the ACA. Again, they're for really good things a lot. But I can guarantee you, no woman in this room needs prostate screening in her insurance plan. And yet, you're paying for it. The men in this room probably don't need obstetrical coverage, and yet we're paying for it.

Each one of these – each one of these benefits – and they're for great things – but each one of these benefits adds somewhere between ½ to 2 to 2 ½ percent of the overall cost to the insurance premiums. So, again, this is something you can do at the state level. Redefine what essential benefit actually means. And then greater use of health savings accounts and high deductible plans. In other words, if you have a catastrophic plan that covers major medical and covers most medical interventions or medical procedures, that potentially could go a long way to getting around this issue with essential health benefits.

Now, some of you may realize that about a month ago the state of Idaho applied through a 1332 waiver to get around the essential health benefits in the Affordable Care Act. And they were turned down last week by Health and Human Services. They were sort of turned down in a wink-wink fashion. And they said: Come back to us with a different kind of plan. And they're going to use a different kind of plan – limited-duration, short-term kinds of insurance, I think, to get around the 10 essential health benefits in the ACA.

Association health plans. What are they? You may or may not have heard of them. What association health plans allow individuals and small groups, employers with a small number of employees – they allow – association health plans allow these individuals to band together and form a large group. Now, the Trump administration talks about buying insurance across state lines. And of course, for years we've heard about that. To me, that simply is code for increasing choice and increasing competition.

And one way to do that – to purchase across state lines is through the use of these association health plans. So what's the big deal? You put a bunch of individuals together, a

bunch of small-group employers together. Well, they form a large group and they fall outside of the Affordable Care Act law, and they become part of the Taft-Hartley or the ERISA laws that large employers now enjoy. And so that's one thing. We're promoting these in the state of Washington. We have over 600,000 individuals in the state of Washington who are in association health plans. And we have found that they are very, very effective and they work very well. So that's another thing that can be done.

Telemedicine. Telemedicine, again, it may be one of those things you've heard about, you don't exactly understand it. It is basically Skyping or talking on the phone to a provider without actually sitting in her or his office. In rural, central, and eastern Washington telemedicine is growing by leaps and bounds. I'm sure there are rural parts of Michigan that could benefit from this as well. It uses, obviously, 21st century technology through Skype and those kinds of programs. It can increase patient access and obviously decrease patient costs if you're not getting in your car, driving to your doctor, sometimes dozens, hundreds of miles away, to access care.

Now, with telemedicine, licensing is a real issue. And what we have found is that potentially the most effective way to use telemedicine is if the point of contact or the location of care is based on where the physician is, not necessarily where the patient is. So think about that for a minute. It means that if a doctor in Idaho wants to see a patient in Michigan, his Idaho license is going to be good enough for him to take care and treat that patient in Michigan, and vice versa. So licensing is an issue here. It may need – it may require one state legislature to work with another state legislature. But it is absolutely doable. And, again, more access, decreasing costs.

Decreasing waste, fraud, and abuse in the Medicaid program. And, again, the data get kind of squishy here depending on what research you actually look at. Waste, fraud, and abuse in any government program may be as high as 25 or 30 percent. And I can't say that it's that high in Washington state. It's probably not that high in Michigan. But I don't know. Now, interestingly enough, the state of Illinois saved millions of dollars in the Medicaid program by essentially doing two things.

What they did was frequent enrollment assessments. And by frequent, I mean by at least twice a year. Quarterly is probably even better. You can't do it once a year, every other year, every third year. You've got to make it frequent because people move in and out of Medicaid eligibility. So that's number one thing that has to be done. And then the second thing that they found in Illinois was it was not adequate to have this done in-house. Too many things were missed. And so they got an outside organization to actually do these assessments and they found, again, they could save millions of dollars.

Home health care I think is one important thing that we're going to see grow and grow in this – in this country. It can certainly decrease costs and decrease overhead if a person can be taken care of in their home rather than in a clinic or rather than in a hospital. And we know from multiple studies that patient satisfaction is high, and much higher than being institutionalized, or getting in a car and driving to a clinic, if they can be taken care of in their home. So to get there probably most states are going to need to liberalize their licensing requirements. And then a

reasonable payment model is going to need to be decided upon, simply to get providers to be willing to do this and go into patients' homes, and to take care of them in the home setting.

Capping Medicaid enrollment, tightening the eligibility requirements. We referred to that just a minute ago. In other words, getting Medicaid back to a safety net. It shouldn't be an end insurance product for the millions of people that are in there now. A couple of ways to do that. Decreased covered services. Now, it covers so many things – eyewear in certain states, things like that. Decreasing provider payments. I am absolutely positively not in favor of that, but that is one thing that states turn to as a first line of defense is just driving down provider payments. Tragically, what that does is it decreases access for our Medicaid patients. Fewer and fewer providers are willing to take Medicaid patients at what Medicaid is willing to reimburse them. And then that leads to long waits and so forth.

System changes. Like I told you, the state of Washington went from fee for service to an accountable care organization. Again, this is one of the things that I am not in favor of. I think accountable care organizations, there's no question that they can control costs. Unfortunately, tragically, they do it through a gatekeeper system, where a primary care doc or a family doctor sees a patient and decides whether they need an x-ray, whether they need those medications, whether they need that procedures. There's no question it can save money. But as far as providing the best care for every individual patient, I'm not sure it does that at all. Work requirements, premium charges, limiting the time in the programs, drug testing, and then we've talked about waste, fraud and abuse. This are all things that are potential. And these are all things basically that states are now trying.

Reviewing scope of practice and licensing laws. And this is a huge political football. Special interest groups – every year we have scope of practice laws in Olympia. And I'm sure you have them here in Lansing as well. At some point, though, we have to face up to this looming physician and nurse shortage that we're facing state by state, and that we're also facing in the nation. So I think what we need to do is look at our licensing laws, relaxing barriers for non-M.D. and non-R.N. providers, and then relaxing licensing and recertification laws in general – especially recertification laws. They definitely add to the cost of health care. And there's little evidence that they actually provide better care on a patient by patient basis.

And encouraging direct primary care. And, again, this may be an expression that you folks haven't heard of. A few years ago this began, and it was called concierge medicine. And it was just for the carriage trade. It was just for the very wealthy individuals in the country. And yet, it doesn't have to be. Direct primary care essentially provides 24/7 family practice of primary care kinds of medicine. And what we found in the Puget Sound area, in the Seattle area, there was an organization that set up direct primary care for our Medicaid population. Interestingly enough, the means-tested and they charged somewhere between $29 to $69 a month for low-income individuals to access primary care 24/7.

And the model was very successful. The organization, it was called Qliance actually went out of business last year simply because they over expanded too quickly into communities that didn't – that were not ready for direct primary care. But, again, this is something that your state legislature can encourage and can pass laws dealing with.

And then if you haven't already, unlike Michigan, unlike Washington, resist Medicaid expansion. And this is an example of what Governor LePage in Maine has done. There was an initiative in Maine, let's expand Medicaid. The state legislature voted to expand Medicaid. And yet, Governor LePage said, OK, I'm adamantly opposed to it. But if we are going to expand Medicaid, these are the criteria. You can't raise taxes on businesses and individuals. You can't tap into the state's rainy-day fund. And you can't use one-time budget gimmicks. Now, I'm not sure how successful he's been, but that's the way he set the program up. And then finally, aggressively pursuing the waivers that we talked about, the 1332 and 1115A waivers.

So in conclusion, basically, states can take reform action. There's just no question about it. The federal government, except for working around the periphery of health reform, I'm not sure they're going to be successful. If we're going to do it, the current federal administration is more than willing to look at these things. After 2020, I'm not sure. But I think we have a window here of another few years where states can really pick up the ball, run with it, and do what's right for your state and the citizens of your state.

So thanks very much. Again, thanks very much for attending. And we can open it up for question and answer, I think.

MR. VAN BEEK: Yeah, absolutely. Thanks, Roger. And if you have questions, jot them down on the cards at your table, and then my colleagues will come pick them up. Since I have the microphone, I'll ask – I'll ask one of my own.

I was interested a lot in the association health plans. What do states need to do to get that balling rolling and make those an option for employers?

DR. STARK: I think there are a couple of things. First of all, I think you can put in statute that association health plans are acceptable, and it's an insurance product that can be used in your state. The other thing that needs to be done, which was the major hurdle that we had in the state of Washington, was making sure that your insurance commissioner doesn't get too heavily involved in establishing these AHPs. In other words, let the free market do it. We had an insurance commissioner basically on two occasions took our AHPs to court. And on both occasions, he lost the lawsuit. These are definable insurance products. So I think those are the things that you need to be aware of.

MR. VAN BEEK: OK. Very good. Here's a question from the audience: What is your opinion of interstate medical compacts? These are often cited as a best path to increase telemedicine?

DR. STARK: Yeah. I think that's a good idea. It gets kind of complex and cumbersome, though, if every state has to pass their own individual law that says: We're going to form this compact with – for example, with Oregon. And then we're going to do another compact with Idaho, and so forth. I think that really gets kind of cumbersome. I think states do need to talk to each other, however, it telemedicine is going to work outside of the confines – the

geographic confines of each individual state. So it really depends on how those compacts are set up and how complex and cumbersome they are, yeah.

MR. VAN BEEK: Here's a – joining together a couple questions we have here related to helping to drive down costs. What do you think the role of consumers is going to be in reforming health care at the state level and at the federal level? You know, I think I was just reading recently that the number of people using high-deductible plans, HSAs, you know, has grown tenfold in ten years. And then also, you know, people are contributing more and more to the cost of their employer-sponsored plans. What's your take on how that might help drive change?

DR. STARK: Yeah. This question hits the nail right on the head. This is the fundamental problem that we have with our health care delivery system. It's the cost, obviously, but then you have to ask yourself, what is driving the cost? And the thing that's driving the cost in our health care delivery system is the fact that 85 percent of health care in this country is paid for by someone else – either our employers or the government – federal government or state government. This question goes right to the point, though. If we're going to decrease costs, if we're going to ensure that the most – that the greatest number of people have access to health care, we are going to have to get away from this third-party payer model. We're going to have to give patients more control over their health care dollars, their health care decisions, and less control by the government – whether it's federal or whether it's state.

So, yeah, we're starting to see that a little bit with high deductible plans, health savings accounts, and so forth. But what we need is a true consumer movement in this country. And that's going to require a number of things. That's going to require on the provider side more transparency, more price transparency. It's going to provide – it's going to mean reform to the insurance industry, allowing the insurance companies to offer us the kind of products that we want, that we need, that we can use, and so forth. So, yeah, I think we're starting to see that. But it's going to take seismic changes to get where we really need to be.

MR. VAN BEEK: So that's on the consumer side. You talked a little bit about this with telemedicine. But what's your view on the role of – that technology might play in innovation in helping to reduce health care costs?

DR. STARK: Yeah. That's another great question. The simple answer is I don't know. But I will tell you this was, like, 1986. I had one of the first cellphones that was available commercially. So that sucker was about this big. It had a handle on it so it was portable, right? And the reception was crappy. And I paid, like, $500 for it, something like that. So I go to Costco. And for a plan I got this, 49 bucks. And I can not only talk on this, but I can answer email, I can surf the web, I can do all kinds of stuff. I'll tell you, it wasn't government directing the high-tech segment of our economy that got from the original cellphone to this. So I think technology is going to be one of the answers. I don't know what's out there. But if we let the free market work, we're going to have all kinds of tremendous things that are going to help us and – live longer and live better.

MR. VAN BEEK: It sounded like a lot of the waivers and other reforms that states are considering deal with eligibility requirements for people on these – on ACA plans and Medicaid expansion plans. What about reforms to utilization rates? And how – can states approach it from that perspective rather than the eligibility perspective?

DR. STARK: Boy, that's really tough. I mean, that's like putting access controls, or something like that. I don't think that's the right approach. Having said that, if we look at other countries that have universal health insurance – whether they're single payer or not – I mean, one of the ways they hold costs down is through rationing. And there are a number of ways you can ration health care. One of them is with waiting lists. And that's what happens in Canada, in our neighbors to the north. So I'm not exactly in favor of that at all. I think that's the wrong direction to go. There's no question we can decrease health care costs if we ration health care. But I don't think that's what we want to do in this country. And I don't think it would be acceptable.

MR. VAN BEEK: Can you provide some more details about certain states that have done some of these reforms that you've talked about? You know, what are some good examples to look to as Michigan policymakers might start to think about some of these ideas?

DR. STARK: Well, one of the – one of the classic – first of all, let me – let me start out by saying that we don't have a lot of time on a lot of these Medicaid reform waivers. We don't have a lot of time on the 1332 waiver. So we don't really know. One good example is the Illinois example with eliminating waste, fraud – or, decreasing waste, fraud and abuse in their Medicaid program. We do know year over year they were – they were successful at doing that. As far as a work requirement, adding a premium in the Medicaid program, I'm not sure how successful they are.

In the state of Washington, we went, like I mentioned, from a fee for service to a health maintenance organization type model, delivery system model. It's really too early to know if we're controlling costs or even increasing access to health care. So unfortunately, I don't have the data on that yet. It's just too early to know, basically, for most of it.

MR. VAN BEEK: OK. What's your opinion on reimbursement – changes to reimbursement rates. I think you touched on it a little bit in the presentation, but things like reference-based pricing. And I'm not sure exactly what this means – case rates? I don't know what that means. Maybe you do.

DR. STARK: Yeah. There are a whole bunch of ways that you can figure out how to pay for providers. And the critical thing to understand is the less you pay providers, the worse access becomes for whatever group you're providing money for. I don't know about Michigan. In the state of Washington, Medicare reimburses about 70 percent what private insurance pays. And in communities like Seattle, what we're seeing is decreased access for our Medicare patients. Medicaid reimburses about 40 percent of what private insurance pays. And it's a statewide issue now in the Medicaid program, where docs limit the number of patients they see. Again, decreasing access for those patient groups.

So I think any kind of provider model, you've got to be very, very careful about how you do it. Going back to consumerism, think about this for a minute. We need price transparency on the provider part. But what, at the end of the day, we want is we want our providers to compete not only on quality, but also on cost. What I mean by that is if somebody can do an MRI for $300 rather than the $1,000 that's charged down the street, well, let's know that and let's go use the MRI that costs $300. And if you're spending your own money, you're going to find those things out. And you're going to make those kinds of decisions.

I get in front of audiences and people say, well, listen, Stark. You're a doc. You know all this medicine stuff. I don't know anything about health care. Believe me, Americans are the best consumers in the world and you will figure this out – with second, third opinions, with the internet talking – with the internet, talking to your neighbors and so forth. You can figure out health care. You can do it. You figure out how to put food on the table. You figure out how to buy automobiles and washing machines. Yeah, health care's different. It's more personal. I understand all that. But believe me, folks, you can figure it out.

MR. VAN BEEK: What about direct primary care? Is that – is that something that really could be become mainstream, become widely used? Or is it going to remain sort of niche field?

DR. STARK: Yeah, that's another good question. It's niche right now, there's no question about it, but it absolutely, positively could become mainstream. Again, direct primary care is really the free market, guys. It's where individuals are paying out of their pocket to get 24/7 primary care. You still need a major medical insurance policy, but you think about it. You're spending your own dollars. And you're making a decision, is it worth those number of dollars so that I have access to my primary care doc 24/7? And I think we are going to see it grow and grow. And, again, going back to the Puget Sound analogy, or experience, it's not just for the wealthy. It's for all socioeconomic classes. We can all – we can all use it.

MR. VAN BEEK: And what are some of the prices that people might pay for direct primary care plans that current exist?

DR. STARK: Well, in our area – like the Medicaid example was $29 to $69 a month, something like that. I think other at the top end, $100 to $200 a month, I would say, something like that. I don't know. I haven't looked at that recently, but that's kind of ball park range, I guess.

MR. VAN BEEK: Looking at how Byzantine and complex the federal health care regulations are, there's a certain appeal about Bernie Sanders' idea of just expanding Medicaid and making it available for everyone. And it's just one program that covers everybody. What do you think about that?

DR. STARK: I think that's a terrible idea. I think – I mean, I've fought my entire career against something like that. Simply because of the cost. Bernie Sanders' original plan when he was running for office was going to add something like $14 trillion to the federal debt over the first 10 years. It – we can't afford it, number one. And number two, who would you rather have make your health care decisions – you and your family or the Jonathan Grubers of the world and

Ezekiel Emanuels and the Bernie Sanders of the world? I would much rather have you as individuals making your own health care decisions. And we're not going to wind up with Medicare for All. It's going to look like Medicaid for all, is basically what it's – what it's going to look like. It truly is not going to be a Medicare for All kind of – kind of program.

MR. VAN BEEK: Can you provide some more details on what is happening at the federal level with regards to reform? There's been packages in the House and the Senate. What's the current status? And how might we keep that in mind as states consider making their own changes?

DR. STARK: Well, the first big thing, of course, was the 2018 tax reform bill. What that tax reform bill actually did was it eliminated the tax penalty for not having health insurance. So basically, it eliminated the individual mandate, which is one of the building blocks of the Affordable Care Act, requiring everyone to have health insurance. So that's number one. And that is probably the most meaningful reform that this Congress is going – is going to do. At the administrative level, they've done a couple of things. One, most recently, they've expanded the use of these short-term, limited-duration health insurance plans. They were originally set up as a – as a bridge from employer insurance to Medicare, or from one employer to another employer. So people could use these on a limited basis.

The Obama administration set a 30-day limit on them. The Trump administration has set 364 days – almost a year, in other words – to use these kinds of plans. The federal government has also started to push association health plans. So we are seeing that. There are still at least two bills in the United States Senate – Graham-Cassidy and I can't remember the other one. But essentially what they do is they shore up the exchanges. They shore up the subsidies in the exchanges. They provide billions more in taxpayer dollars to help offset this premium increase that we're seeing in the exchanges. And so I'm very suspect about those bills. Obviously 2018's an election year. I think potentially that the United States Senate would go for one of these bills. I'm not sure about the House. There's a huge conservative movement, as you know, in the House. They may or may not go for this. But the legislation currently being proposed looks like it doesn't do anything to reform the ACA. It essentially props it up.

MR. VAN BEEK: What's the constitutional justification or rationale for the federal government getting involved in health care markets at the state level to begin with? Is this not just a – is this a state issue? And has it always been – has the federal government always sort of been involved at this – at this level? How did that evolve over time?

DR. STARK: Well, again, historically the short answer is no. It hasn't always been. I mean, when we started in this country, the American public was adamantly opposed to any kind of nationalized, socialized medicine. But there were certain areas that they understood – like public health, like the VA system, things like that, that by tradition the American public has been in support of. The turn of the 20th century was – actually, there was a socialist movement throughout the world. Germany socialized their health care in the 1880s. And there was a movement – Teddy Roosevelt actually ran – one of his planks on his platform was nationalized health care. And yet, the American public said no, no, no, no. Until approximately – well, the late '40s, really.

Part of – part of the New Deal included nationalized health care. The American public revolted. They said, no way. And yet, FDR really, really wanted Social Security. So he said, OK, I'll back off on health care, and we'll do Social Security, and we'll wait. Truman was in favor of nationalized health care. And then in the late '40s, early '50s, a law was passed – Congress passed a law called the Hill-Burton Act. And what that did is it provided a bunch of money, millions of dollars at the time, for communities to build hospitals. But the other side of the coin was hospitals could not reject any patient, theoretically. They had to take all-comers.

And that was really sort of the first step – the first step of government really being involved nationwide in our health care delivery system. And then obviously in 1965 they got completely entrenched in health care, with the passage of Medicare, Medicaid, and then the Affordable Care Act in 2010. So, no, it's not always been that way.

I'll also say one other really important historic date is 1943, because that's when employers got involved in the health care delivery system. And that came about simply because of the wage and price controls during World War II. The federal government said: You can't – you can't compete for new employees on the basis of giving them more money. But you can provide them with benefits, specifically health care benefits. And you can deduct those health care benefits from your company income tax. And that was the beginning, really, of the third-party payer model in this country. That's when employers got involved.

And if you go into any community today and you say: Should employers provide health care benefits? I guarantee you, nine out of 10 people will say, absolutely, simply because we've now had, what, two, three, four generations of people who've grown up under that. What we need to do is allow individuals to take that same individual tax deduction that companies can and get away from this employer model. Half of the people in this country have employer-paid health insurance, 155 million people last count. And so, again, just parenthetically, if you go to Medicare for All, you're going to dump 155 million people into a government program. It's third-party payer, but it's going to be government rather than the employer program. And so there's going to be a huge revolt along that way. But the short answer is, no, the government's not always been involved.

MR. VAN BEEK: Well, very good. That's all the questions we have. So I'll wrap us up. Thanks very much for your presentation today. I wanted to just remind everybody that we host these events on a regular basis in Lansing. So if you want to learn more about upcoming events, just go to our website, Mackinac.org, and you can see a link there for upcoming events that we have. So thanks, again, for coming and for your participation and hope you have a great rest of your day.

DR. STARK: Great. Thanks. Let me also say that a copy of our publication, the stuff we've just talked about, is on the back table, if you want to take an extra copy. And, again, I'd like to thank you all for attending this afternoon as well. Thanks so much. (Applause.)

(END)